STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

MARCH 11, 2014
10:00 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

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

II. ADOPTION OF FEBRUARY 11, 2014 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

III. INFORMATION ITEMS:

i. **NEW YORK STATE MEDICAID WAIVER UPDATE**

LARAY BROWN, SENIOR VICE PRESIDENT
CORPORATE PLANNING, COMMUNITY HEALTH AND INTERGOVERNMENTAL RELATIONS

ii. **IMPROVING ACCESS TO HEALTHCARE SERVICES FOR WOMEN WITH DISABILITIES**

MARILYN SAVIOLA, VICE PRESIDENT OF ADVOCACY AND WOMEN'S HEALTH PROGRAM
INDEPENDENCE CARE SYSTEM

DINAH SURH, MPH, SENIOR EXECUTIVE ADMINISTRATOR
DAVID JOHN, MD, MEDICAL DIRECTOR
MORRISANIA DIAGNOSTIC AND TREATMENT CENTER

EDWARD FISHKIN, MD, MEDICAL DIRECTOR
PAUL KASTELL, MD, CHAIRMAN, OB/GYN SERVICES
PATRINA PHILLIP-KING, MD, OB/GYN
WOODHULL MEDICAL AND MENTAL HEALTH CENTER

MARK WINIARKSI, PHD, ASSISTANT DIRECTOR
CORPORATE PLANNING SERVICES

IV. OLD BUSINESS

V. NEW BUSINESS

VI. ADJOURNMENT **JOSEPHINE BOLUS, RN**

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

FEBRUARY 11, 2014

The meeting of the Strategic Planning Committee of the Board of Directors was held on February 11, 2014 in HHC's Board Room located at 125 Worth Street with Josephine Bolus presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, NP-BC, Chairperson of the Committee
Alan Aviles
Anna Kril
Robert F. Nolan
Bernard Rosen
Rev. Diane Lacey
Andrea Cohen, representing Deputy Mayor Lilliam Barrios-Paoli

OTHER ATTENDEES

C. Fiorentini, Analyst, New York City Independent Budget Office
J. DeGeorge, Analyst, State Comptroller
J. Wessler, Guest

HHC STAFF

M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations
T. Carlisle, Associate Executive Director, Corporate Planning Services
E. Casey, Assistant Director, Corporate Planning and HIV Services
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
T. Hamilton, Assistant Vice President, Corporate Planning Services

L. Haynes, Assistant Systems Analyst, President's Office
L. Isaac, Assistant Director, Corporate Planning Services
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
A. Marengo, Senior Vice President, Communications and Marketing
K. McGrath, Senior Director, Communications and Marketing
H. Mason, Deputy Executive Director, Kings County Hospital Center
A. Martin, Executive Vice President and Chief Operating Officer, President's Office
I. Michaels, Director, Media Relations, Communications and Marketing
T. Miles, Executive Director, World Trade Center Environmental Health Center
Z. Nelley, Assistant Director, Office of Internal Audits
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
S. Operowsky, Associate Executive Director, Gouverneur Healthcare Services
K. Park, Associate Executive Director, Finance, Queens Health Network
C. Pean, Associate Director, Harlem Hospital Center
S. Penn, Deputy Director, World Trade Center Environmental Health Center
L. Robinson, Administrator, World Trade Center Environmental Health Center
E. Russo, Assistant Director, Corporate Planning Services
S. Russo, Senior Vice President and General Counsel, Office of Legal Affairs
C. Samms, Generations+ Northern Manhattan Network Chief Financial Officer
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations
J. Wale, Senior Assistant Vice President, Behavioral Health
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations
R. Wilson, Senior Vice President, Corporate Chief Medical Officer, Medical and Professional Affairs

CALL TO ORDER

The meeting of the Strategic Planning Committee was called to order at 10:30 a.m. by the Strategic Planning Committee Chairperson, Josephine Bolus, NP-BC. The minutes of the January 14, 2014 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

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

Federal Update

Two Midnight Rule

Ms. Brown reported that the "two-midnight" rule had been promulgated by the Centers for Medicare and Medicaid Services (CMS). She explained that the rule stipulates that, if the duration of a patient's visit does not cover two midnights for the purpose of evaluation and/or observation that stay would not count as an inpatient stay. Ms. Brown stated that this rule had created a great deal of anxiety on the part of hospitals as well as hospital-based physicians because it arbitrarily used two midnights to determine when an inpatient admission would be justified. The rule fails to address the provider community's concern with developing a new payment policy for short inpatient high acuity stays; and there is no guarantee that this issue will be addressed in the proposed inpatient payment rule this April. This new rule, if implemented, could cost HHC between $23 million and $28 million per year.

Ms. Brown informed the Committee that there was significant provider level advocacy concerning the "two-midnight rule." In response to advocacy from hospital groups, physicians and others, on January 31, 2014, CMS announced a six month delay until September 2014, of the enforcement of this rule. Ms. Brown further explained that, during the delay period, CMS contractors would continue to carry out probe and educate prepayment reviews on a sample of inpatient claims with dates of admissions from October 1, 2013 through March 31, 2014. The probe and educate reviews are intended to determine if hospital inpatient claims comply with the new rule. Those that fail to comply with the new benchmark requirements will be denied. Contractors will also continue to carry out educational outreach to providers.

Mrs. Bolus, Committee Chairperson, asked if the diagnostic related groups (DRGs) would have any impact on the "two-midnight" rule. Ms. Brown responded that these were two separate issues. Mrs. Bolus asked if staff within HHC's observation units would have a problem with the rule. Ms. Brown clarified that the major concern was that CMS had created a fixed rule that was based on how long a patient stayed in a particular setting, which defined or determined whether the patient during that period of time would receive inpatient services/resources or not. Ms. Brown explained that, through this rule, CMS is saying that any stay less than two midnights would be classified as outpatient services, which are reimbursed at a lower rate.

Ms. Brown provided a brief update on the implementation of the Affordable Care Act. She stated that the Administration had granted another extension to business groups; specifically, businesses with 50-

99 employees. These employers were given an additional year through January 1, 2016, to comply with the coverage mandate. For businesses with 100 or more employees, their deadline will continue to be January 2015. Ms. Brown added that there were newly released technical provisions concerning the calculation of work hours, full-time versus part-time, which may also provide some relief for those businesses. Ms. Brown commented that one entity's relief may become another entity's problem. Workers in companies with less than 100 employees will have to wait another year before they have the opportunity to obtain coverage through their employer. On the other hand, some workers in companies with 100 or more employees may not have the opportunity to gain employer-based coverage as a result of the new formula for calculating work hours. Ms. Brown commented that, this was a political maneuver on the part of the Administration as they have been criticized in recent news articles with headlines that equated Obamacare with the loss of jobs.

World Trade Center Environmental Health Center Program Update

Ms. Brown informed the Committee that the World Trade Center Environmental Health Center (WTC EHC) had received a positive written evaluation of its 2013 performance under the World Trade Center Healthcare Program's Clinical Centers of Excellence (CCE) contract. Ms. Brown added that this positive evaluation had been reinforced by a positive site visit that had occurred during that past week from the CCE's Program Officer. She added that HHC's WTC EHC was congratulated for meeting all required deadlines throughout 2013 for the submission of numerous routine reports. Ms. Brown reminded the Committee that the WTC EHC is an important program for community residents, workers, passersby and students of the areas that had been affected by the destruction of the World Trade Center. She also reminded the Committee that WTC EHC services were being provided at three HHC facilities including Bellevue and Elmhurst Hospitals and Gouverneur Diagnostic and Treatment Center. Ms. Brown noted that the reporting and documentation requirements that had been designed by the federal government were very strict and required a great deal of discussion and negotiation. Ms. Brown thanked HHC's General Counsel, Mr. Salvatore Russo, Mr. Wayne McNulty, the Corporate Compliance Officer, Ms. Marlene Zurack, and in particular, Ms. Maxine Katz of HHC's Central Office Finance Division, for their assistance with securing this positive evaluation. She informed the Committee that, "it takes a village."

City Update

Ms. Brown reported that the City Council Health Committee had scheduled a hearing on February 24, 2013, to review HHC's restructuring plan. Ms. Brown noted that this hearing would be the first hearing led by the new Committee Chair, Councilmember Corey Johnson. In addition to learning about what progress HHC had made on its objectives, Ms. Brown commented that, it was expected that the Council would also be interested in learning about how these initiatives have affected both HHC staff and patients.

INFORMATION ITEMS

2014-2015 New York State Fiscal Year Executive Budget Overview

Wendy Saunders
Assistant Vice President, Office of Intergovernmental Relations

Ms. Saunders greeted Committee members and invited guests. She began her presentation by stating that, two weeks ago, Governor Cuomo had released his Executive Budget for SFY 2014-2015, which would begin on April 1, 2014. Ms. Saunders reported that the $137.2 billion budget would increase overall spending by 1.7%; and it projected a $2 billion surplus by SFY 2017-18, which would result from a two percent reduction in spending over that time period. She added that a large part of the Governor's budget focused on a $489 million tax cut package and an increase in education spending.

Ms. Saunders reported that, in the area of Medicaid spending, the Governor's budget included a proposal to increase Medicaid total spending by 3.8% for a total of $58.2 billion. Ms. Saunders explained that this increase equated to $604 million more in Medicaid spending over last year's budget. In addition, this year's budget represents the second year of a two year agreement on Medicaid spending that was enacted last year. Ms. Saunders cautioned that the increase in Medicaid spending did not mean an increase to providers. This increase will cover enrollment expansion, increases in patient acuity and increases in the total number of Medicaid patients who are currently enrolled in the State. Along with the increase in Medicaid spending, there is a proposal to extend the Global Medicaid Cap for one year. Ms. Saunders explained that, in addition to the extension of the Global Medicaid Cap, the Commissioner of the State Department of Health (SDOH) had been granted "superpowers" to make cuts to providers and to ensure that Medicaid spending remained under that cap. Ms. Saunders explained that, if spending exceeded the cap, the Commissioner of Health had the ability to administratively cut providers' rates.

Ms. Andy Cohen referred to the childless adult population and noted that there had been a significant change in the way that Medicaid would be funded for that population. Ms. Cohen asked, since the cost to the State for caring for that population had been significantly reduced, how this change would be reflected in the Global Cap. Ms. Saunders responded that, last year, there had been a projection of a very significant increase in federal funding for this budget year and that projection was revised downward. In addition, fiscal relief is included in the Medicaid budget. Ms. Saunders further explained that there was roughly $300 million that was proposed in the budget as state fiscal relief. She explained that elsewhere in the State budget attempts were being made to keep this amount in the healthcare section and to spend it by addressing the Office of People with Developmental Disabilities (OPWDD) pay back to the federal government. Ms. Saunders added that $300 million would be shifted from Medicaid to pay for that outside of the Global Cap. Ms. Saunders noted that this would be possible due to the availability of ACA funding and because Medicaid spending had been less than what had been budgeted.

Ms. Cohen commented that the two big items that the fiscal relief amount would be spent on were the OPWDD pay back and the county caps. Ms. Saunders explained that two years ago, the State had capped the amount of increase that any county or locality would be expected to pay for their portion of the Medicaid budget. She reminded the Committee that Medicaid funding is comprised of a federal and non-federal share, which is split between the State and the localities. She commented that states spend more on Medicaid.

Ms. Cohen referred back to Ms. Saunders' statement about last year's projection of the federal portion of Medicaid funding. She asked how much of the savings had been revised downward. Ms. Saunders answered that she could not recall the exact number. However, Ms. Saunders added that, while it was originally anticipated that there would be 100,000 single childless adults, the actual number was closer to 70,000 or 79,000 newly eligible adults.

Ms. Saunders reported that the Global Cap had been extended for another year and would remain in place until March 31, 2016. She added that a second year of a two year agreement on Medicaid spending, which had been agreed to by Legislature, was included in this year's budget. This action has helped to stabilize funding.

Ms. Saunders reminded the Committee that the Governor had proposed to restore the two percent across the board rate cut which was implemented in his first year in office as part of the Medicaid Reform Taskforce (MRT) recommendations. She added that the total value of the two percent is $17.6 million for HHC and some additional funds for MetroPlus Health Plan. Ms. Saunders reported that the State Department of Health (SDOH) had been given the authority to restore those funds, which were already included in HHC's financial plan.

Ms. Saunders informed the Committee that there would be no inflationary increase or trend factor for Medicaid providers this year. She stated that, as part of last year's budget, the inflationary rate had been frozen. However, if HHC were to receive a trend factor, the impact to HHC would be $26.4 million.

Ms. Saunders reported that the Governor's budget included a positive new proposal related to the Global Cap called the "shared savings" plan. She explained that under the "shared savings" plan, each year (before January) SDOH would calculate actual spending under that Medicaid Global Cap amount. If spending is less than projected, the delta, or savings, would be returned to health care providers and health plans in two ways:

- At least 50% of any shared savings would be distributed proportionately to all providers and plans (based on Medicaid claims in the previous 3 years), and
- No more than 50% would go to "financially distressed and critically needed providers" as determined by SDOH.

Ms. Saunders reported on the capital funding proposal that was included in the budget. She explained that the Governor proposed a $1.2 billion capital program over seven years. This program will provide $200 million a year in the first five years and $100 million for the last two years. Hospitals, nursing homes, diagnostic and treatment centers, and licensed clinics will be eligible to receive this funding for closures, mergers, restructuring, infrastructure improvements, primary care capacity expansion, for promoting integrated healthcare delivery systems and for providing continued access to essential health services. Ms. Saunders noted that the program's intent is to compliment the proposed Medicaid Redesign Team (MRT) 1115 Waiver that the State has been negotiating with the federal government. Ms. Saunders added that this funding would be distributed at the discretion of the SDOH Commissioner. Applicants will not be required to go through a competitive process. However, providers who are eligible for funding under the proposed Waiver would be given preference for these funds.

Ms. Saunders reported on the Regional Health Improvement Collaboratives (RICs) that had been proposed in the budget. Ms. Saunders informed the Committee that the federal government had determined that the RICs would not be eligible for Waiver funding. She reported that $7 million would be allocated to establish 11 RICs. These RICs will be modeled on the Finger Lakes Health Systems agency. Their purpose would be to convene health care stakeholders to identify challenges and to recommend and implement solutions. Ms. Saunders stated that, while RICs' main goal is to achieve savings across the health care system through collaboration and restructuring, major RIC's activities will include the following:

- Assuring high-quality accessible primary care;
- Providing technical assistance for financial and business planning to encourage the development of integrated health care delivery systems; and
- Providing assistance to primary care providers for adopting and using electronic health records.

Mr. Robert Nolan, Board Member, asked if New York City would be considered a RIC. Ms. Saunders responded that New York City would be its own RIC. Long Island and Rochester would each have their own RIC. Mr. Bernard Rosen, Board Member, asked if RICs have sought capital funding. Ms. Saunders responded that later in her presentation, she would discuss the Vital Access Program, under which, HHC had received $5 million in addition to funding through the HEAL NY program. Ms. Brown added that the $1.2 billion is another iteration of the HEAL-NY program, which was mostly capital dollars that HHC had received. She informed the Committee that HHC had received significant HEAL NY funding across the enterprise. Ms. Brown reported that the most recent HEAL NY funding had been for the Vital Access Program which, in last year's budget, included both service and capital. She added that the $1.2 billion was basically an extrapolation of what had been originally included in the $10 billion Medicaid Waiver. Ms. Brown explained that there had been robust discussions with the federal government on this issue.

Health Information Technology

Ms. Saunders reported that the proposed budget included $95 million for Health Information Technology (HIT). She added that $55 million of that allocation would be for the State Health Information Network of New York or SHIN-NY, which is often described as a health information "superhighway." Ms. Saunders explained that SHIN-NY was designed to provide statewide interoperability between the various Regional Health Information Organizations (RHIOs). She added that SHIN-NY was described by the State Health Commissioner as the "tubes" that are used to connect the RHIOs so that, if a New Yorker gets in a car accident in Buffalo, the hospital treating him could access his records at Jacobi Medical Center to provide him with the best care possible. Ms. Saunders highlighted that SHIN-NY would be funded in a new way through Healthcare Reform Act (HCRA) surcharges. She explained that these health care surcharges are covered lives assessments. Ms. Saunders stated that, because of the increase of the number of people with health insurance made possible through the Health Exchange, these surcharges or covered live assessments are expected to increase. Ms. Saunders reported that, in addition to the $65 million allocated to SHIN-NY, another $10 million would be allocated to create the database, which would house the data on health care utilization and spending. She noted that there was a plan to make this database available to the Regional Health Improvement Collaboratives (RICs) and others. Moreover, this funding includes another $10 million to support ongoing SDOH HIT needs including electronic medical records (EHRs), etc. Ms. Saunders commented that the funding amounts will not necessarily add up because another $30 million in funding is anticipated from matching federal funds.

Hospitals

Ms. Saunders reported on hospital focused proposals that had been included in the executive budget. She stated that there was a proposal to restore presumptive eligibility for the Modified Adjusted Gross Income (MAGI) population. She explained that this term formerly referred to the Aid to Families with Dependent Children (AFDC) population or individuals who qualified for the Medicaid program based on

their household income. This population excludes individuals who are elderly and disabled. She added that, while the details of the proposal were still under scrutiny, restoring Medicaid presumptive eligibility for this population was important for HHC hospitals. She noted that it was eliminated as a by-product of the movement of Medicaid enrollment to the New York State Health Exchange.

Ms. Saunders reported that the proposed budget included a proposal that would delay hospital inpatient rebasing by three to six months (from January 1, 2014 to a time between April 1, 2014 and July 1, 2014), and would allow for periodic updates to base year of inpatient psychiatric, specialty and detoxification facilities, by no later than January 1, 2015. The proposal called for adjustments to both inpatient and outpatient rates related to the implementation of the new International Classification of Diseases Version 10 (ICD-10) coding system. Ms. Saunders noted that under these proposals, rates could be adjusted to prevent a net aggregate increase in Medicaid spending.

Ms. Saunders reported that the budget included a proposal to extend the Excess Medical Malpractice Program through June 30, 2015, and to continue current eligibility. Ms. Saunders noted that this one year extension was preferable to previous budget proposals that would have reduced the number of HHC physicians that would receive coverage. Mr. Nolan asked how long the Excess Medical Malpractice Program had been in existence. Ms. Saunders answered that this program had been in existence for quite a long time. She added that the program provided coverage for medical malpractice for high risk specialty physicians, notably obstetricians and neurologists as they have trouble accessing insurance on their own due to high malpractice insurance rates. Ms. Brown asked Mr. Russo, HHC's General Counsel, to describe how the program benefited HHC. Mr. Russo explained that this program was designed to help providers who serve in underserved areas. The program offers a primary layer of insurance of $1.3 million or $3.2 million for the aggregate. In addition, the State provides an additional layer of $1 million at no charge to the provider. He noted that the physician's primary coverage comes out of the hospital funding. Mr. Russo further explained that, in order to participate in this program and qualify for this matching fund, HHC had to have an insurance carrier, which prompted HHC to form a captive insurance carrier some years ago. Ms. Brown added that this program helped to retain high need physicians in low-income communities at a time when a lot of physicians were getting out of providing care particularly for high risk services. Those physicians could not afford the burden of very expensive medical malpractice insurance. The program helps to maintain doctors in those areas.

Ms. Saunders reported that the Governor proposed in his budget to allocate an additional $40 million in funding for the Vital Access program. Ms. Saunders explained that the Vital Access Program (VAP) provided grants to essential health care providers who had been affected by system transformations like closures. She noted that this increase would bring the total funding to $194 million. Ms. Saunders informed the Committee that, to date, Lincoln Medical Center, Woodhull Medical and Mental Health Center and Kings County Hospital had received more than $5 million in VAP funding. In addition, the SDOH has received more than 150 applications totaling $1.2 billion. Ms. Saunders commented that VAP was included in New York State's Medicaid Waiver proposal. Reverend Diane Lacey, Acting Board Chairman, asked if that proposal also included funding for hospitals that had been affected by Hurricane Sandy. Ms. Saunders responded that VAP funding was not intended to cover Hurricane Sandy claims.

Long Term Care

Ms. Saunders reported on the long term care provisions of the Governor's proposed budget. She stated that the Governor's budget included a provision that would prevent Medicaid rate increases for nursing homes with rapid increases in patient acuity. She stated that this proposal was still being analyzed and could be of concern for HHC. She explained that, if the statewide measure of patient acuity, called the case mix index, increased more than two percent in six months, the State would proportionately reduce facilities' reimbursement rates until it fell below the two percent level. She explained that this initiative would save the State $42.9 million beginning July 1, 2014. The intent of this budget provision is to address "up coding" of rehabilitation services. Ms. Saunders highlighted HHC's concern after all the work that was done at Henry J. Carter Specialty Hospital and Rehabilitation Center. She added that HHC believed that it was complying with the State's request by moving low acuity patients into less restricted settings and only retaining the ones that could only be served in a nursing home setting. She added that it was difficult to predict what the impact would be for HHC.

Ms. Saunders reported on another long term care proposal to create a Medicaid nursing home default rate. The proposal states that, in the absence of any negotiated rate with managed care plans, nursing homes would be reimbursed the current fee-for-service Medicaid rate. Ms. Saunders noted that this initiative would not apply to rehabilitation services.

Ms. Saunders added that the Governor's proposed budget allocated $350 million in funding to support a new requirement for home health care workers to be paid a living wage, or wage parity. Ms. Saunders reported that the Home Care Association was concerned about the funding amount, which they stated was only half of the $700 million to $750 million that was needed to meet the requirements of the new law.

Ms. Saunders reported on the affordable housing provisions that were proposed in the Governor's budget. She stated that, as part of the next phase of the Medicaid Redesign Team (MRT) recommendations, the budget added 200 new supportive housing units for nursing home residents, which would raise the total to 600 units by the end of 2015. This will expand the number of new beds by 1,000 for a total of 5,550 new supportive housing beds added as a result of MRT efforts by the end of 2015. Ms. Saunders noted that these beds would be available for nursing home residents, adult home residents and people in the homeless housing assistance program. As a member of the Medicaid Redesign Team (MRT) Housing Workgroup, Ms. Brown informed the Committee that SDOH staff who hosted the MRT Housing Workgroup had asked for ideas for the next meeting, which was scheduled for late February. She stated that HHC had partnered with three entities to submit the following proposals:

1. CAMBA Gardens II in Brooklyn. Learning from CAMBA I, the major issue is that rental subsidies and service supports for individuals with special medical and mental health needs is very limited. Through the NY-NY III program, the principal criteria is being homeless or in a shelter. Therefore, there are a lot of HHC patients who are homeless or living in a shelter and who need that housing but cannot access it because they need rental support. HHC's proposal is to take 50 of the units that are being built and get rental support for 25 years for 50 residents who are not homeless but are patients of Kings County Hospital, Dr. Susan Smith McKinney Nursing and Rehabilitation Center, Woodhull Medical and Mental Health Center and HHC's Health Homes to be able to access this housing with the rental support.

2. Communilife in Queens. HHC's proposal is to take 75 individuals from the Queens Health Network for whom rental subsidy is needed and for whom it would not have been possible to get them. A total of 125 new units to be made available for HHC patients.

3. Medical Site Respite Housing. This program is designed to serve individuals who have already been medically cleared in the inpatient units. HHC has identified these individuals who have moved to the alternate level of care (ALOC) status and still occupying inpatient beds as a major challenge throughout HHC. Ms. Brown added that this program, with an average stay of 6-8 weeks would allow HHC to discharge these individuals into the respite program and help to finalize their housing arrangements.

Mrs. Bolus commented that some low-income pensioners were also just above the mark to meet the criteria for housing eligibility and were moving to shelters. Ms. Brown clarified that this program was part of the Medicaid program and it had to be targeted to Medicaid beneficiaries. She highlighted its dual purpose as the following:

1. A cost saving objective of the State and federal Medicaid program; and
2. A service policy for people who should not be in skilled nursing facilities and/or hospitals longer than they need to be.

Ms. Brown explained that the program does not assist other New Yorkers who are not on Medicaid (i.e., pensioners and others) with obtaining rental supports in order to secure New York City housing.

Reverend Diane Lacey inquired about veterans' eligibility for housing. Ms. Brown responded that veterans are not Medicaid beneficiaries. There are programs for housing subsidies and support for veterans but it is not a state program.

Mr. Bernard Rosen, Board Member, asked if the respite program would be different from moving the patient from an acute bed into a rehab bed. Ms. Brown responded that if the patient needed rehabilitation services, that patient would go to a skilled nursing facility. She clarified that the Medical Site Respite Housing program would serve patients who do not need acute care or rehab services, who were medically cleared by the inpatient units but need housing support. Ms. Brown explained that, rather than waiting days for housing placement in the hospital, these patients would have the opportunity to be placed in the community with support and services, but in a different setting.

Ms. Saunders informed the Committee that the budget included the same nursing home wage proposal that had been advanced by the Governor in last year's budget. This proposal required nursing homes to pay standard wage and benefits to direct care workers. Ms. Saunders explained that this proposal would require Managed Long Term Care (MLTC) plans to pay nursing homes at a level to support a statewide standard wage and that the State Department of Labor would establish the amount of the wage and benefits. Ms. Saunders noted that HHC had raised its concern last year that the proposal did not clearly exempt facilities with labor agreements nor would it allow regional rates to account for the increased cost of living in New York City compared to Buffalo, which could require a reduction of wage or benefits for HHC employees. Ms. Saunders informed the Committee that this proposal had been rejected by the Legislature last year and that its status this year remained to be seen.

Managed Care

Ms. Saunders reported on the proposals that were included in the budget that focused on managed care. She stated that there was a proposal to allocate $5 million in grants to support the transition of foster care children into managed care. She explained that the funding was intended to prepare foster care agencies for the eventual transition and to help the State collect needed data to set the rates.

Another managed care proposal that was included in the Governor's proposed budget would require the use of enrollment brokers for behavioral health patients. Ms. Saunders stated that, because of all the transitions into managed care, there had been an outcry by consumer advocates and others for more focus and attention being placed on the Medicaid Managed Care Advisory Review Panel. An addition of four new members was proposed to the panel, which would increase the panel to 16 members. Ms. Saunders noted that the new members would represent behavioral health consumers, consumers who are "dually-eligible" for both Medicaid and Medicare, behavioral health providers and providers caring for dually-eligible patients.

Ms. Saunders further reported that the Governor included $17 million in the budget to aid managed care plans with complying with the cost of a new home care requirement. The State Department of Health Department is expected to issue guidance requiring managed care plans to use certified home health agencies (CHHAs) to provide any skilled home care services. Ms. Saunders noted that the funding is intended to assist with the cost of providing the services through a CHHA, which is typically more expensive than providing the services through a licensed agency.

Behavioral Health

Ms. Saunders reported that most of the seven Behavioral Health budget proposals were focused on the move to managed care and integrating this population with traditional health care. These proposals are described below:

1. A proposal to create a Community Based Behavioral Health Services Reinvestment Program. The program would be funded by State General Fund savings generated by transitioning this population to managed care. It would be designed by the State Department of Health (SDOH) and the State Department of Mental Health to increase funding for community-based services for the behavioral health population.

2. A proposal to create a Collaborative Care Clinical Delivery Model. The model is aimed at clinics licensed by the SDOH that treat depression and other mental or substance abuse disorders. The State Departments of Health and Mental Health would work jointly to develop criteria to designate clinics to participate. SDOH would be authorized to waive any needed regulations and to issue new rates for the model.

3. A proposal to advance co-location of behavioral health and physical health services. The budget reallocates $15 million from last year's budget for programs that support the co-location of services. It also allows the State to issue emergency regulation to implement the integration of co-located behavioral health and physical health services that were authorized as part of last year's budget.

4. A proposal to provide funding for the transition to managed care. The budget includes $20 million for training, HIT and transition costs related to the transition of behavioral health into managed care. The State is authorized to provide the funding to health homes, plans, providers and others pursuant to a plan that will be developed. The transition is scheduled to begin with adults in New York City next January.

5. A budget provision to increase the rates for ambulatory behavioral health services. The budget provides authority to the State Office for Mental Health (OMH) and the State Office of Alcohol and Substance Abuse Services (OASAS) to transfer funds to SDOH to pay for rate increases for ambulatory behavioral health services. The increase would be effective through January 2016 for New York City providers, except for patients under 21 where the increases would remain in place for an additional year. The proposal does allow managed care plans to negotiate different rates with providers.

Reverend Diane Lacey asked when the behavioral health proposals would be implemented. Ms. Saunders responded that they were expected to be rolled out by next year starting in New York City and continuing with the rest of the State. Reverend Diane Lacey asked for clarification on the proposal of co-location of services. Ms. Brown responded that the idea of co-location is for a primary care clinic to have the opportunity to co-locate mental health services within that primary care facility. She added that, since it is a state program, HHC, as any other organization, could take advantage of it in its facilities. Ms. Brown highlighted that the program also worked both ways. Mental health clinics, many of which are operated by community-based mental health agencies, would also have the opportunity to co-locate a primary care clinic in their centers. Ms. Brown commented that, there are many people with chronic and non-behavioral health conditions who also experience significant mental health conditions. Their progress would not have been optimized without addressing their non-behavioral conditions. Moreover, many patients who, over the years who have been receiving their mental health services in a community mental health setting without there being extensive attention paid to their chronic medical illnesses (i.e., a heart condition, diabetes etc.,) run the risk of their conditions being exacerbated over the years by psychotropic medications. Ms. Brown noted that the idea is to ensure that the whole patients' medical needs are being addressed. Ms. Brown stated that past regulations that supported segregated services had to be changed to support and reinforce integration of care as well as allocating funds to pay for it. Mr. Nolan commented that a key benefit of co-location was the convenience of having health services housed in one facility versus moving from one building to another. Ms. Brown added that co-location also provided a greater chance that the patient will be provided with that service opportunity.

Reverend Lacey commented that the co-location concept was excellent. She inquired how HHC would take advantage of it. She asked if this would require a separate planning and development process for HHC. Mr. Antonio Martin, HHC's Executive Vice President/Corporate Chief Operating Officer responded that, even without additional State funding, that concept was already at work at HHC because it is the way for the future. Mr. Martin emphasized that the goal is to optimize patient care. He explained that co-location of services have proven to be very successful. Ms. Brown stated that Mr. Aviles had reported at the Finance Committee Meeting that HHC had received grant funding as part of its advancement to the next level of its Patient-Centered Medical Home certification. HHC is now investing in different types of staffing and expanding its services. She stated that one element of that investment was the integration of behavioral and physical health care in primary care settings.

Other Important Health Care Related Proposals in Governor's Budget

Ms. Saunders concluded her presentation by highlighting other budget proposals that did not have a direct budgetary implication for HHC but were of importance to HHC. These proposals include:

1. **Private equity pilot proposal**. The budget includes a slightly revised proposal that was advanced as part of last year's budget. It would allow the State Health Commissioner to approve up to five business corporations to "assist in restructuring health care delivery systems by allowing for increased capital investment in health care facilities." They would have to affiliate with an academic medical center or teaching hospital. They could not be publicly traded. Last year, it was unclear if there was a particular venture in mind. One of the requirements was that there had to be a pilot for the Borough of Brooklyn, which is no longer included in this year's proposal.

2. **Limited services "retail" health clinics, urgent care and office based surgery.** This proposal proposes to implement changes that were recently recommended by the Public Health and Health Planning Council (PHHPC) to license limited service clinics, require full accreditation of urgent care providers, and impose more stringent requirements on office-based surgery practices (beyond the current registration requirements). The Governor did propose to license retail clinics, which are typically publicly traded, as part of last year's budget.

3. **Nurse Practitioner Modernization Act**. The Governor again proposes to modify the requirement under which nurse practitioners (NPs) would practice. As recommended by the MRT, nurse practitioners would be allowed to establish collaborative relationships with a hospital or a physician in their specialty rather than the current requirement for a written practice agreement.

4. **Out-of-Network proposal**. The budget includes new requirements for health plans, hospitals and other providers related to billing for health care services that are provided by out-of-network approved providers that are covered under the patient's health care plan. This includes new notice requirements for health plans and providers, a new consumer dispute process, new reimbursement disclosure and an expansion of network adequacy requirements.

5. **Health Care Reform Act (HCRA) extension.** The budget would extend HRCA for three years through 2017. HCRA includes the Medicaid hospital reimbursement methodology and surcharges that fund a variety of health care programs.

6. **HIV Testing requirements.** The budget includes an overhaul of the requirements governing HIV testing. It would eliminate the requirement for written informed consent, except for patients in correctional facilities.

7. **Basic Health Plan.** Finally, the budget authorizes the State to take advantage of an option under the Affordable Care Act (ACA) to implement a Basic Health Plan, if it is in the financial interest of the State. The State would receive subsidies that would otherwise be available for participants to purchase coverage under the Health Exchange. The plan would cover individuals with incomes between 138-200 percent of the federal poverty level (about $16,000 -$23,000 for an individual or $27,000-$39,000 for a family of three.) The plan would be available for many

legal immigrants who cannot qualify for Medicaid due to their immigration status (but not for undocumented immigrants).

Ms. Brown thanked Ms. Saunders and John Jurenko, Senior Assistant Vice President for the 2014-15 State Fiscal Year Executive Budget overview presentation.

Ms. Anna Kril, Board Member, asked about individuals, such as pensioners and veterans, who are falling between the cracks. She commented that these individuals, who have worked all their lives, suffer enormous hardships because they are slightly above the eligibility mark for Medicaid and are out of the loop of all of these available programs. Ms. Brown answered that these issues should be raised consistently for these individuals because they are not Medicaid beneficiaries and are not entitled to some of these programs. Ms. Brown recommended that the issue should be raised with their Congressional representatives as some of these issues concern federal rules. For instance, there are some HUD requirements that are very specific to certain incomes. Housing developments that use either HUD or Section-8 funding for rental assistance have to adhere to specific program income guidelines. Ms. Brown emphasized that these programs are federal programs and federal representatives would have to change these programs to address these issues. Ms. Brown explained that the City and the State have tried to take full advantage of federal rules to leverage State funds and City opportunities (i.e., parcels of land etc.) to pull together, within the constraints of the federal rules, opportunities to create housing for low income, homeless Medicaid beneficiaries. She commented that the way to address these issues involved people coming together and using the political process to make it happen. For example, Kings County Hospital's CAB members were engaged with CAMBA Ventures in Brooklyn and had called upon the Brooklyn delegation to address this issue. The same process can be done in the other boroughs. She stated that, while federal change involved federal officials, it was possible to start raising the issue with the New York State delegation.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:40 a.m.

Presentation to the Strategic Planning Committee

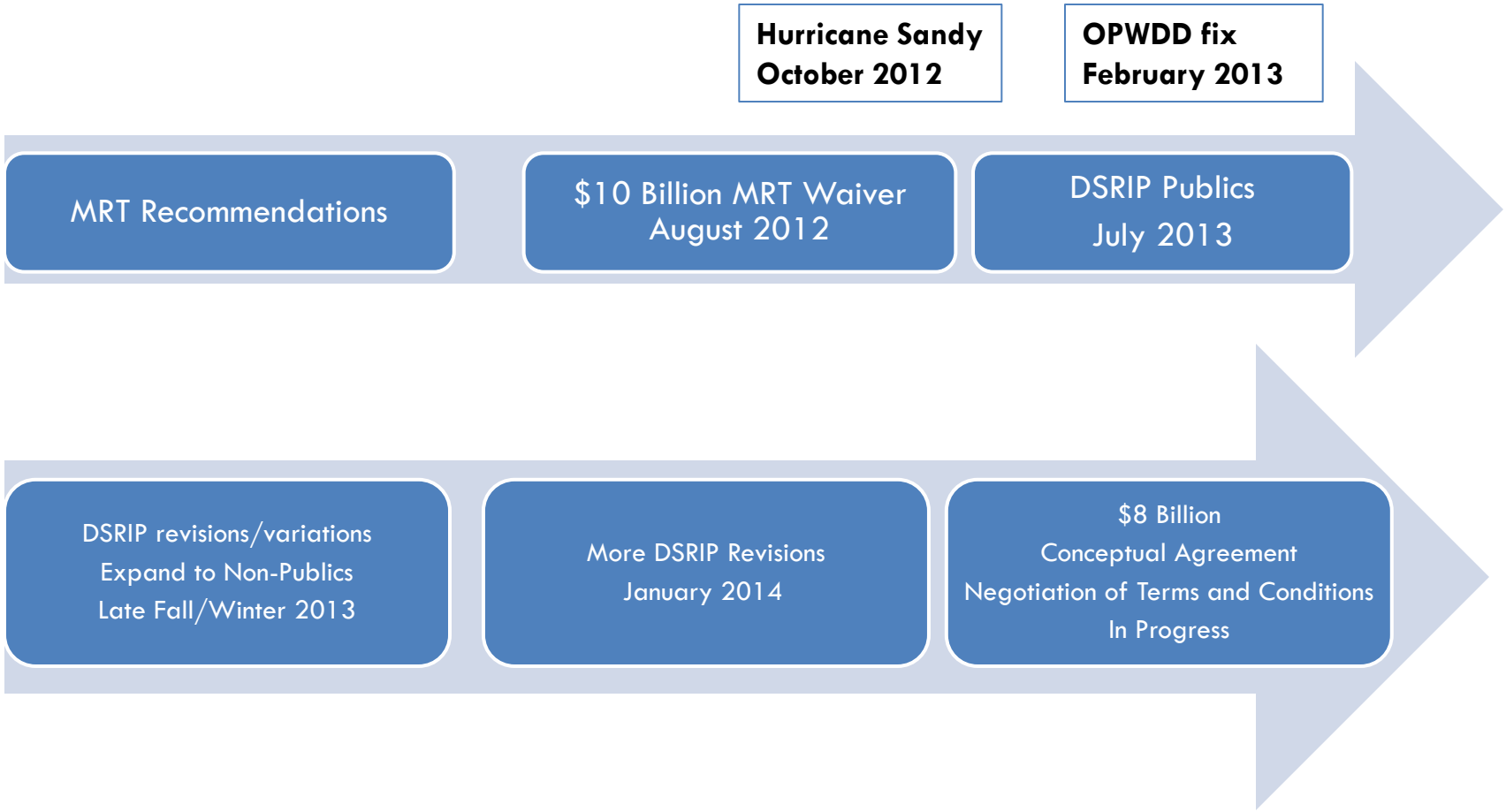
New York State Medicaid Waiver Update

LaRay Brown
Senior Vice President,
Corporate Planning, Community Health and Intergovernmental Relations

March 11, 2014

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

Medicaid Waiver Evolution



Note: All of the information that follows is subject to change as details are negotiated

Source: HANYS

Funding Allocations

December 2013

$10 Billion Submission

DSRIP $7.6 B	State Plan Amendment: $0.5 B	Managed Care Contracts: $1.9 Billion
• Hospital transition • Public hospital innovation • Vital Access Provider (VAP) • Long Term Care Transformation • Public Health Innovation • Health Workforce	• Health Homes	• Primary care expansion • Health workforce (MLTC) • Managed long term services and supports for serious behavioral health/substance abuse

$2 billion reduction to be allocated among programs – **How TBD**

January 2014

$10 Billion Submission

DSRIP $7.3 B	State Plan Amendment: $0.5 B	Managed Care Contracts: $2.2 B
• Hospital transition • Public Hospital innovation • Vital Access Provider (VAP) • Long term care transformation • Public health innovation	• Health Homes	• Primary care expansion • Health workforce • Managed long-term services and supports for serious behavioral health/substance abuse

DSRIP is the primary funding source for hospitals and health systems

HHC will apply for $2.6 B over the 5 year term of Waiver

Source: HANYS

DSRIP Funding Flows

- Public hospitals providing Intergovernmental Transfer Funds (IGTs)
- Part of federal match for IGT used to support DSRIP for non-publics
- Significant funding contingent on public hospitals' cooperation and success

Source: HANYS

DSRIP Key Themes

- Different kind of Waiver
- Delivery system transformation
- Safety Net sustainability
- Potential support to build ability to assume risk
- State proposing to link other investments ($2B Capital Fund in Executive Budget)

Source: HANYS

DSRIP Key Components

- Reduce avoidable hospitalizations
- Statewide initiative for public hospitals and array of Safety Net providers
- Payments are performance-based
- Menu of CMS-approved programs
- Collaboration is expected and rewarded
- DSRIP payments can be used to refund front-loaded investments, support new investments, or other needs

Source: HANYS

DSRIP Eligible Providers

- Major public general hospitals
- Safety Net providers
  - Hospitals, nursing homes, clinics including FQHCs, behavioral health providers, and home care agencies
- Safety Net criteria – under negotiation
  - December – DOH proposed broad parameters
  - January- DOH proposed 3 domains
  - HANYS advocating for definition that represents diversity across the State
- State proposing non-Safety Net hospitals and Safety Net hospitals can partner
  - Lead applicant must be a Medicaid provider

Source: HANYS

DSRIP Overarching Goal

Reduction in Potentially Preventable Hospitalizations – 25% in 5 years and 50% in 10 years Measured by:

- Potentially preventable Emergency Room visits
- Potentially preventable readmissions
- Prevention quality indicators – adult
- Prevention quality indicators – pediatric

Source: HANYS

DSRIP Program Menu

- Hospital transition projects
  - Disease management
  - Transitional care
  - Expand/co-locate primary care
  - Integrate behavioral health with primary care
  - Care management infrastructure
  - Infrastructure for improved geriatric health services
  - Telemedicine strategies
  - Ambulatory detox capability in community
  - Evidence-based medication adherence programs
  - Expansion of palliative care
  - Comprehensive strategy to reduce AIDS/HIV Transmission

Source: HANYS

DSRIP Program Menu

- Long term care transformation
  - Transfer avoidance
  - Hospital-Home Care collaborations
  - Pressure ulcer prevention programs
  - Medication error prevention programs
  - Bed buy back
- Public health innovation
  - Asthma self-management
  - Home visits (Lead poisoning/new mothers etc.)
  - Collaborations for community-based strategies to reduce health disparities
- Off-menu option

Source: HANYS

DSRIP Project Plan Requirements

- A new initiative for the provider
- Substantially different from other CMS-funded initiatives, but could build, expand or augment
- Address significant health issues in the catchment area
- Substantial and transformative change
- Commitment to life-cycle change and organizational resources to ensure success
- Collaboration with other providers with special attention paid to coordination with Health Homes

Source: HANYS

Local Partnerships to Transform Delivery System

Local Partnerships to Transform the Delivery System

Partners should include:

- *Hospitals*
- *Nursing Homes*
- *Clinics & FQHCs*
- *Behavioral Health Providers*
- *Home Care Agencies*
- *Other key stakeholders*

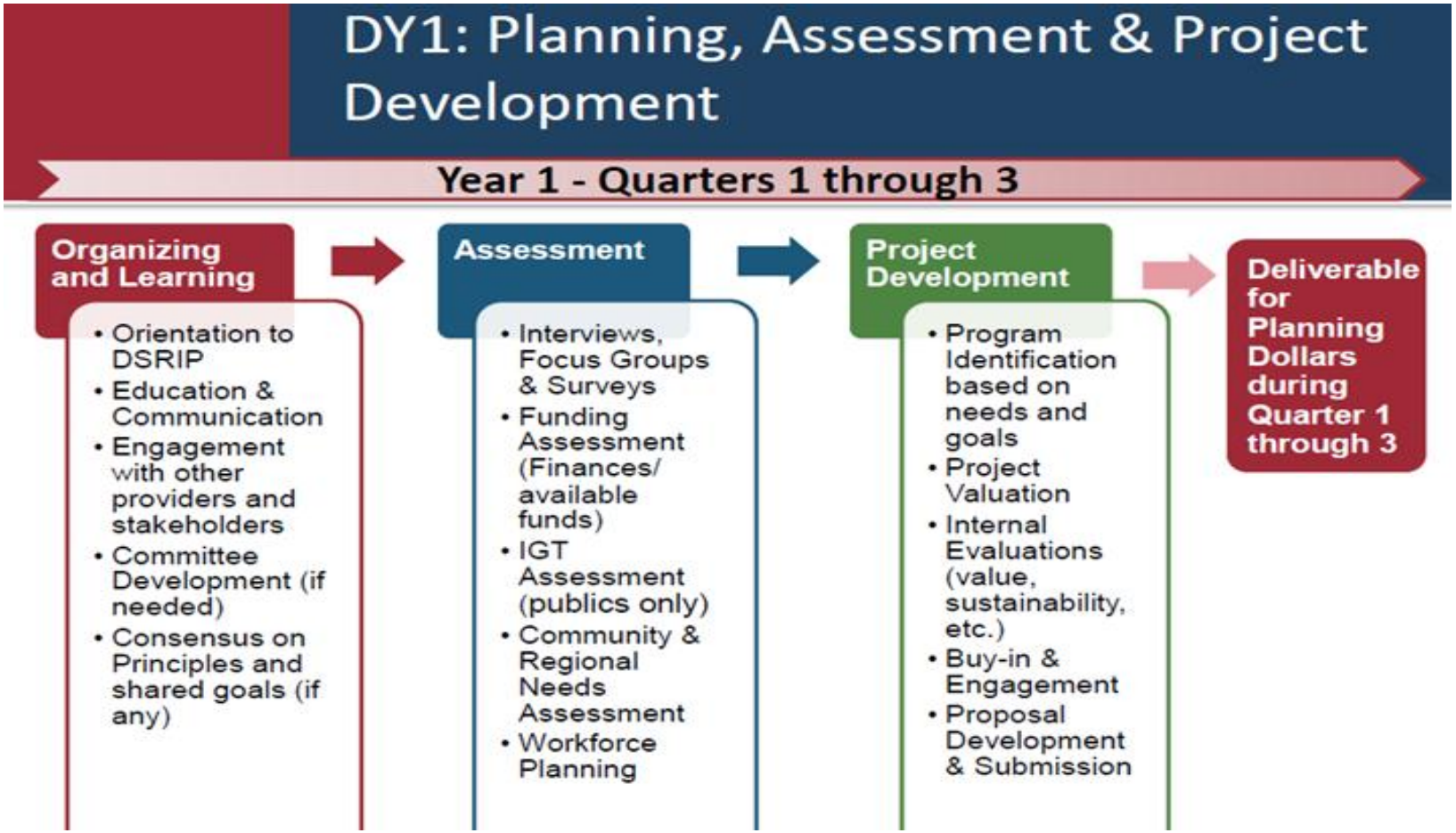
Source: DOH presentation February 24, 2014

DSRIP Timeline (as of January 2014, details will shift)

Stage	Estimate
Target approval date by CMS	Early March 2014
Providers submit project planning application to DOH	April 4, 2014
DOH feedback on project planning applications	April 25, 2014
Funds allocated to approved planning projects	May 2, 2014
Providers submit final project plans	November 28, 2014
DOH reviews and decides on final project plans	December 26, 2014

Source: HANYS

DSRIP Timeline



Note: If awarded planning funds and a final application is not approved then DOH will recoup.

Source: DOH presentation February 24, 2014

DSRIP Final Application Requirements

- Select goals and programs
- Performance assessment
  - Current status of the community
  - Evidence of regional planning
  - Root cause of poor performance
  - Evidence of public input
- Work plan development
- Milestones and metrics
- DOH developing a “databook” for providers

Source: HANYS

DSRIP Program Valuation – Application Scoring Being Negotiated

- Each of the following categories (1-5 points)
  - Alignment with avoidable hospitalization and quality objectives
  - Potential for cost savings
  - Degree of community collaboration and comprehensive partnerships
  - Robustness of evidence base
  - Number of Medicaid members impacted
  - Financial viability of lead applicant

Source: HANYS

DSRIP Program Measures

- Process measures (i.e. plan, action steps)
- Outcome measures (i.e. QARR, HEDIS, CAPHS, BRFSS, SPARCS, CHIRS)
- Avoidable hospitalization measures
- Measures of overall system change (e.g., reduction in inpatient, increases in primary care)
- Financial sustainability metrics to assess long term viability

Source: HANYS

DSRIP Funding Distribution Stages

(under discussion)

DSRIP Funding Distribution Stages	Year 2	Year 3	Year 4	Year 5
Project Process Metrics (Includes Infrastructure and Project Design and Management)	70%	60%	30%	5%
Project Specific Outcomes Metrics (Includes quality improvement, chronic disease management and population health)	10%	15%	25%	25%
Provider Financial Viability Metrics (If applicable, if not applicable to a given provider, this percentage will get moved to the other three categories)	15%	15%	15%	15%
Avoidable Hospitalizations	5%	10%	30%	55%
Total	100%	100%	100%	100%

Note: Year 1 payments primarily for planning

Source: HANYS

Final Stretch

- Many outstanding issues being negotiated with CMS
  - Safety net definition
  - Valuation goals/distribution
  - Program scoring
  - Metrics and value for attainment

- Goal is agreement on terms and conditions by early March 2014

Source: HANYS

Improving Access to Health Care Services for Women with Disabilities

Presentation to the Strategic Planning Committee of the Board of Directors

March 11, 2014

“There are too many women with disabilities who have been silenced. We can’t be. Some people don’t want to tell their stories because it’s so painful. When it comes to health care, it’s happened so many times, it feels like it’s not going to change.”

- M. Lyons, Member, Independence Care System

Independence Care System - Who are we?

- Non-profit Medicaid Managed Long Term Care Plan
- Coordinates home care, health care, and social services to enable adults with physical disabilities and chronic conditions to live at home
- Only plan specifically designed for people with physical disabilities
- Serves over 5000 members in Brooklyn, the Bronx, Manhattan and Queens
- Half use wheelchairs or other mobility aides
- Over 30% require 24-hour personal care
- Most are Hispanic/African-American
- Approximately half are over the age of 65.
- Many ICS members use HHC facilities to meet their healthcare needs

The Beginnings

"Breaking Down Barriers, Breaking the Silence: Making Health Care Accessible for Women with Disabilities." Authored by the Independence Care System (ICS) and New York Lawyers for the Public Interest.

- Report released in 2012
- Described commons barriers to receiving health care services
- Offered recommendations to improve access to care

Common Barriers to Accessing Healthcare Services

- Physical access
  - ✓Facility design
  - ✓Accessible equipment
- Communication barriers
  - ✓Language access
  - ✓Alternative media
  - ✓Signage
- Attitudinal barriers and lack of training

> "When you have a physical disability and you're looking for a gynecologist, you usually have to settle. Most women don't know that the facility should be accessible, so we tend to adapt. We don't know any better, so we settle. For example, I went to one place and the only thing that was accessible was the front door."
>
> – C. Cruz, Member, Independence Care System

Example: Attitudinal Barriers

"Another young lady with a disability was [at the gynecologist's office] when I was there and the doctor raced around the place saying, "Oh my god, she's pregnant; I can't believe it, she can't be!" She was so loud everyone in the waiting room heard it. I was disgusted. When I went in for my appointment they did a pregnancy test on me even though I didn't request it. When it came back negative, they said "Oh, well thank god you're not pregnant!" I cannot even begin to tell you how upset I was, not only for myself, but for the other woman– she was a grown woman with a job – and they carried on so horribly."

– Kim Yancy, Member, Independence Care System

Legal Framework for Providing Accessible Care

Anti-Discrimination Laws that Protect New Yorkers with Disabilities:

- Americans with Disabilities Act
- Section 504 of the 1974 Rehabilitation Act
- Local and State Anti-Discrimination Laws

ICS Access to Healthcare for Women with Physical Disabilities Program

- Improving Cancer Screening Accessibility in New York City
- Reducing/Eliminating Physical Barriers & Inaccessible Equipment
  - ✓ *Mammography Project*
  - ✓ *Gynecological Project*
- Educating Staff to Address Provider Misconceptions & Lack of Sensitivity, Awareness and Competencies
- Creating Procedures to Increase Efficiency & Accessibility

"It's important because my mother had breast cancer and if I don't get that mammogram I could get cancer and not know it. If I get the mammogram maybe I could catch it in time. I like to have my mammogram every year."

– Esther J., Member, Independence Care System

Program Challenges

- Finding medical facilities willing to create partnerships
- Securing executive and clinical staff buy-in
- Accommodations
  - ✓Accessible equipment
  - ✓Transfer assistance
- Time Commitments
  - Longer appointments
  - Staff Training

"My first time in the ICS program, everything was in one room so I didn't have to undress and come in through the back door. I usually have a real hard time with spasticity, but the chair lift worked and I was able to get on the chair pretty much by myself. That the table actually came down to me – that made a huge difference. She did the examination the way it should be done. I'm 49 years old and that was the first time I had a totally accessible experience."

– M. Lyons, Member, Independence Care System

Launch of ICS – HHC Collaboration

- In 2011, Marilyn Saviola, VP, Advocacy and the Women's Health Access Program (ICS) and staff began a series of meetings with Morrisania D& TC leadership to explore the possibility of creating new access to services for women with disabilities.

- In May 2011, a Business Agreement was signed by HHC and ICS to start a pilot project at the Morrisania D&TC to accept ICS referrals for mammography services.

Morrisania Diagnostic and Treatment Center

- Part of Generations+ Northern Manhattan Network
- Provides comprehensive Primary Care, Women's Health, Adult Medicine, Pediatrics, Behavioral Health, Dentistry, HIV, Optometry, Podiatry, Child Development Clinic (CDC), Pharmacy, Radiology, Social Work, Nutrition, WIC, and enabling services including Medicaid Assistance Program (MAP) onsite.
- Hours: Mondays- Fridays 7:30 AM – 8:00 PM
- 190+ staff
- 80,000+ visits annually

Network Vision Statement:
We provide a caring, value added outpatient experience that anticipates patient and community needs and exceeds expectations through a highly engaged patient centered workforce.

Morrisania D&TC – Mammography Equipment

- Assessments of mammography and sonography suites were conducted to identify equipment needs.
- ICS provide recommendations to create a comfortable setting for women with disabilities.
- Special mammography chair and cushions were purchased to position patients for procedures.
- Hoyer lifts were obtained from HHC's Goldwater facility

Morrisania D&TC - Mammography Services Processes

- In 2011-12 joint ICS/Morrisania Partnership meetings were convened to develop patient referral processes, appointment schedules, communication strategies between caregivers, patients and support staff to coordinate care and provide consultative reports and plan for staff training.

- Traditional mammography and sonography services were offered in 2012.

- In 2013, Morrisania installed a new digital mammography unit with federal funding from HRSA.

Morrisania D&TC - Gynecological Services

- Special equipment purchased: Hoyer lifts, weight scale, exam table, large exam room
- Women Health Services has provided 400+ visits/year:
  - ✓Routine GYN visits
  - ✓Colposcopy services
  - ✓Abnormal uterine bleeding evaluation and treatment
  - ✓STD testing and treatment
  - ✓Mammography and sonography services
- ICS has a dedicated nurse educator who accompanies ICS' members to appointments at Morrisania D&TC

Morrisania D&TC - Staff Training

- In 2012, a series of Disability Sensitivity and Awareness Staff Training workshops were conducted by ICS

- Training included didactic training and role playing with interdisciplinary staff in Women's Health, Radiology, Adult Medicine
  - ✓ Staff participants included clerical, nursing, clinical providers, administrators and other support staff

- Staff responded positively to training workshops

Wheelchair Tune-Up Event

You are invited to attend a Wheelchair Tune-Up event, sponsored by Morrisania Diagnostic & Treatment Center and Independence Care System (ICS). Wheelchair users and their caregivers, as well as friends and family members of wheelchair users, are welcome.

Date: Tuesday, March 11, 2014

Time: Session 1: 10:30 am—12 pm
Session 2: 12 pm—1:30 pm

Place: Morrisania Diagnostic & Treatment Center (Room 1A)
1225 Gerard Avenue, Bronx, New York

Both sessions will include a 30-minute lecture focused on general wheelchair maintenance, followed by 60 minutes where individuals can meet one-on-one with ICS wheelchair technicians. All attendees will receive a Wheelchair Maintenance Tip Sheet. Light food and drink will be provided upon conclusion of each session.

Space is limited so kindly RSVP to Sonia Rodriquez at 718-960-2607 or *rodrigus6@nychhc.org* by **Tuesday, March 4**. Indicate which session you'll be attending and whether you plan to bring someone. You can also contact Sonia with any questions.

Lessons Learned from Morrisania D&TC

- Provided access to services for women with disabilities
- Learned about clinical barriers to care (e.g. spasticity)
- Enriched clinical acumen of providers
- Provided staff expertise and promoted staff ease in providing care to women with disabilities

Morrisania D &TC - Next Steps

- Adult Primary Care services to start in April 2014
- Special emphasis on preventative medicine
- Chronic disease management
- Expand the number of physicians providing services
- With City Council funding, a bathroom located within mammography suite will be renovated to become handicap accessible

Woodhull Medical and Mental Health Center - Emerging Hospital-based Model of Care for Women with Disabilities

- Staff training
  - ✓Disability Sensitivity and Awareness
  - ✓Clinical Competency
- Commitment to quality and compassionate care for women with disabilities
- Improvements/enhancements made in Women's Health Services area at Woodhull

Expanding Efforts to Improve Access to Services for Women with Disabilities Across HHC

Three key projects:

- An environmental survey of accessibility at 9 HHC facilities
- Accessibility renovations made possible by City Council funds
- Curriculum development and staff training made possible by a New York Community Trust grant

Environmental Assessments

- HHC contracted with ICS to conduct environmental assessments of the Women's Health Services areas of 9 HHC facilities
  - **Manhattan**: Bellevue, Renaissance D&TC, Metropolitan
  - **Bronx:** Lincoln Hospital, North Central Bronx Hospital
  - **Brooklyn**: Cumberland D&TC, Woodhull
  - **Queens**: Elmhurst Hospital, Queens Hospital
  - **Staten Island**: 155 Vanderbilt D&TC (desk review)
- ICS developed a standardized assessment tool
- ICS will provide HHC with findings and short term recommendations that could be implemented with minimal investment at targeted facilities to improve access to services for women with disabilities

$5 million City Council Funding Commitment for FY'14 and FY'15

- Received $2.5 million in FY'14 with $2.5 million pledged for FY15
- Led by Council Members Maria Del Carmen Arroyo and Julissa Ferreras
- Part of a Council initiative to expand access to women's healthcare services for women with disabilities
- Will fund renovations and equipment to make exam rooms and bathrooms optimally accessible for persons with disabilities
  - ✓ In hospitals, D&TCs, long term care facilities
  - ✓ Exam rooms, including adjustable exam tables and Hoyer lifts
  - ✓ Bathrooms used by women in wheelchairs
  - ✓ Radiology suites that provide mammograms
- First phase preliminary design work and cost estimates for 8 facilities to be completed in June 2014

Training Curriculum Development for HHC Staff Through Collaboration with ICS

- HHC secured grant funding from New York Community Trust totaling $135,000 to develop a training curriculum and to train staff

- ICS will develop two curriculums
  - ✓ Face-to-face training
  - ✓ Online teaching using PeopleSoft
  - ✓ Provide face-to-face training at 8 facilities

- HHC will:
  - ✓ Purchase equipment for training
  - ✓ Facilitate a curriculum advisory group
  - ✓ Conduct a comprehensive project evaluation

What's Next for ICS/HHC Partnership?

- Presentation to the New York State Department of Health Accessibility Workgroup convened by Deputy Executive Commissioner Sue Kelly(April 2014)
- Replication of model into additional facilities
- Development of Model Program/ "Center of Excellence" criteria
- Expansion to men with disabilities and other healthcare areas
  - ✓Develop/train on clinical competencies
  - ✓Extension of environmental survey to other areas of facilities
- Work in partnership to facilitate continuity of care