STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

JULY 14, 2015
10:30 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

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

II. ADOPTION OF JUNE 9, 2015 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEMS

i. **KEY UPDATES FROM 2015 NEW YORK STATE LEGISLATIVE SESSION**
WENDY SAUNDERS, ASSISTANT VICE PRESIDENT, OFFICE OF INTERGOVERNMENTAL RELATIONS

ii. **IDA G. ISRAEL COMMUNITY HEALTH CENTER UPDATE PRESENTATION**
DANIEL COLLINS, SENIOR ASSOCIATE DIRECTOR OF FACILITIES, CONEY ISLAND HOSPITAL

V. OLD BUSINESS

VI. NEW BUSINESS

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

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

JUNE 9, 2015

The meeting of the Strategic Planning Committee of the Board of Directors was held on June 9, 2015 in HHC's Board Room, which is located at 125 Worth Street with Ms. Josephine Bolus, NP-BC, presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, NP-BC, Chairperson of the Committee
Ram Raju, M.D.
Gordon J. Campbell, Acting Chair of the Board
Anna Kril
Robert F. Nolan
Bernard Rosen

OTHER ATTENDEES

N. Berlinger, Ph.D., Research Scholar, The Hastings Center
C. Calhoon, MPH, Director of Health Advocacy, The New York Immigration Coalition
M. Dolan, Senior Assistant Director, DC 37
J. DeGeorge, Analyst, New York State Comptroller
M. Gusmano, The Hastings Center
E. Kelly, Analyst, New York City Independent Budget Office
K. Raffaele, Analyst, Office of Management and Budget

HHC STAFF

S. Abbott, Assistant Director, Corporate Planning Services
P. Albertson, Senior Assistant Vice President, Operations
C. Barron, Medical Director, Bellevue Hospital Center
C. Barrow, Associate Director, Lincoln Medical and Mental Health Center

M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
D. Cates, Chief of Staff, Office of the Chairman of the Board of Directors
E. Davis, Senior Associate Director, World Trade Center Environmental Health Center
C. Dunn, Senior Director, Office of Communications and Marketing
S. Fass, Assistant Vice President, Corporate Planning Services
D. Green, Chief Operating Officer, Queens Hospital Center
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
L. Isaac, Assistant Director, Corporate Planning Services
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
D. Lee, Intern, Office of the President
N. Link, MD, Medical Director, Bellevue Hospital Center
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman of the Board of Directors
K. Madej, Director of Marketing, Office of Communications and Marketing
A. Martin, Executive Vice President and Chief Operating Officer, Office of the President
K. McGrath, Senior Director, Office of Communications and Marketing
I. Michaels, Director, Office of Communications and Marketing
T. Miles, Executive Director, World Trade Center Environmental Health Center
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
C. Pean, Special Project Manager, Corporate Planning Services
S. Penn, Senior Director, World Trade Center Environmental Health Center
S. Ritzel, Associate Director, Kings County Hospital Center
L. Robinson, Analyst, World Trade Center Environmental Health Center
M. Roman, Senior Director, Medical & Professional Affairs
S. Russo, Senior Vice President, Office of Legal Affairs
L. Sainbert, Assistant Director, Office of the Chairman of the Board of Directors
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
D. Thornhill, Associate Executive Director, Harlem Hospital Center
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

The Strategic Planning Committee Chairperson, Ms. Josephine Bolus, NP-BC, called the meeting of the Strategic Planning Committee to order at 10:35 A.M. The minutes of the May 12, 2015 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

Federal Update

Sustainable Growth Rate (SGR) Passed by Congress and Signed into Law

Ms. Brown reported that, on April 17, 2015, Congress had passed and President Obama had signed a repeal of the Medicare Sustainable Growth Rate (SGR). Ms. Brown explained that the new law would postpone the start of the Medicaid Disproportionate Share Hospital (DSH) funding cuts for one year or until 2018; but it would also extend and increase DSH cuts through 2025. Ms. Brown informed the Committee that the estimated cost for the "Doc Fix" was $214 billion over the next ten years. A temporary fix was instituted over the last decade to limit Medicare program physician payments. Congress delayed the reduction every year to shield physicians from having to incur significant cuts in their payments and to thwart physicians' retreat from the Medicare program. The issue became so large that it needed to be fixed. HR.2 is the 'permanent fix'. The 'pay fors' are from other sources of funding that would not significantly impact HHC.

Mr. Nolan commented that it appeared that a large number of physicians were leaving the Medicare program. He asked if a change in Congress would push those physicians to return to the Medicare program. Ms. Brown responded that there had been a significant loss of physicians who participate both in the Medicare and Medicaid programs. The loss is because many physicians are retiring and are not being replaced, particularly general practitioners; and young physicians are going into specialties. With the "permanent fix' the goal is to lessen the exodus.

Mr. Nolan asked when the new law would take effect. Ms. Brown responded that the new law would be effective as of October 1, 2015, which is the start of the federal fiscal year. Ms. Brown emphasized that the DSH cuts that were slated to take effect in 2017 would be moved to 2018. The originally scheduled 2017 DSH reductions for HHC could have amounted to $181 million. However, in shifting the start of the DSH cuts to 2018, the impact to HHC is estimated to be the following:

- Of the $2 billon national cut in **2018**, HHC's loss could go up to **$578** million
- Of the $3 billion national cut in **2019**, HHC's loss could go up to **$785** million
- Of the $4 billion national cut in **2020,** HHC's loss could go up to **$800** million
- Of the $5 billion national cut in **2021**, HHC's loss could go up to **$817** million
- Of the $6 billion national cut in **2022**, HHC's loss could go up to **$833** million
- Of the $7 billion national cut in **2023**, HHC's loss could go up to **$850** million
- Of the $8 billion national cut in **2024**, HHC's loss could go up to **$925** million
- Of the $8 billion national cut in **2025**, HHC's loss could go up to **$925** million

Ms. Brown explained that half of the projected losses would be federal and the other half local. The idea of half of $578 million in 2018 is overwhelming. Ms. Brown reminded the Committee that the assumptions on which the DSH cuts were originally conceived, as defined in the Affordable Care Act, were that there would

be a significant number of individuals who would become insured and that safety net hospitals would need less DSH funding as a result. She also reminded the Committee that, because DSH funding was provided to hospitals that serve a disproportionate share of uninsured and low-income individuals, those DSH hospitals would benefit from the growth in the number of insured individuals. There are some DSH funded hospitals in some parts of the country that have a disproportionate share of not just uninsured patients, but also uninsured and undocumented individuals.

Mrs. Bolus asked if hospitals would have to prove that they serve uninsured individuals in order to receive DSH funding. Ms. Brown responded that, right now, all DSH funding goes to the state. She explained that the ACA included language that provides the Secretary of Health and Human Services (HHS) with the authority to determine what states' DSH funding cuts would be based upon what states are doing to allocate DSH funding to those hospitals that serve the most uninsured and low-income individuals. Ms. Brown explained that institutions including the New York Immigration Coalition, The Hastings Center and others have been pushing for New York State to change how it allocates its Bad Debt and Charity Care funding. This push is to ensure compliance with the HHS requirement that states must show that their DSH/ Bad Debt and Charity Care funds go to those hospitals who serve the most uninsured and low-income individuals. Ms. Brown commented that New York State is very democratic, everybody gets some. She added that some voluntary hospitals in New York City that serve only 1-5% of uninsured patients also receive Uncompensated Care and Bad Debt and Charity Care funding.

Ms. Brown informed the Committee that HHC's top strategic and intergovernmental priority is to advocate to change how DSH funds are being allocated in New York State. Ms. Brown agreed with Mr. Nolan that the goal is to have the DSH funds follow the patients. Ms. Brown added that the DSH lump sum that is allocated to a hospital should be based on the percentage of uninsured patients served by that hospital. HHC is the single largest safety-net provider of uninsured care, not just only for New York City but also in New York State. There are some other hospitals, while not public, that also serve uninsured, undocumented and low-income individuals. HHC's message is that DSH, Uncompensated Care, and Bad Debt and Charity Care funding should follow the patient.

Mr. Nolan commented that some Republican Senators, in particular those who represent Long Island and upstate New York, have been fighting this because they want their share of the funding for their neighborhoods. Ms. Brown added that there are some Republican Senators who have public hospitals in their districts and they want DSH funding to go to their public hospitals. Additionally, there are also some non-Republican legislators who are interested in the status quo. Ms. Brown commented that this is not an upstate or downstate issue.

Setback for Obama Administration on DAPA/DACA Executive Orders

Ms. Brown informed the Committee that there have been some setbacks concerning the implementation of President Obama's Immigration Executive Order. She reported that, on May 26, 2015, the U.S. Court of Appeals for the Fifth Circuit denied the U.S. Department of Justice's request for an emergency stay in the Texas et al. vs. United States et al lawsuit against President Obama's immigration-related executive actions. She informed the Committee that the ruling came as a split 2-1 decision, which permits a lower court's decision to block implementation of initiatives that would allow millions of immigrants to apply for work authorization and protection from deportation. This block will remain in place while the Justice Department's formal appeal of the lower court's decision is considered. She also added that the Fifth Circuit decision only concerned the emergency stay request.

Ms. Brown reported that there were several next steps or legal options that could be taken. The federal government may seek an "en banc" review by the Fifth Circuit where 15 active judges of the 5th Circuit would render a decision; appeal the stay to the Supreme Court; or ask the Supreme Court to narrow the decision to Texas and those states that were included in the suit. Ms. Brown announced that oral arguments were tentatively scheduled for the week of July 6, 2015. There is no deadline for a decision on the appeal, which could come after the oral argument. Ms. Brown commented that, while many people celebrated the President's Executive Orders, these orders have not been executed. She highlighted that the President's executive order would have also enabled states to provide health insurance to undocumented immigrants. In New York State's case, the Governor has set aside funding to expand health insurance access in response to the President's immigration executive orders.

Harmful 340B Drug Discount Program Language Dropped from 21st Century Cures Bill

Ms. Brown commented that, for about a year, she had been speaking about the 340B Drug Discount Program. She reminded the Committee that the 340B Drug Discount Program allows safety net hospitals, FQHCs and other similar types of providers to purchase drugs at a discounted rate. There has been ongoing discussions by Big Pharma to limit the 340B program, which has grown. She informed the Committee that HHC saves $40 million a year as a result of this program. Accordingly, HHC is always concerned whenever there is talk about restricting or eliminating the 340B program. Ms. Brown explained that the 21st Century Cures Bill was introduced recently in Washington to speed up the drug approval process to combat various rare diseases, and for disease treatment, management, and cures. She stated that the bill recognizes that health research and technology that produced breakthrough medicines moved quickly, but the federal drug and device approval processes have not kept pace. Ms. Brown reported that the bill was reported out of committee on May 21st by a vote of 51 to 0 and was heading to the House floor for a vote in coming weeks. Ms. Brown commented that the bill did not include negative language about the 340B program, which is a success for HHC.

Update on Re-authorization of James Zadroga 9/11 Health and Compensation Act

Ms. Brown stated that, as reported in March, various activities have been launched in support of the re-authorization of the James L. Zadroga Health and Compensation Act of 2010 (Zadroga), which is set to expire in the current Congress. She added that, most recently, a House Energy and Commerce Hearing had been scheduled on June 11th focused on H.R. 1786 – Zadroga legislation. There is also a Senate Bill – S. 928, which has 19 co-sponsors. The House bill – H.R. 1786 – has 80 co-sponsors. Ms. Brown added that Congressman Pallone from New Jersey is the Democratic lead at the hearing with Republican Lepton of Michigan serving as the Chair. They are working to secure bi-partisan support for reauthorization. The New York Congressional Delegation supports the bill. Ms. Brown informed the Committee that HHC gets $10 million/year in grant and fee for service (FFS) payments through this Act for 9/11 related health care services provided to survivors at the World Trade Environmental Health Care Center (WTC EHC). Ms. Brown reminded the Committee that HHC's WTC EHC provides care specifically to community residents, not first responders. She clarified that NYC's FDNY and Mount Sinai Hospital receive funding specifically for their first responder programs. Ms. Brown commented that there were a lot at stake and that HHC's $10 million was only one piece. There are World Trade Center Health Programs in other parts of the country that are funded by Zadroga. Ms. Brown reminded the Committee that there were a lot of first responders who came from all over the country to assist with the World Trade Center site. Many of those first responders, residents of the communities surrounding the World Trade Center including lower Manhattan and parts of Brooklyn, and day laborers from Queens came to help with the cleaning of the apartments near Ground

Zero. A significant number of those individuals have experienced residual health effects from the materials, fumes, dust and other elements that resulted from the 9/11 attack. Ms. Brown added that HHC's WTC EHC program, led by Terry Miles, had been very active in working with legislative staff and other community representatives on this re-authorization. At the request of local elected officials, HHC was prepared to identify a consumer from a non-Democrat district to attend the hearing to ensure bi-partisan support for this national act.

State Update

Ms. Brown reported that HHC continued to actively work on the issue of behavioral health rates for the Medicaid managed care program. She explained that, as part of its new policy of "care management for all," the New York State Department of Health (NYDSOH) is transitioning Medicaid enrollees with severe and persistent mental illness into managed care. The premiums that the state will be providing for Medicaid patients who are transitioning from fee for service into managed care are too low to cover the cost of providing care; and would result in a $120 million revenue loss for HHC. Accordingly, HHC has been meeting regularly with NYSDOH to develop a workable solution. Ms. Brown stated that HHC had a little more time to work this out since the transition to Behavioral Health Organization Health and Recovery Plans (BHO HARPs) had been delayed by three months or until October 2015.

Ms. Brown informed the Committee that HHC's Albany-based lobbyist, Ms. Wendy Saunders, had been working very hard in Albany as the State Legislature worked to conclude the 2015 session over the next two weeks. Ms. Brown added that, with just five more scheduled session days to go, HHC has been closely monitoring all of the activities in Albany. She reported that there had been activity on several legislative proposals that were important to HHC including:

Informal Caregivers: Both Houses have passed legislation that would put in place new requirements for contacting and coordinating discharge of inpatients with any informal caregivers that patients designate. It is anticipated that the Governor will approve this legislation.

Nurse Staffing Ratios: The Assembly moved legislation mandating specific, inflexible nurse staffing ratios for hospitals and nursing homes. If this legislation were to pass, HHC would need to hire 3,200 new nurses at a cost of more than $388 million.

Medical Malpractice: There are several bills that would alter the rules governing medical malpractice. At this point, proponents appear to be focusing their efforts on legislation that would extend the statute of limitations from thirty months from the date of the alleged malpractice, to thirty months from whenever the alleged malpractice is discovered. The bill was reported out of the Assembly Codes Committee last week. HHC is working closely with other stakeholders, including the hospital and nursing home associations and the Medical Society. There is heightened concern this year given the recent change in leadership in both houses.

HHC-Specific Legislation: There are two perennial bills, also called the "Lanza bills" by HHC's IGR staff, requiring HHC to financially support the two hospitals on Staten Island. One would require HHC to provide financial support to the Staten Island-based hospitals. HHC does not have an acute care hospital on Staten Island. In the other bill, Senator Lanza and his predecessor contends that 10% of HHC's budget should be spent on Staten Island. Both bills have moved to the floor of the Senate and are poised for passage. The Assembly moved one of the bills to the Ways and Means Committee, but no further action is expected in

that house. HHC will continue to be vigilant on these bills as well as any last-minute issues that could affect HHC.

City Update

City Budget Hearings

Ms. Brown reported that, HHC provided testimony before the Council Finance, Health and Mental Health Committees on May 20, 2015, for its FY 2016 Budget. Unlike the preliminary budget hearing, there is also a public session before the Council, which was scheduled for 1:00 pm later today. Ms. Brown informed the Committee that some of HHC's Community Advisory Board members (CABs) and others who are advocates for HHC and about healthcare services would be providing testimony before the Council. Ms. Brown added that the budget deliberations between the Administration and the Council would intensify over the next couple of weeks before concluding by the end of June.

INFORMATION ITEM

Presentation: Identifying Fair, Effective & Sustainable Local Policy Solutions: Undocumented Immigrants and Access to Health Care in New York City

Claudia Calhoon, MPH, Director of Health Advocacy, the New York Immigration Coalition
Nancy Berlinger, Ph.D., Research Scholar, The Hastings Center
Michael Gusmano, The Hastings Center

Ms. Brown introduced Ms. Claudia Calhoon, Director of Health Advocacy, the New York Immigration Coalition and The Hastings Center's Research Scholars, Nancy Berlinger, Ph.D. and Mr. Michael Gusmano. She invited the presenters to proceed with their presentation on a report titled, "*Identifying Fair, Effective and Sustainable Local Policy Solutions: Undocumented Immigrants and Access to Health Care in New York City.*"

Dr. Nancy Berlinger began the presentation by informing the Committee that this independent report was based on a meeting that was convened by the New York Immigration Coalition and the Undocumented Patients' Project of The Hastings Center, which was hosted by the Vera Institute of Justice in New York City on December 11-12, 2014. The goals of the meeting were to sharpen local stakeholders' understanding of gaps in access to health care for populations that are left out of the Affordable Care Act (ACA) -- in particular, New York City residents who are both undocumented and uninsured – and to identify proven or promising local solutions to close these gaps in other cities, counties, and states, and discussed applicability to New York City.

Dr. Berlinger informed the Committee that this project was funded by a discretionary grant from the RS Clark Foundation. She explained that the convening of meeting participants, report, and recommendations were independent of the Mayor's Task Force process but aimed to complement it with regard to timing and utility. She added that the authors of the report were responsible for recommendations; and all meeting participants were provided with opportunities to provide their insights via discussion and subsequent review of the meeting summary.

Dr. Berlinger reported that a total of 25 local stakeholders participated in the meeting who represented:

New York City Government

- Department of Health and Mental Hygiene
- Health and Hospitals Corporation
- Human Resources Administration's Office of Citywide Health Insurance Access
- Office of the Deputy Mayor for Health and Human Services
- Mayor's Office of Immigrant Affairs

Labor/Advocates

- SEIU
- Community Service Society
- Coalition for Asian American Children and Families
- Make the Road
- Vera Institute for Justice

Clinicians

- Primary Care (HHC Bellevue) and FQHC's (Community Health Care Association of New York State)
- Discharge Planning (Montefiore)
- Specialty Care (Memorial Sloan Kettering Cancer Center)

Funders

- Altman Foundation

Dr. Berlinger reported that the following individuals were external speakers who participated in the December meeting:

- Tangerine Brigham Deputy Director, Managed Care Services Division of Los Angeles County Department of Health Services (Healthy San Francisco and My Health LA)
- Sherri Rice and Nikki King, President/CEO and Chief Operating Officer of Access to Healthcare Network, Nevada
- Rajeev Raghavan, Assistant Professor of Medicine, Baylor College of Medicine and Ben Taub Hospital-Harris Health System of Houston, Texas
- Andrew Cohen and Kate Bicego, Massachusetts' Health Law Advocates/Health Care for All

Dr. Berlinger provided the Committee with an overview of the 2015 report. She stated that the report described New York City's undocumented uninsured population; the City's safety-net health care system; and specific gaps in coverage and financing that would impede access to health care for this population. She stated that the report highlighted special opportunities and challenges for health care system improvement in the City; compared models that are proven or promising as sustainable ways to improve access to uninsured populations; and offered six actionable recommendations for City stakeholders, supported by guidance for ongoing planning, program development, and system improvement

Ms. Claudia Calhoon described New York City's undocumented and uninsured population as the following:

- Approximately 500,000 immigrants who live in New York City are undocumented
- About 250,000 are insured through employer sponsored coverage, private insurance purchased outside of ACA marketplace, or Child Health Plus
- About 250,000 remain uninsured:

    - 155,000 will be eligible for Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) or Deferred Action for Childhood Arrivals (DACA)
    - Of these, 40-50% will be income-eligible for Medicaid after enrollment in DAPA or DACA
    - As of May 2015 DACA/DAPA was delayed
- TAKE HOME: At least 200,000 of the currently uninsured are likely to remain uninsured

Ms. Calhoon described the existing health care services resources and gaps for undocumented and uninsured immigrants as the following:

- Safety-net health care systems in New York City
    - *HHC*
    - *Federally Qualified Health Centers (FQHCs)*
    - *Voluntary Hospitals (to limited degree)*
- Emergency Medicaid and its limits in New York State
    - *Functions as limited form of coverage*
    - *Gaps*
- Gaps in the New York City's safety-net
    - *Chronic conditions*
    - *Life-threatening conditions*
    - *Discharge planning and post-hospital care*
    - *Efficiency and cost effectiveness*

Ms. Calhoon also described some of the opportunities and challenges in improving access to health care for the undocumented uninsured in New York City as the following:

- Opportunities
    - Medicaid Redesign and DSRIP
    - Better linkages with voluntary hospitals
    - Municipal ID card (IDNYC) or other type of enrollment card

- Challenges that require policy solutions above the local level
    - Improving existing state programs and closing remaining gaps
    - Expanding the primary care workforce
    - Indigent Care Pool (ICP) and Disproportionate Share funding (DSH*)*

Mr. Michael Gusmano described the similarities and differences among solutions to closing gaps in systems outside of New York City including:

1. "My Health LA"
    - No-cost health care program launched in October 2014
    - Offers comprehensive health care for low-income (at or below 138 percent of the FPL), uninsured county residents, regardless of immigration status or medical condition
    - Does not require out-of-pocket payments or user fees
    - Offers care through 164 community clinic medical home sites, where patients receive primary and preventive health care services and some diagnostic services
    - Los Angeles County Department of Health Services facilities also provide County clinic medical home sites, plus emergency, diagnostic, specialty, inpatient, and pharmacy services
    - Of the estimated 400,000 remaining uninsured in Los Angeles County, 135,000 are now served, with capacity to reach another 145,000

2. Healthy San Francisco
   - Low-income program for San Francisco County residents with incomes up to 500 % FPL regardless of employment status, immigration status, or medical condition
   - Charges participation fee and point-of-service fee to all patients except for those under 100 % FPL and those who are homeless; one set of fees for all public clinics; non-public clinics set their own fees
   - Fee information provided at time of enrollment to help applicants select medical home
   - Participants receive a card with the name of their medical home
   - Large, interconnected care network made up of different types of providers
   - Predictable affordable participation fees decreases client fear of large bills
   - Encourages preventive care and offers customer service, health education, care management
   - Focus on primary care home to reduce duplication and improve coordination
   - Centralized eligibility system to maximize public entitlement and centralized system of record to create accountability
   - Non-insurance (care) model lowers costs and protects federal and state funds for counties

3. Access Care, Harris County, Texas
   - Financial assistance program of the Harris Health System, the hospital district that includes the city of Houston
   - Open to uninsured Harris County residents
   - Provides access to discounted health care at more than 20 community clinics, a dental clinic, and surgical and other sub-specialty clinics, one long-term care facility
   - Scope of services exceeds that of most FQHCs in the area, although wait times for sub-specialty clinic appointments and for elective surgeries can be long

4. Massachusetts
   - One application for all available programs, including the insurance marketplace
   - Mass Health Limited
     - State version of Emergency Medicaid
     - Available to undocumented immigrants and some immigrants who are PRUCOL
   - Children's Medical Security Plan
     - Financed by the state and offers primary care and preventive services to low-income children up to 200 % FPL
   - Health Safety Net
     - Grew out of the state's ICP to pay for care at acute care hospitals and community health centers
     - Massachusetts residents earning less than 400 percent of the FPL are eligible for HSN funds, which follow individuals rather than institutions
     - Patients with incomes between 200-400 percent of the FPL can apply once they incur a health care cost
   - HSN's Medical Hardship Program can be applied up to a year retrospectively to cover medical debts

5. Access to Healthcare Network in Nevada
   - Offers medical discount programs, specialty care coordination, a health insurance program, non-emergency medical transportation services, a pediatric hematology/oncology practice, and a toll free statewide call center
   - 35,000 members, more than half of whom are presumed to be undocumented

- Members must be at 100-325 % FPL, live and/or work in Nevada, and be ineligible for public insurance such as Medicaid or Medicare
- Members pay $35 a month for deeply discounted medical services plus care coordination

Mr. Gusmano concluded his presentation by highlighting some common elements of the existing models. These common elements include:

- Eligibility
- Financing
- Provider networks
- Care coordination
- Political support

Ms. Calhoun presented to the Committee the recommendations of the report, which includes the following:

1. Improve access to primary and preventive health care, and to specialty care and other services, through primary care medical homes in FQHCs and at HHC ambulatory centers networked to specialists
2. Explore the potential for the City's municipal ID card to function as an enrollee card for a primary care medical home network for uninsured New Yorkers
3. Acknowledge that a primary care oriented medical home solution, while important, will not resolve health care access for undocumented immigrants and other uninsured populations who have medical and related social service needs that significantly exceed the scope of a primary care medical home and that further efforts are needed to close these gaps
4. Describe explicitly the potential role of the City's major voluntary hospitals in supporting access to health care for the undocumented uninsured and other uninsured populations, with attention to their current role in emergency and inpatient care and to access problems that exist at the hospital/ post-hospital transition
5. Integrate new efforts to improve access to primary care for uninsured New Yorkers into current efforts of New York City Performing Provider Systems to meet their DSRIP goal
6. Advocate for state-level policymakers to identify a mechanism that will provide health coverage to immigrant populations who remain uninsured

Dr. Berlinger presented suggestions for effective local planning during national health care system change:

- Improve public systems
- Anticipate emerging issues in organizational collaboration
- Promote knowledge sharing and problem solving among public and voluntary hospitals

Ms. Calhoon described the reception of the report and next steps:

- Forum on meeting and report planned for when the Mayor's Taskforce Report is released
- Requests for technical assistance from:
    - Illinois Coalition for Immigrant and Refugee Rights
    - Public Citizens for Children and Youth (Philadelphia)
- Report featured on CUNY TV's Informed Comment Program
- Cited in the NYC Comptroller's Report "Holes in the Safety Net"
- Invitation from Milbank Quarterly to submit article based on report

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:57 AM.

2015 New York State Legislative Session

2014 Statistics

- ✓ 14,335 bills introduced
- ✓ 919 bills passed Senate only
- ✓ 347 bills passed Assembly only
- ✓ 718 bills passed both houses
- ✓ HHC actively tracking 833 bills

Staffing Ratios

A.1548 (Gottfried)/S.782 (Hannon)

- Imposes mandatory nurse staffing ratios for hospitals and nursing homes.
- Would require HHC to hire 3,200 new nurses costing more than $388 million just for hospitals
- **Did not pass EITHER House**

Medical Malpractice

A.285 (Weinstein)/S.911-A (Libous)

- Extends New York's statute of limitations from thirty months from the date of the alleged malpractice, to thirty months from whenever the alleged malpractice is discovered
- Amended to clearly apply to HHC and other public facilities
- **Passed Assembly Only**

HHC Specific Legislation

A.5222 (Cusick)/S.3326 (Lanza)

- Requires HHC to spend 10% of Operating Budget on Staten Island ($670 million)
- **Passed Senate ONLY**

A.5221 (Cusick)/S.3322 (Lanza)

- Requires HHC to finance the operation of at least 2 Emergency Departments on Staten Island
- **Did not pass EITHER House**

Facilities Legislation

- **A.1323B (Rosenthal)/S.676B (Hannon)**
  CARE Act: Hospitals and nursing homes must provide discharge information to patient-designated informal caregivers
- **A.7791A (Mayer)/S5892 (Valesky)**
  Discharge Information for the Elderly: patients 60+ must be given a list of senior services & programs
- **A.7465, Gottfried /S.4874, Hannon)**
  Sepsis Data Collection: Delays public release of hospital-reported information until validated & analyzed
- **All bills Passed BOTH Houses**

Professional Issues

- **A.123B (Paulin)/S.4739 (Hannon)** Pharmacist Immunization Administration: allows pharmacists to vaccinate for acute herpes zoster, meningococcal, tetanus, diphtheria and pertussis
- **A.1034A (Gunther)/S.3621 (Funke)** Assault on Direct Care Workers: makes assault a class D felony
- **A.2150 (Gottfried)/S.1153 (Hannon)** Surrogate Decisions for Hospice: allows physicians to make decisions for incapacitated patients who don't have a surrogate
- **All bills Passed BOTH Houses**

Other Issues

- **A.7208 (Gottfried)/S.4893 (Hannon)**
  Prescriber Prevails: requires Medicaid FFS to pay for certain drugs not on formulary
- **A.8172 (Morelle)/S.5883 (Robach)**
  Limited Medicaid Claim Extension: allows exemption of 90 day submission requirement if computer-related problems
- **A.1327A (Cahill)/S.4922A (Hannon)**
  Coverage for Court-Ordered Behavioral Health Services: creates expedited process for determining coverage by commercial insurers
- **All bills passed BOTH Houses**

Questions?

Wendy Saunders
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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

Ida G. Israel Community Health Center

Presentation to the Strategic Planning Committee of the Board of Directors
July 14, 2015

Former Ida G. Israel Community Health Center Damages from Super Storm Sandy

Ida G. Israel Community Health Center

Utilization of Services
Pre-Sandy Annual Visits

Chemical Dependency	17,632
Dental	10,637
Adult Medicine	7,368
Pediatrics	2,477
OBS	337
Total	**38,451**

Community Demographics

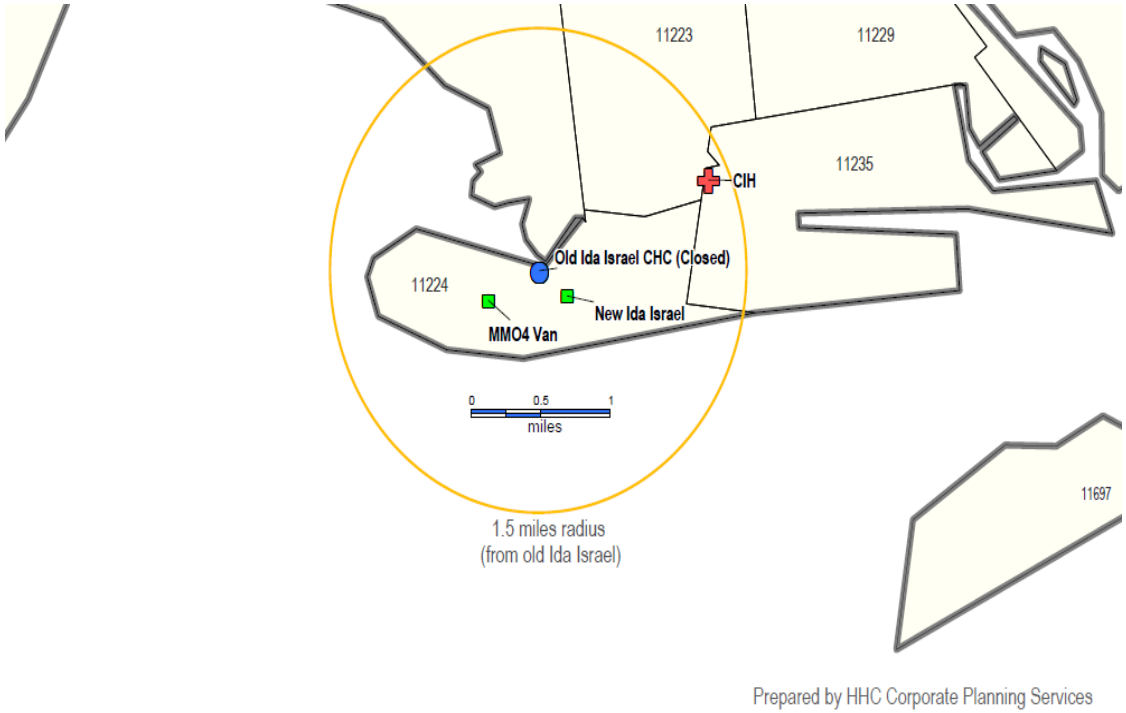
- Majority of patient population served by Ida G. Israel Community Health Center: Zip Code 11224
- Coney Island peninsula is designated as HPSA qualified in program areas such as Primary Care, Mental Health and Dental Care.

Demographic Overview:

- White - 54%
- Black - 21%
- Hispanic - 18%
- Asian - 6%

- Less Than Age 20 – 22%
- Between Ages 20 & 44 – 27%
- Between Ages 44 & 64 – 28%
- Ages 65 and Over – 23%

NYC HHC Ida G. Israel Community Health Center Former and Present Location



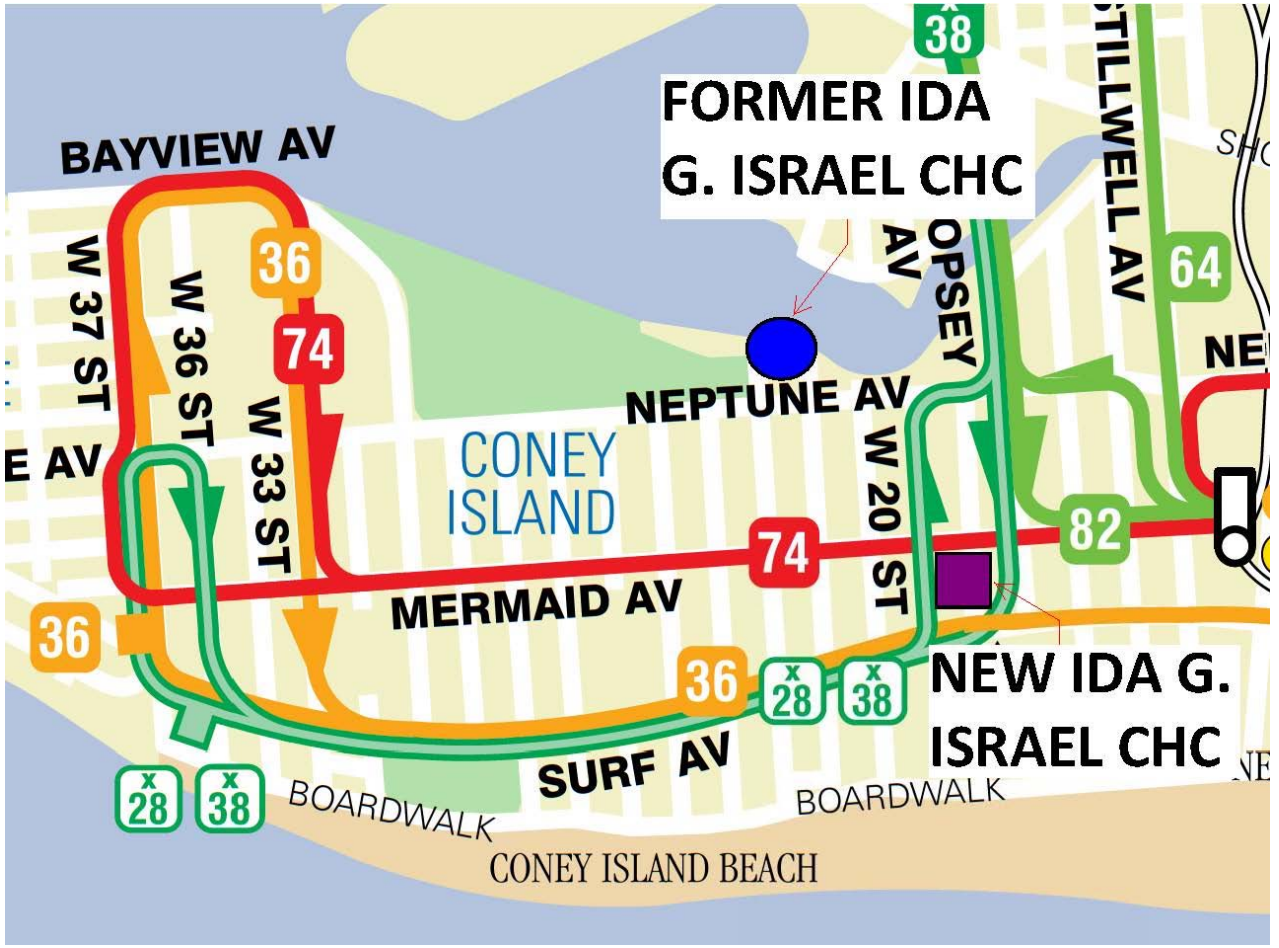
Former Ida G. Israel CHC – 2201 Neptune Ave

New Ida G. Israel CHC - 2925 West 19th Street

Access to Transportation

Subway Lines F, N, Q and D

Bus Lines B36 and B74



Ida G. Israel Community Health Center

Initial Hours of Operation*

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Behavioral Health	8:00am - 8:00 pm	8:00am - 8:00 pm	8:00am - 8:00 pm	8:00am - 8:00 pm	8:00am - 4:00 pm	8:00am - 4:00 pm	TBD
Dental	8:00am - 4:00 pm	8:00am - 4:00 pm	8:00am - 4:00 pm	8:00am - 4:00 pm	8:00am - 4:00 pm	TBD	TBD
Adult Medicine	9:00am - 5:00 pm	9:00am - 5:00 pm	9:00am - 5:00 pm	9:00am - 5:00 pm	9:00am - 5:00 pm	TBD	TBD
OBS	No Hours	No Hours	1:00pm - 5:00pm	No Hours	No Hours	TBD	TBD
Pediatrics	12:00pm - 4:00 pm	9:00am - 12:00 pm	12:00pm - 4:00 pm	12:00pm - 4:00 pm	9:00am - 12:00 pm	TBD	TBD

* Extended hours will be established post ramp-up.

CONEY ISLAND HOSPITAL
2601 OCEAN PARKWAY
BROOKLYN, N.Y. 11235
T. 718.616.4140 F. 718.616.4129

CONEY ISLAND HOSPITAL- IDA ISRAEL REPLACEMENT CLINIC

Scale: 1/8" = 1'-0" Date: 06-19-2015 Project #: 21312.01

MJCL Architects, PLLC
1418 Avenue N, Brooklyn, NY 11230
Tel.: (718) 339-3300 Fax: (718) 339-3642

Ida G. Israel Community Health Center

Ida G. Israel Community Health Center

Ida G. Israel Community Health Center

Timeline

Community Advisory Board Notices	June 4, 2015
Construction Completion Date	July 13, 2015
Ribbon Cutting Ceremony	July 15, 2015
Pre-Opening Department of Health Survey	Target Date: July 31, 2015
Scheduling of Office Practice Appointments to Commence	August 1, 2015
Coney Island Hospital Health Fair	September 20, 2015

Community Advertisement

- Rendering of new facility stating "Coming Soon Summer 2015" posted at construction site and on the homepage of CIH Intranet
- Two half page advertisements posted for (2) weeks in April 2015 and the last week of June 2015 in the *Brooklyn Spectator*
- Flyer with rendering of new facility distributed to CIH Health Fair attendees on September 7, 2014
- Broadcasted on social media via *Twitter*