STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

DECEMBER 1, 2015
10:30 A.M.
NYC HEALTH AND HOSPITALS BOARD ROOM
125 WORTH STREET

AGENDA

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

II. ADOPTION OF NOVEMBER 10, 2015 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEMS:

i. NYC Health and Hospitals' Journey Toward Being a Leader in LGBT Healthcare Equality
Mark Winiarski, Ph.D., Assistant Director, Corporate Planning Services

ii. Forces Driving the Future of Post-Acute Care and Long Term Care Services
Scott Amrhein, President, Continuing Care Leadership Coalition

Gabriel Oberfield, J.D., M.S.J, Vice President of Policy and Operations, Continuing Care Leadership Coalition

V. OLD BUSINESS

VI. NEW BUSINESS

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

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

NOVEMBER 10, 2015

The meeting of the Strategic Planning Committee of the Board of Directors was held on November 10, 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
Lilliam Barrios-Paoli, Chairman of the Board
Robert F. Nolan
Bernard Rosen

OTHER ATTENDEES

J. Agrawal, Office of Management and Budget
J. DeGeorge, Analyst, New York State Comptroller
T. Derulo, Analyst, Office of Management and Budget
M. Dolan, Senior Assistant Director, DC 37
E. Kelly, Analyst, New York City Independent Budget Office
S. Wheeler, Budget Analyst, Office of Management and Budget

HHC STAFF

S. Abbott, Assistant Director, Corporate Planning Services
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
J. Bender, Assistant Director, Media, Communications and Marketing
A. Berkowitz, Senior Director, Finance
L. Brown, Senior Vice President, Corporate Planning, Community Health and

Intergovernmental Relations
T. Carlisle, Associate Executive Director, Corporate Planning Services
E. Casey, Director, Corporate Planning, HIV Services
D. Cates, Chief of Staff, Office of the Chairman of the Board of Directors
R. Dixon, Associate Director, Harlem Hospital Center
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
C. Jacobs, Senior Vice President, Safety and Human Development
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
Z. Liu, Senior Management Consultant, Corporate Planning Services
L. Lombardi, Chief Strategy Officer, Bellevue Hospital Center
P. Lockhart, Secretary to the Corporation, Office of the Chairman of the Board of Directors
A. Marengo, Senior Vice President, Communications and Marketing
R. Mark, Chief of Staff, Office of the President
A. Martin, Executive Vice President and Chief Operating Officer, Office of the President
T. Miles, Executive Director, World Trade Center Environmental Health Center
D. Ng, Senior System Analyst, Finance
K. Park, Associate Executive Director, Queens Health Network
S. Penn, Deputy Director, World Trade Center Environmental Health Center
N. Peterson, DSRIP Facility Manager, Woodhull Medical and Mental Health Center
C. Philippou, Assistant Director, Corporate Planning Services
S. Ritzel, Associate Director, Kings County Hospital Center
J. Roman, Senior Associate Director, Metropolitan Hospital Center
E. Russo, Senior Director, Corporate Planning Services
S. Russo, Senior Vice President, Office of Legal Affairs
D. Wilson, Director, Office of Legal Affairs
R. Wilson, M.D., Senior Vice President, Corporate Chief Medical Officer, Medical and Professional Affairs
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

CALL TO ORDER

Ms. Josephine Bolus, Chairman of the Strategic Planning Committee called the November 10, 2015, Meeting of the Strategic Planning Committee (SPC) of the Board of Directors to order at 10:35 A.M. The minutes of the October 13, 2015 SPC meeting were adopted.

SENIOR VICE PRESIDENT REMARKS

Federal Update

Two-Midnight Rule Update

Ms. Brown reported that the final Outpatient Prospective Payment System (OPPS) Rule concerning the Two Midnight Policy was released last week with some positive changes. A major positive change is that CMS will allow, on a case-by-case basis, inpatient payment if the medical record supports the physician's determination that inpatient care is required, regardless of length of stay. The rule codifies these changes giving physicians discretion in classifying stays less than two midnights as inpatient. Key factors for physicians' consideration include severity of patient's symptoms, predictability of an adverse medical event for patient and the need for diagnostic studies that could be conducted appropriately on an outpatient basis. Ms. Brown announced that the rule would take effect on January 1, 2016; and it should be considered a major victory for hospitals and the hospital industry.

Ms. Brown reminded the Committee that a key precipitant for all the attention on the Two-Midnight Rule had to do with patients getting stuck with a bill after discharge from the Emergency Department (ED) stating that they were on observation in an outpatient setting while they thought that they were in a hospital. Consequently, there are major implications with regard to co-payments and whether the costs would be picked up by their insurance. Additionally, for patients who are being discharged to a post-acute care setting, it would impact when Medicaid reimbursement would kick-in versus Medicare reimbursement. Ms. Brown added that this most recent rule provided some clarification and would allow for physicians' discretion.

340B Drug Discount Program Update

Ms. Brown reported that NYC Health and Hospitals had been participating in the 340B program since its inception in 1992. NYC Health and Hospitals saves an estimated $25 million (when compared to GPO prices) on purchases of $71 million. Moreover, NYC Health and Hospitals benefits from contract pharmacy arrangements that could save up to $20 million/year. The proposed changes would eliminate NYC Health and Hospitals' savings. Furthermore, the prohibition on discharge medicines being 340B eligible could impact a key CMS goal to reduce inpatient readmissions.

Ms. Brown reported that NYC Health and Hospitals submitted its comment letter concerning the comprehensive 340 B Drug Discount Program Mega Guidance to the Health Resources Administration (HRSA) on October 27th. NYC Health and Hospitals' key issue is the change of 340B patient definition to "billable outpatient service," which would result in the exclusion of discharge drugs from the 340B Program. This exclusion includes drugs provided to patients who are being discharged from an inpatient setting. Discharge drugs are provided on an interim basis until a patient can get to his or her primary care physician to ensure that there is continuity of the medication and the possible reduction of the patient having to be

readmitted within a short timeframe from that discharge. This guidance would not allow for the provision of discharge drugs; it excludes the use of 340B drugs for observation and ED visits that lead to inpatient stays; and for infusion only services. Ms. Brown added that the guidance may potentially exclude non-NYC Health and Hospitals' physicians (those employed by an affiliate) from dispensing 340B qualified pharmaceuticals.

Ms. Brown explained that, because of a groundswell of comments from affected parties including Federally Qualified Health Centers (FQHCs), the American Essential Hospitals (AEH), critical care hospitals, health care consumers and many others, it would be a long time before the 340 B Drug Discount Program guidance is implemented.

Bipartisan Budget Act of 2015 signed into law on November 2, 2015

Ms. Brown reported that the Bipartisan Budget Act of 2015 includes a provision that would reduce the amount of increase in Medicare Part B premiums for certain beneficiaries in 2016. Seventy percent of Medicare beneficiaries will be held harmless from any reduction in their social security benefits under any circumstances. Other seniors will be held to an increase from the current $104 to $123 per month. The Budget law will raise budget cap allowances; suspend the debt limit until March 15, 2017; partially roll back the sequester of discretionary spending scheduled for FY 2016 and FY 2017 – but would extend the Medicare 2% sequester by an additional year to 2025 (at a cost of $12 million for NYC Health and Hospitals); and provide a Medicaid rebate for generic drugs. Ms. Brown added that the law does not include any cuts to GME, IME or Medicaid Disproportionate Share Hospital (DSH) funding. Ms. Brown commented that NYC Health and Hospitals was grateful for Senator Charles Schumer's and Congressman Joseph Crowley's actions in pushing back these cuts.

Ms. Brown reported that, as part of the pay-fors, the Budget bill creates a Medicare Site-Neutral Payment Policy. The site-neutral provision will prohibit Outpatient Prospective Payment System's (PPS) payments to newly created or acquired provider-based off-campus sites, which the Congressional Budget Office estimates would save $9.3 billion nationally. This provision does not impact NYC Health and Hospitals. While the bill leaves many details of the site-neutral payment policy to the regulatory process, the legislative language states:

- Any "new" provider-based off-campus hospital outpatient departments (HOPD) would not be eligible to receive reimbursement under the outpatient prospective payment system (PPS) unless it is located on the main campus or within 250 yards of a remote location of a hospital facility.

- A "new" off-campus provider-based HOPD, including an acquired physician practice that is converted to a HOPD, is defined as an entity that executed a CMS provider agreement and billed for a covered HOPD service after the date of enactment.

- The provision applies to all covered services provided at the facility, except items/services furnished by a dedicated emergency department.

Ms. Brown commented that, as a result of the NYC Health and Hospitals' decision to expand the FQHC and FQHC-LAL network, the payments will be $50 more for outpatient services than in a doctor's office. This

added revenue validates the strategy to increase the focus on FQHC expansion. FQHC's are diagnostic and treatment centers not hospitals.

New Speaker of the House of Representatives

Ms. Brown reported that Representative Paul Ryan (R- WI) was elected Speaker of the House on October 29th with strong support of Republican and conservative members. Ms. Brown highlighted some of Mr. Ryan's characteristics which are described below:

- He believes in small, less intrusive government.
- He is very conservative.
- He had proposed to block grant Medicaid as Chairman of the House Budget Committee.
- He had also proposed to turn Medicare into a voucher-based program – seniors would use vouchers to purchase health insurance.

City and State

CARE Act

Ms. Brown reported that Governor Cuomo had signed the CARE Act (Caregiver Advice, Record & Enable), which would allow patients to formally designate a caregiver who may provide aftercare assistance following discharge. As such, hospitals must inform patients of the opportunity to designate a caregiver. Ms. Brown commented that many hospitals have already been doing this informally. She informed the Committee that the Act would take effect on April 24, 2016. The New York State Department of Health (NYSDOH) is in the process of developing the regulations. She commented that this Act was AARP's first priority and was part of a campaign to have laws in every state that would provide patients, particularly seniors, with the opportunity to designate a caregiver who would provide post hospital care.

New York City Election Results

Ms. Brown reported that the balance of power had remained unchanged in Albany. She announced the following appointments:

- 1 New State Senator:
  Roxanne Persaud of Brooklyn will replace John Sampson, former Assembly Member

- 2 New Assembly Members:
  Alicia Hyndman of Queens will replace Bill Scarborough, former Community Education Council President
  Pamela Harris of Brooklyn will replace Alec Brook-Krasny, former Corrections Officer and Coney Island Hospital Community Advisory Board (CAB) member

- New Council Members**:**
  Barry Grodenchik of Queens will replaces Mark Weprin, former Assembly Member
  Joseph Borelli of Staten Island will replaces Vinnie Ignizio, former Assembly Member

INFORMATION ITEM

Presentation: HHC's Primary Care Expansion Initiative

Steven Fass, Assistant Vice President, Corporate Planning Services
Mari Millet, Deputy Executive Director, Ambulatory Care Services
Alice Berkowitz, Senior Director, Corporate Budget
Tamika Campbell, Director, Office of Facilities Development, Construction & Maintenance

Ms. Brown reminded the Committee that, most recently, the Mayor had announced a major healthcare expansion initiative called, "Caring Neighborhoods" to bring primary care to underserved areas across the City. This initiative has two components: the establishment or creation of new primary care sites and/or expansion of primary care services in the most high need communities of the City throughout the five boroughs. NYC Health and Hospitals is playing and extremely prominent role in that initiative as well as the Economic Development Corporation (EDC). While NYC Health and Hospitals' role is to expand several of its existing primary care sites in those high need communities and to create/develop new primary care locations in some of those high need communities, the EDC involvement will do a similar body of work with the non-NYC Health and Hospitals' FQHCs. Ms. Brown informed the Committee that this initiative involved not only NYC Health and Hospitals' staff, but also staff from the Office of Management and Budget, the Deputy Mayor's Office as well as liaisons from the Department of Buildings. Ms. Brown emphasized that NYC Health and Hospitals will engage anyone and everyone to help with the implementation of this initiative within the timeframe Dr. Raju had committed to the Mayor and Deputy Mayor. She highlighted that this initiative will require support from NYC Health and Hospitals' Medical and Professional Affairs (MPA) leadership as well as the Chief Operating Officer, Mr. Antonio Martin.

Mr. Fass introduced himself and members of the project team. He informed the Committee that the team's presentation would describe the primary care expansion initiative and the project's status to date. As the Project Manager, he would provide an overview and describe how the neighborhoods and locations were selected for expansion. Ms. Mari Millet, Deputy Executive Director for Ambulatory Care for Gotham Health, would describe the model of care that will be employed and how all aspects of the design of the new sites will support the care model. Alice Berkowitz, Senior Director, Corporate Budget, would provide information regarding the anticipated revenues and expenses of this initiative. Tamika Campbell, Director, Office of Facilities Development, Construction & Maintenance, is the projects' design and construction manager. She would present an overview of the design process, anticipated capital costs and construction schedule.

Mr. Fass stated that many disciplines must come together to create a new or expanded clinic. The work groups and key staff involved in the NYC Health and Hospitals' Primary Care Expansion Initiative included the following:

- Project Owner and Intergovernmental Affairs
  - LaRay Brown
- Project Manager
  - Steven Fass
- Operations and End User
  - Mari Millet
- Community Needs Assessment
  - Christopher Philippou
- Real Estate and Legal
  - Dion Wilson

    - Jeremy Berman
- Regulatory
    - Elena Russo
- Finance and Capital
    - Fred Covino
    - Alice Berkowitz
    - Dean Moskos
- Design, Engineering, and Construction
    - Roslyn Weinstein
    - Louis Iglhaut
    - Tamika Campbell, D&C Project Manager
    - Mahendranath (Menji) Indar
    - Jacobs Engineering
    - MJCL Architects
    - Workspace Consulting Group
- Information Technology
    - Robert Hinton, IT Project Manager

Mr. Fass read the following Problem Statement, which stated, "Unequal access to quality, affordable, primary and preventive health care has contributed to wide disparities in the health of NYC communities."

Mr. Fass stated that this initiative would address the disparity in the health of New York's communities by expanding access to primary care in the City's neediest neighborhoods. For primary care to be accessible it must be:

- Conveniently located
- Available at a time of day and day of the week that is convenient
- Affordable
- Culturally sensitive
- High quality
- Designed to address the needs of the community

Mr. Fass reported that the impetus for this initiative was to support the Mayoral initiative named, "Caring Neighborhoods," support the NYC Health and Hospitals Vision 2020 goals and to expand market share. While the Mayor announced that the goal is to expand and create at least 11 health care centers in high need areas by 2017, NYC Health and Hospitals is striving for a total of 16 sites. Mr. Fass informed the Committee that all of these sites would live under the Gotham Health umbrella. Therefore, these sites must abide by the stringent requirements of all FQHC's including providing primary care that is comprehensive, culturally competent, and to provide care regardless of patients' ability to pay. They must have community oversight and report to the Human Resources Services Administration (HRSA) on quality and cost of care on an annual basis. Mr. Fass noted that, as a benefit, these new and expanded sites will also participate in the same reimbursement program as all FQHCs.

Mr. Fass reported that the NYC Health and Hospitals had conducted an extensive review to determine the most appropriate neighborhoods and the location within each neighborhood. The process was led by Corporate Planning Services and included Medical and Professional Affairs, Finance and facilities' leadership throughout New York City.

Mr. Fass stated that the analysis was conducted on a three tier level:

- Identify population health
- Analyze demographics describing the health challenges or socioeconomic determinants of health
- Identify expansion opportunities, some of which are specific to NYC Health and Hospitals

Mr. Fass explained that, to compare population health among neighborhoods, some of the chosen indicators (listed below) included the level of chronic disease prevalence, potentially avoidable hospitalizations and potentially preventable emergency department (ED) visits in relation to the citywide and statewide averages. Mr. Fass noted that these indicators were also chosen by the state as key DSRIP goals.

Mr. Fass highlighted that population demographics were used to determine the number and percent of a neighborhood's population that had the greatest challenges with accessing healthcare; income below 200% of the federal poverty level (FPL); the number of Medicaid beneficiaries; the number of uninsured individuals; and number of immigrants, as outlined below:

Population Health

- Chronic disease prevalence
- Potentially avoidable hospitalizations
  - Circulatory
  - Diabetes
  - Respiratory
- Potentially preventable ED visits

Demographics

- Uninsured Rate
- Medicaid Beneficiaries
- Income below 200% FPL
- Population less than age 18 and greater than age 65
- Cognitive Difficulty
- Ambulatory Difficulty
- Speaking English "Less than Well"
- Non-Citizen (as % of Foreign Born)

Mr. Fass reported that the Community Health Care Association of New York State (CHCANYS) had conducted a similar study in early 2013, which was repeated in late 2015 that ranked NYC neighborhoods by need (see below). While different methods were used by NYC Health and Hospitals, the findings were very similar.

2013

Bronx
- **Fordham – Bronx Park**
- **Crotona – Tremont**
- **High Bridge – Morrisania**
- **Hunts Point – Mott Haven**

Brooklyn
- **Bedford Stuyvesant – Crown Heights**
- **East New York**
- **Sunset Park**
- **East Flatbush - Flatbush**
- **Williamsburg – Bushwick**

Manhattan
- **Washington Heights – Inwood**
- **Central Harlem – Morningside Heights**
- **East Harlem**

Queens
- **Long Island City – Astoria**
- **West Queens**
- **Flushing – Clearview**
- **Jamaica**

2015

Bronx
- **Fordham – Bronx Park**
- **Crotona – Tremont**
- **High Bridge – Morrisania**
- **Hunts Point – Mott Haven**
- **Pelham-Throgs Neck**

Brooklyn
- **East New York**
- **Sunset Park**
- **East Flatbush - Flatbush**
- **Williamsburg – Bushwick**
- **Borough Park**
- **Coney Island-Sheepshead Bay**

Manhattan
- **Washington Heights – Inwood**
- **East Harlem**

Queens
- **West Queens**
- **Flushing – Clearview**
- **Jamaica**

Mr. Fass stated that once the high need neighborhoods had been designated the next step was to identify primary care expansion opportunities for NYC Health and Hospitals by:

- Identifying potential existing sites for expansion and lease sites
- Projecting the service area
    - 12 to 18 minute distance by foot, bus, or subway
- Quantifying the target market population within the projected service area
    - Income less than 200% Federal Poverty Level
    - New immigrants
    - NYCHA development residents
- Determining proximity to existing article 28 primary care providers within projected service area and identify any gaps in services
    - HHC facilities
    - Non-public facilities
- Quantifying NYC Health and Hospitals' and MetroPlus' market share
- Determining neighborhood demand for additional primary care (unmet need)
    - Percent of Medicaid beneficiaries who do not use ambulatory care services
    - Percent of Medicaid beneficiaries who use an ambulatory care provider outside of their neighborhood
- Evaluating the infrastructure of projected service area
    - Foot traffic
    - Visibility and signage opportunities
    - CBO linkages opportunities
    - Pharmacies
- Analyzing market potential based on estimated market share penetration by primary, secondary, and tertiary service areas
- Forecasting primary care providers that can be supported by site

Mr. Fass explained that neighborhoods are quite large because they are the aggregate of two or three zip codes. Based on the analysis of NYC Health and Hospitals' existing sites, it was determined that at a typical site, most patients would be willing to travel 12 to 18 minutes by foot, car, bus or subway. This information was used to estimate the potential service area for the sites. In addition, the target market population within the projected service area was quantified based the number of households with income less than 200% Federal Poverty Level, the number of new immigrants and NYCHA development residents. The next step was to look at proximity to existing Article 28 primary care providers (NYC Health and Hospitals' facilities or non-public facilities) within the projected service area and identify service gaps. NYC Health and Hospitals' and MetroPlus' market share were considered along with the neighborhood demand for additional primary care (unmet need), the percent of Medicaid beneficiaries that do not use ambulatory care services, and the percent of Medicaid beneficiaries that use an ambulatory care providers outside of their neighborhood. Key factors in determining the projected service area included foot traffic, visibility and signage opportunities, linkage opportunities with community-based organizations and pharmacies. The potential market was derived based on an estimated market share penetration of the primary, secondary, and tertiary service areas and the forecast of primary care providers that can be supported by the site.

<u>Anticipated Expanded and New Sites</u>

Mr. Fass presented the sites that were expected to be expanded and/or opened. He explained that the site list was continuously being modified as new information is obtained from engineers, architects and real estate agents

Mr. Fass reported that among the city owned properties, the Jamaica site (Parson's Boulevard location) and the East

New York site on Sutter Avenue site were undergoing a site review by the design team, engineers and architects. He also added that lease sites in particular were uncertain because until a lease is signed, anything is possible. There are two sites that are listed as TBD because a suitable location has not yet been identified.

Borough	Neighborhood	HHC Site Name	Address
HHC Expansion in City Owned Bldgs..			
Bronx	East Tremont	Tremont Clinic	2nd flr 1826 Arthur Ave. 10457
Brooklyn	Brownsville / Bed Stuy - Crown Heights	Brownsville CHC	259 Bristol S. 11212
Brooklyn	Bushwick	Bushwick Communicare	335 Central Ave. 11221
Brooklyn	Bushwick	Bedford Clinic	485 Throop Ave. 11221
Brooklyn	Crown Heights	Crown Heights CHC	1218 Prospect Place. 11213
Brooklyn	East New York	Sutter CHC	1091 Sutter Ave. 11208
Queens	Jackson Heights / West Queens	Junction CHC	34-33 Junction Blvd 11372
Queens	Jamaica	Parsons Blvd	90-37 Parsons Blvd., 11432
Staten Island	Stapleton	Vanderbilt D&TC	155 Vanderbilt Ave. 10304
HHC Expansion in Lease Bldgs..			
Brooklyn	Bedford Stuyvesant / Crown Heights		765 Nostrand Ave 11216
Brooklyn	East Flatbush-Flatbush		2231 Church Ave 11226
Brooklyn	East New York		TBD
Manhattan	Sugar Hill / Washington Heights		414 W 155 St 10032
Manhattan	Washington Heights		TBD
Queens	Elmhurst / West Queens		89-22 Queens Blvd., 11373
Queens	Jackson Heights / West Queens		87-10 Northern Blvd., 11372

Ms. Brown added that NYC Health and Hospitals had optimized the opportunity where free rent was available and where it could co-exist with NYC Department of Health and Mental Hygiene, already engaged in an initiative called "Neighborhood Hubs." NYC Health and Hospitals looked at city owned buildings where it provides services and city buildings where it does not provide services. After a lot of discussion and negotiation with DOHMH, a list of sites that would be expanded or would newly provide healthcare services was created. That list did not address the unmet need in terms of targeted high need neighborhoods. As such, an additional strategy was to look for building sites in which NYC Health and Hospitals' flag could be planted in order to create new locations.

Mr. Fass added that the current list of sites was constantly being modified. However, Ms. Brown added that NYC Health and Hospitals was at the juncture of making some decisions. She added that NYC Health and Hospitals was cautious in having the Mayor announcing only 11 sites as opposed to 16 because some sites were still up in the air. Ms. Lilliam Barrios-Paoli, Board Chair, asked if the Sugar Hill/Washington Heights site was a not-for-profit. Ms. Brown responded that all of the leased sites were with private, for-profit owners.

Mr. Fass turned the meeting over to Ms. Mari Millet and invited her to describe the care model and patient services.

<u>Patient Centered Medical Home</u>

Ms. Mari Millet introduced herself and stated that she was the Deputy Executive Director of East New York and most recently, Cumberland. In that capacity, she oversees the administrative operations of all clinical services of New York City Health and Hospitals' primary care sites, school-based health sites and all of the child health care sites. Ms. Millet informed the Committee that her role was to ensure that NYC Health and Hospitals' sites provided primary and specialty care to underserved communities using a "whole health" approach. The focus is on preventive health care

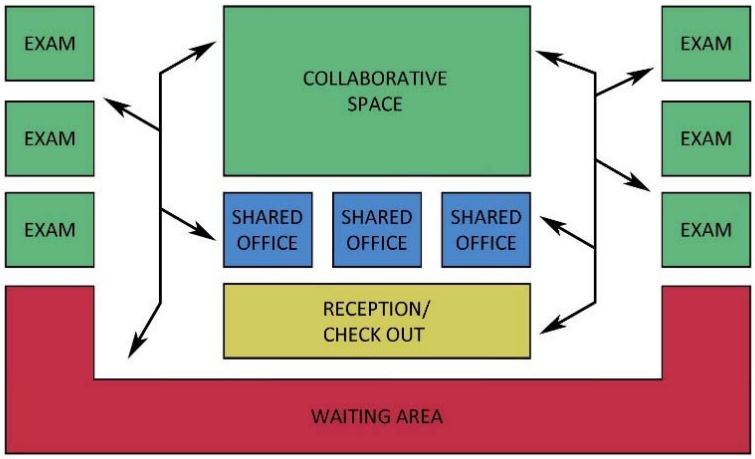
in order to reduce preventable Emergency Room and acute care admissions, and to be instrumental in improving the quality of life of the community, which is the true meaning of managed care.

Ms. Millet explained that a Patient-Centered Medical Home (PCMH) puts the patient at the core. It entails working with a multidisciplinary team to ensure that the patient's needs are met in a well-coordinated and collaborative fashion. The care disciplinary team is called a "care team." It consists of providers, nursing, health educators, dietitians, social workers and sub-specialists working together with focused attention on caring for the patient.

Ms. Millet explained that, as part PCMH care, the goal is to understand and respond to each patient's needs. It is about providing the right care at the right time; providing care that takes into account beliefs, and values; communication among the providers of services; access to appointments when needed, the promise that providers will do their best to make the patient's experience in healthcare a satisfying one; and to empower staff to provide their input on how these services could be improved.

Ms. Millet presented the PCMH health care facility design pod configuration. She described the benefits of having a pod configuration within the health centers. These benefits include:

- Making it easy for staff to find each other
- Making it easy for clinicians to see their work
- Patients feel at ease in personal spaces
- Exam rooms are used functionally in flexible ways
- Team communication and collaboration can occur more organically



Ms. Millet described her role on the Primary Care Expansion Committee. She informed the Committee that she is the operations lead staff and that she represented the end user as the Deputy Executive Director of Brooklyn and Queens sites. Her role is to ensure that the product being delivered to the communities is patient-centered care that will improve patients' quality of life and that would optimize their health care experience. Ms. Millet described the anticipated services that are being planned for the health center sites as outlined in the chart provided below.

Borough	Neighborhood	HHC Site Name	Services
HHC Expansion in City Owned Bldgs.			
Bronx	East Tremont	Tremont Clinic	Adult Medicine/Pediatrics/Women's Health/Behavioral Health
Brooklyn	Brownsville / Bed Stuy - Crown Heights	Brownsville CHC	Pediatrics/Adult Medicine/Women's Health/Behavioral Health/Optometry/Podiatry/Cardiology/General Ultrasound/Mammography
Brooklyn	Bushwick	Bushwick Communicare	Women's Health/Family Planning/Behavioral Health/Diagnostics (Cardiovascular ultrasound, general ultrasound)/Podiatry/Optometry/Cardiology
Brooklyn	Bushwick	Bedford Clinic	Adult Medicine/Behavioral Health
Brooklyn	Crown Heights	Crown Heights CHC	Pediatrics/Women's Health/Behavioral Health
Brooklyn	East New York	Sutter CHC	Pediatrics/Adult Medicine/Behavioral Health
Queens	Jackson Heights / West Queens	Junction CHC	Women's Health/Pediatrics/Behavioral Health
Queens	Jamaica	Parsons Blvd	Adult Medicine/Pediatrics/ Women's Health/Behavioral Health/Optometry/Cardiology/Podiatry/Cardiovascular ultrasound/ General ultrasound
Staten Island	Stapleton		Primary, Specialty, and Diagnostics
HHC Expansion in Lease Bldgs.			
Brooklyn	Bedford Stuyvesant / Crown Heights	765 Nostrand Ave 11216	Women's Health/Pediatrics/Adult Medicine/Dental/Behavioral Health
Brooklyn	East Flatbush-Flatbush	2231 Church Ave 11226	Pediatrics/Adult Medicine/Women's Health/Behavioral Health
Brooklyn	East New York	TBD	Pediatrics/Adult Medicine/Behavioral Health
Manhattan	Sugar Hill / Washington Heights	414 W 155 St 10032	Women's Health/pediatrics/Behavioral Health
Manhattan	Washington Heights	TBD	Pediatrics/Adult Medicine/Behavioral Health
Queens	Elmhurst / West Queens	89-22 Queens Blvd., 11373	Pediatrics/Adult Medicine/Women's Health/Behavioral Health
Queens	Jackson Heights / West Queens	87-10 Northern Blvd., 11372	Pediatrics/Adult Medicine/Women's Health/Behavioral Health/Diagnostics (mammography, general ultrasound)

***Hours at all sites will be Monday through Saturday and will include evening hours a minimum 3 days per week.**

Ms. Millet stated that, while the NYC Health and Hospitals was following the Mayor's primary care expansion initiative, some sub-specialty services such as behavioral health, podiatry, optometry and cardiology will be added when appropriate. She clarified that behavioral health included higher level interventions and social worker services. Ms. Millet highlighted that, in some instances, like at the NYC DOHMH buildings, healthcare services such as child health and family practice were already being provided. She added that some of these sites had more services than others. This is because they were able to maximize their square footage, and utilize the space to provide health care services to their community.

Ms. Brown clarified for Ms. Barrios-Paoli how behavioral services would be delivered at the health center sites. Patients will be screened by the on-site social worker who will refer them to an NYC Health and Hospitals' site for more comprehensive behavioral services. Both pediatric and adult behavioral services will be provided at these sites. While the goal is to provide as many health care services as possible at these locations, patients will be referred to larger sites as needed. Ms. Millet explained that dental services would only be provided at the Nostrand Avenue site because the need for dentistry services is significant in that community. This site provides the opportunity to offer dental services at low-cost in a brand new pre-existing suite.

Dr. Raju emphasized that the hours of operation at all these sites would be Monday through Saturday, including evening hours at least three days a week. He commented that this would be a huge shift in the way NYC Health and Hospitals delivers care. Ms. Millet added that it is also a PCMH requirement to extend service hours to teach people to take ownership of their health care, and to make health care resources available to them at the most convenient times for them, not for us.

Financial Projections

Mr. Fass invited Ms. Alice Berkowitz, Senior Director of Corporate Budget, to present the financial projections for the

Primary Care Expansion Initiative. Ms. Berkowitz explained that Finance used the following assumptions to calculate the financial projections for the new primary care clinics:

- Personnel expenses were calculated using the PCMH model that was developed by Medical and Professional Affairs and tailored to the specific needs of each new or enhanced clinic by Mari Millet and her group.

- OTPS expenses were based on NYC Health and Hospitals' past experience and the cost of purchasing janitorial and security services from the Department of Health for the sites located in DOHMH-owned buildings.

- Revenue was projected based on the productivity of each clinical staff member assigned to the clinic and the payer mix was assumed to be similar to the nearest diagnostic and treatment center. It is assumed that all of the clinics will receive reimbursement rates associated with the FQHC program.

Ms. Berkowitz added that NYC Health and Hospitals intends to phase the start-up of these clinics so that staff would be added as the clinic's volume increases. The phased opening of the clinics will occur during the first two years of the program. This financial model predicts full implementation of this initiative at the beginning of year three of the program's operation.

Ms. Berkowitz added that during the full year of implementation, it is projected that the initiative will have 228 providers and support staff, who will be able to provide an additional 240,000 visits. The total program cost will be $60.4 million with revenues of $49.6 million. It is anticipated that the program will operate at an annual deficit of $10.9 million. Ms. Berkowitz explained that these projections excluded the workload, expenses and revenue for the Vanderbilt Avenue, Staten Island site, which was still in the early design phase. The financial projections are outlined in the chart below:

Neighborhood	HHC Site Name	New Visits	New Patients	Operating Revenue	Operating Expense (excl. interest and depreciation)	Net Loss
HHC Expansion in City Owned Bldgs.						
East Tremont	Tremont Clinic	7,360	2,300	2,461,243	3,506,635	(1,045,392)
Brownsville / Bed Stuy - Crown Heights	Brownsville CHC	17,875	5,586	5,060,693	5,822,962	(762,269)
Bushwick	Bushwick Communicare	12,135	3,792	2,367,539	3,303,572	(936,033)
Bushwick	Bedford Clinic	8,560	2,675	1,382,410	1,710,122	(327,712)
Crown Heights	Crown Heights CHC	9,143	2,857	2,078,745	2,607,752	(529,007)
East New York	Sutter CHC	11,055	3,455	2,682,029	2,977,306	(295,277)
Jackson Heights / West Queens	Junction CHC	11,533	3,604	3,285,313	4,157,474	(872,161)
Jamaica	Parsons Blvd	16,676	5,211	5,242,177	5,944,663	(702,486)
Subtotal		94,337	29,480	24,560,149	$30,030,485	$(5,470,336)
HHC Expansion in Lease Bldgs.						-
Bedford Stuyvesant / Crown Heights	765 Nostrand Ave 11216	32,460	10,144	5,595,030	6,435,481	(840,451)
East Flatbush-Flatbush	2231 Church Ave 11226	12,060	3,769	2,078,745	2,793,223	(714,478)
East New York	TBD	12,060	3,769	2,078,745	2,768,223	(689,478)
Sugar Hill / Washington Heights	414 W 155 St 10032	12,060	3,769	2,205,244	2,724,945	(519,701)
Washington Heights	TBD	12,060	3,769	2,205,244	2,768,223	(562,979)
Elmhurst / West Queens	89-22 Queens Blvd., 11373	32,460	10,144	5,242,177	6,400,859	(1,158,682)
Jackson Heights / West Queens	87-10 Northern Blvd., 11372	32,460	10,144	5,595,030	6,505,013	(909,983)
Subtotal		145,620	45,506	25,000,216	30,395,968	(5,395,753)
Total		239,957	74,987	49,560,365	$60,426,454	$(10,866,089)

Mr. Fass invited Ms. Tamika Campbell to provide an update on the design and construction status of the Primary Care Expansion Initiative. Ms. Campbell introduced herself as the Construction Manager for the Primary Care Expansion Initiative. She added that she was part of the Project Design Team, which consisted of the end user, operations, the architects, EITS and Mr. Fass. Ms. Campbell reported that the team had identified DOHMH locations currently occupied and providing patient care services. Ms. Campbell stated that the construction goal was to expand primary care services and to enhance the patient experience, and to build it as fast as possible with the least amount of disruption. Ms. Campbell informed the Committee that the design plans were also included in the Certificate of Need (CONs) packages. She described the status of the project's design and construction milestones as the following:

- Project Milestones:
  - 30% Design Plans
  - 90% Design Plans
  - 100% Design Plans

- Project Progress Impacting Tasks
  - 100% Design Plans for Construction and Bid
  - Department of Buildings Approval process to obtain permits
  - Final State Approval (DOHMH)

Ms. Campbell reported the projected dates for construction and completion as described in the chart below. She commented that construction would not begin until CONs have been approved.

Neighborhood	HHC Site Name	Obtain CON Approval	Begin Renovation	Complete Renovation	Open Date
HHC Expansion in City Owned Bldgs.					
East Tremont	Tremont Clinic	9/25/15	1/16	6/16	6/16
Brownsville / Bed Stuy - Crown Heights	Brownsville CHC	9/28/15	7/16	4/17	4/17
Bushwick	Bushwick Communicare	10/13/15	5/16	1/17	1/17
Bushwick	Bedford Clinic	11/16/15	3/16	9/16	9/16
Crown Heights	Crown Heights CHC	11/6/15	1/16	3/16	3/16
East New York	Sutter CHC	12/29/15	6/16	2/17	2/17
Jackson Heights / West Queens	Junction CHC	2/10/16	4/16	8/16	9/16
Jamaica	Parsons Blvd	3/15/16	7/16	2/17	2/17
Stapleton	155 Vanderbilt Ave., S.I.	4/12/16	9/16	4/17	4/17
HHC Expansion in Lease Bldgs.					
Bedford Stuyvesant / Crown Heights	765 Nostrand Ave 11216	2/16/16	6/16	10/16	10/16
East Flatbush-Flatbush	2231 Church Ave 11226	3/8/16	7/16	11/16	11/16
East New York	TBD	3/29/16	8/16	11/16	12/16
Sugar Hill / Washington Heights	414 W 155 St 10032	2/9/16	6/16	10/16	10/16
Washington Heights	TBD	3/22/16	8/16	11/16	12/16
Elmhurst / West Queens	89-22 Queens Blvd., 11373	3/1/16	7/16	1/17	2/17
Jackson Heights / West Queens	87-10 Northern Blvd., 11372	2/11/16	6/16	11/16	11/16

Ms. Brown informed the Committee that CON approvals had already been obtained for the Tremont, Brownsville, and Bushwick sites. She added that CON approvals for the Bedford and Crown Heights sites would be received in the

near future. Ms. Brown commented that, while getting CON approvals could be a lengthy process, the New York State Department of Health (SDOH) have been very amenable to accelerating their review.

Ms. Campbell stated that the anticipated capital costs or build-out costs was $49.6 million as described in the table below. She commented that this estimate did not include the Vanderbilt Avenue site in Staten Island. Ms. Brown added that the Vanderbilt Avenue site was a much larger site with 22,000 sq. ft. Its anticipated build-out cost is expected to be $23-24 million. In addition, the Vanderbilt site will be a modular building, which will help to defray some of the costs and more importantly, will help to defray some of the timeframe for construction.

Neighborhood	HHC Site Name	Construction	Contingency (10%)	Total Capital Needs
HHC Expansion in City Owned Bldgs.				
East Tremont	Tremont Clinic	1,039,750	35,705	1,075,455
Brownsville / Bed Stuy - Crown Heights	Brownsville CHC	3,663,942	226,239	3,890,181
Bushwick	Bushwick Communicare	3,657,572	225,087	3,882,659
Bushwick	Bedford Clinic	1,608,199	94,945	1,703,144
Crown Heights	Crown Heights CHC	844,149	18,000	862,149
East New York	Sutter CHC	2,489,813	169,621	2,659,434
Jackson Heights / West Queens	Junction CHC	2,652,950	180,000	2,832,950
Jamaica	Parsons Blvd	4,239,200	330,000	4,569,200
Subtotal		$20,195,575	$1,279,598	$21,475,173
HHC Expansion in Lease Bldgs.			-	
Bedford Stuyvesant / Crown Heights	765 Nostrand Ave 11216	4,302,950	360,000	4,662,950
East Flatbush-Flatbush	2231 Church Ave 11226	3,352,950	250,000	3,602,950
East New York	TBD	3,352,950	250,000	3,602,950
Sugar Hill / Washington Heights	414 W 155 St 10032	3,168,600	240,000	3,408,600
Washington Heights	TBD	3,552,950	250,000	3,802,950
Elmhurst / West Queens	89-22 Queens Blvd., 11373	7,139,200	600,000	7,739,200
Jackson Heights / West Queens	87-10 Northern Blvd., 11372	1,339,200	-	1,339,200
Subtotal		26,208,800	1,950,000	28,158,800
Total		$46,404,375	$3,229,598	$49,633,973

Mr. Nolan asked if the Staten Island's site was larger because NYC Health and Hospitals planned to expand its footprint. Ms. Brown's responded that almost 10 years ago, St. Vincent went bankrupt and NYC Health and Hospitals purchased the parcel of land for a very nominal sum. The building will accommodate a large footprint. NYC Health and Hospitals made a commitment to Staten Islanders to create comprehensive primary health care, not hospitals. This site will allow NYC Health and Hospitals to provide a significant number of services at that site.

Dr. Raju stated that all the sites were working towards NYC Health and Hospitals' strategic goal. For example, MetroPlus Health Plan is being expanded to include Staten Island, which will allow NYC Health and Hospitals to increase its market share and have a much bigger presence to improve access in Staten Island. Dr. Raju commented that the Primary Care Expansion Initiative was a thoughtful project. He commended the team for their approach. Dr. Raju emphasized that, one of NYC Health and Hospital's strategic goal is to increase market share, but only in places where there is a need, and not by competition. It is expected that the capital costs would be refunded by the City. So far, $12 million have been collected from the City for the Primary Care Expansion Initiative.

Dr. Raju added that, in order to address the projected operations loss of $10.8 million over a period of time, NYC Health and Hospitals must figure out how to increase productivity and engage more people in the system. He referred to an article in the November 9, 2015 edition of the New York Times that stated that, in spite of all the efforts, one

million people are still uninsured and some of them reside in the neighborhoods of the clinic locations.

Dr. Raju praised the team for a job well done in carefully selecting these sites based on real data. Ms. Brown referred back to the slide that was presented by Mr. Fass and emphasized the tools that were used by the team to identify and prioritize NYC high need neighborhoods. These tools included the review and analysis of population health indicators, demographics, and CHCANYS' data analysis. Ms. Brown added that the team went even further by looking at those criteria Dr. Raju articulated including addressing a need for services, identifying locations that were accessible, foot traffic, visibility, linkages, pharmacies, transportation and partnering with DOHMH staff.

Ms. Campbell explained how the capital cost estimates were calculated. For the City-owned buildings (DOHMH), the architects provided their estimates based on conceptual plans. However, for the leased buildings, the estimates were based on square footage. The budget for the sites will be reviewed once the scope of work is finalized.

Ms. Brown added that the team was working very closely with DOHMH facility staff to coordinate the work to ensure that they are aware of the types of renovation being made and that the design and services are consistent with Dr. Raju's and NYC Health and Hospitals' Vision 20/20.

Dr. Raju acknowledged the team for their accomplishments for working on this project for only four months. Ms. Brown invited other project team members, who were present at the meeting to stand up. She acknowledged Corporate Planning Services' staff including Elena Russo, Christopher Philippou and Sharon Abbott, who had compiled the CON packages. Ms. Brown added that Mr. Philippou was very involved in the initial analysis, which helped to inform which neighborhoods should be prioritized. She acknowledged the real estate team, Jeremy Berman and Dion Wilson, who were not in attendance at the meeting, for working with the realtors to identify possible locations and for negotiating lease arrangements with landlords. She acknowledged Alice Berkowitz, Maxim Katz, Linda Dehart and the other staff from Corporate Finance division. Additionally, Ms. Brown acknowledged security and IT staff.

Mr. Nolan commented that, in 2013, Candidate DeBlasio's message was to identify these types of facilities in the vicinity of City employees' residences. He praised that two years later, in 2015, the Mayor's project is real and partially funded. However, as a resident of the Bronx, Mr. Nolan stated that he was puzzled that there would be only one site in the Bronx considering that the Bronx is #1, in almost every major health category in the history of New York City, for conditions such as cancer, strokes, diabetes and asthma.

Ms. Brown responded by stating that the Mayor's "Caring Neighborhood, Caring Communities" initiative focuses on the highest need neighborhoods. There are many more neighborhoods that have needs than the ones that are being addressed by this initiative. As noted on the slide, Fordham, Crotona, High Bridge and Hunts Points are some of the neighborhoods that were identified. However, the southern part of the Bronx already have two NYC Health and Hospitals facilities, which are Segundo Ruiz-Belvis and Morrisania. As these sites are part of Gotham Health, under the leadership of Dr. Michelen and Mari Millet, extended service hours are already being provided at these sites. In those neighborhoods there are opportunities for other than NYC Health and Hospitals to expand, particularly the non- NYC Health and Hospitals' FQHCs. Ms. Brown emphasized that the Mayor's "Caring Neighborhood, Caring Communities" is a two-sided strategy. The first being NYC Health and Hospitals' actions to expand existing sites and to add new ones. The other strategy involves the NYC Economic Development Corporation (EDC). EDC has set aside $8 million in grants to facilitate non-NYC Health and Hospitals' FQHCs to expand their existing sites and/or create new sites in these various neighborhoods.

Dr. Raju added that NYC Health and Hospitals will be partnering with other FQHCs because this initiative is about collaboration. He added that this is the same strategy for DSRIP, which is all about collaboration. Clinics will not be set up in every neighborhood in need, but NYC Health and Hospitals will work with other partners to provide services where gaps exist. In acknowledgement of Mrs. Bolus' question prior to the Committee meeting concerning the

Brooklyn neighborhood of Canarsie, Ms. Brown added that Canarsie was not on the list because the need is not the greatest in that neighborhood. She stressed that the Mayor, as a candidate, had committed to reaching the highest need neighborhoods; and he is making sure to fulfill that commitment.

Dr. Raju added that access does not necessarily equals the elimination of disparities. He stated that there are other factors in addition to access that must be addressed in order to eliminate disparities in health care. Other factors include the ability to reach individuals and bring them into the system, cultural competent care, convenient hours, geographic and convenient access.

Ms. Brown stated that, what is most important are the services that will be placed in those locations as well as using the PCMH model. Implicit in that approach is addressing a patient's "whole health", not just the health issue that the patient presents with. It is about preventing disease and illness.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:35 AM.

NYC Health + Hospitals' Journey Towards "Leader in Healthcare Equality for LGBT Patients"

Presentation to the Strategic Planning Committee of the Board of Directors

December 1, 2015

Mark G. Winiarski, Ph.D.
Assistant Director,
Corporate Planning Services

Commitment in the Mayor's Management Report (2014)

HEALTH AND HOSPITALS CORPORATION

Dr. Ramanathan Raju, President/Chief Executive Officer

WHAT WE DO

The Health and Hospitals Corporation (HHC), the largest municipal hospital and health care system in the country, is an $8 billion public benefit corporation. It provides medical, mental health and substance abuse services through its 11 acute care hospitals, four skilled nursing facilities, six large diagnostic and treatment centers and more than 60 community and school-based clinics. HHC also provides specialized services such as trauma, high risk neonatal and obstetric care and burn care. HHC acute care hospitals serve as major teaching hospitals. HHC operates a

FOCUS ON EQUITY

HHC's mission "to extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services of the highest quality in an atmosphere of humane care, dignity and respect" underscores HHC's commitment to equity. An affirmation of HHC's mission is the continuous work to reduce healthcare disparities among New Yorkers who experience the greatest challenges accessing equitable, inclusive, patient-centered and welcoming healthcare. All HHC facilities will complete the Human Rights Campaign's Healthcare Equality Index (HEI) survey in 2015, required to earn the designation "leader in LGBT healthcare equality." All equality leaders must document adoption of foundational policies and practices, and provide training to staff, to ensure lesbian, gay, bisexual, and transgender (LGBT) patient-centered care. In August 2014 nine of 11 HHC hospitals and one of six Diagnostic and Treatment Centers achieved leadership status. In addition, HHC continues its collaboration with disability advocates to increase access to primary care for women with disabilities by renovating patient care areas, redesigning exam rooms, purchasing specialized equipment, and training of staff at eight HHC facilities.

NYC HEALTH+ HOSPITALS

Alignment with 20/20 Vision

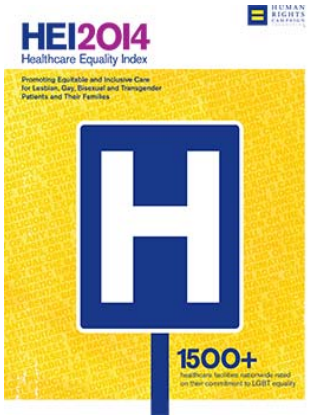
"There is one common thread that ties all these [20/20 Vision] goals together. One fundamental component to make all this happen. And that's our ability -- our singular ability -- to extend the very best experience possible to our patients and their families.

"We need to own every patient's experience. We need to put ourselves in their shoes every day, every time. And make sure we do no less than what we would expect for ourselves, for our families, for our mothers and our own children."
–Dr. Raju

NYC HEALTH+ HOSPITALS

HUMAN RIGHTS CAMPAIGN.

The Human Rights Campaign's (HRC) designation "Leader in LGBT Health Equality" provides direction to our journey



- Promotes staff education and provides training
- Lists national benchmarks for LGBT care, LGBT employees and community interaction
- Allows us to compare our progress with 1,500+ other health care systems
- 427 health care facilities in the US met HRC's "Leader" criteria in 2014

NYC Health + Hospitals' Journey

2008

- Public Advocate issued report on LGBT health access.

  Findings:

  - The healthcare environment is heterocentric, gender-normative
  - Providers lack knowledge about health disparities affecting LGBT people
  - LGBT individuals experience hostility and discrimination in care
  - Concerns about homophobia and transphobia keep LGBT individuals from using healthcare services
  - Voluntary training does not reach all staff

NYC Health + Hospitals' Journey

2008-2013

- Internal working group is convened and makes recommendations
- Curricula developed, training launched and is made mandatory in 2012
- Gouverneur opens LGBT clinic
- Metropolitan becomes the first NYC Health and Hospitals facility to obtain HRC Leader designation

NYC HEALTH+ HOSPITALS

NYC Health + Hospitals' Journey

2014

- Seven acute care facilities, one network, and one diagnostic and treatment center earned Leader designation
- Metropolitan LGBT Clinic opens
- LGBT Advisory Group established by LGBT colleagues and allies
  - Enlists board members, executives and managers to acknowledge the special challenges of serving LGBT patients and to commit to a policy of informed and respectful treatment
  - Advocates for creation of a safe space in the healthcare system for the LGBT community
  - Fosters a respectful environment for LGBT employees

NYC HEALTH+ HOSPITALS

NYC Health + Hospitals' Journey
2015: More facilities work to meet HRC's criteria

- **Criterion One**: Patient non-discrimination statement includes "sexual orientation" and "gender identity"

- **Criterion Two**: Statement of equal visitation rights for LGBT patients and their visitors

- **Criterion Three**: Employment non-discrimination policy includes "sexual orientation" and "gender identity" and must be publicly promulgated
  - Shared with patients and public
  - Employees educated
  - Policies posted on facility websites

- **Criterion Four:** Training on LGBT patient-centered care
  - Nearly 1,000 employees trained

NYC Health + Hospitals' Journey

What it took to be designated

- Worked with the Office of Legal Affairs, added City's anti-discrimination paragraph to Patient Bill of Rights

  In addition, HHC is committed to compliance with the New York City Human Rights Law that states it is unlawful to discriminate on the basis of actual or perceived sex, including a person's "gender identity, self-image, appearance, behavior or expression," whether or not different from "that traditionally associated with the legal sex assigned to that person at birth." ***Administrative Code of the City of New York Title 8***

- Worked with the Office of Culturally and Linguistically Appropriate Services, translated anti-discrimination paragraph in 13 languages

NYC Health + Hospitals' Journey

What it takes to make HRC Leaders

- Working with EEO and HR to inform job seekers about our excellent EEO policy
- Working with Communications to create links to Patient Bill of Rights on all facility websites and posters
- Working with facilities to ensure that all criteria are met
- Working with HRC to explain our complicated system

NYC HEALTH+ HOSPITALS

HUMAN RIGHTS CAMPAIGN FOUNDATION 2015 LEADER IN LGBT HEALTHCARE EQUALITY HEALTHCARE EQUALITY INDEX™

NYC Health + Hospitals' Journey

This year's outcome: 21 facilities named "Leader in LGBT Healthcare Equality" for 2015 and 2016

- **First time**: Belvis, Carter, Coler, East New York, Gouverneur, McKinney, Kings, Morrisania, Queens, Renaissance, Sea View
- **Second year:** Bellevue, Coney Island, Cumberland, Elmhurst, Harlem, Jacobi, North Central Bronx, Lincoln, Woodhull
- **Third year**: Metropolitan

NYC HEALTH+ HOSPITALS

For 2017 HRC will raise the bar: New benchmarks will include:

- Organization's plan to reduce health disparities must include LGBT patients
- Updated on-line training for employees
- LGBT information added to corporate website
- Clinical services are reviewed and gaps addressed
- LGBT-responsive facilities are publicized
- Practice changes are disseminated
- Brochures are published for patients
- For employees, insurers add clear statements regarding transition services to insurance summary plan documents

NYC HEALTH+ HOSPITALS

NYC HEALTH + HOSPITALS

With thanks to NYC Health + Hospitals' Facility Representatives including:

- **Evelyn Borges**: Bellevue
- **Shelay Alava & Dennise Alvarado**: Belvis
- **Jeannette Rosario & Nelson Cabrera**: Coler
- **Young Lee**: Coney Island
- **Glenn Zuraw**: Elmhurst
- **Steve Hemraj**: East New York
- **Mark Baehser**: Gouverneur
- **Mary Caram**: Harlem
- **Jeannette Rosario & Nelson Cabrera**: Henry J. Carter
- **Vivian Nolan**: Jacobi
- **Natasha Burke**: Kings
- **Hyacinth Johnson**: Lincoln
- **Sarah Bender**: Metropolitan
- **Olayemi Abioye**: Dr. Susan Smith McKinney
- **Deborah Mabry**: Morrisania
- **Vivian Nolan**: North Central Bronx
- **Gertie Brown & Carolyn Adderley**: Queens
- **Gregory Atwater & Sandra Sanson**: Renaissance
- **George Taylor**: Sea View
- **Anthony Divittis**: Woodhull

FORCES DRIVING THE FUTURE OF POST ACUTE AND LONG TERM CARE SERVICES

NYC HEALTH+ HOSPITALS

STRATEGIC PLANNING COMMITTEE
DECEMBER 1, 2015

CONTINUING CARE LEADERSHIP COALITION CCLC

2 Presentation Outline

Forces of Change for Long Term Care

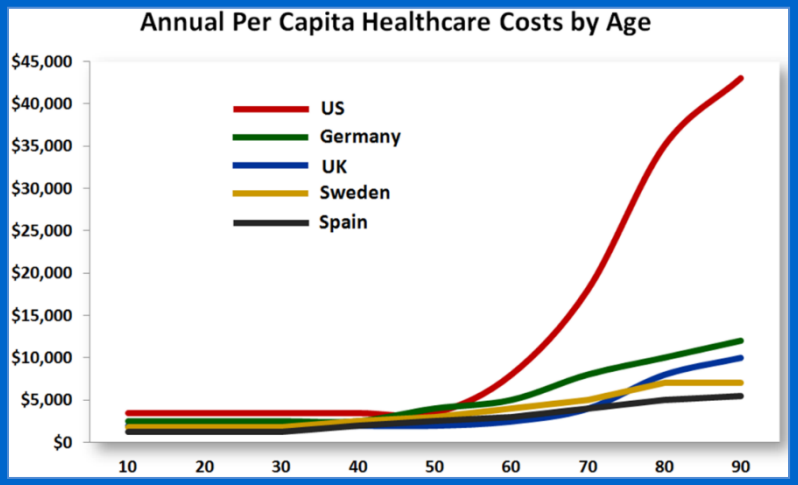
- Market
- Policy
- Regulatory

Steering a Path to Success

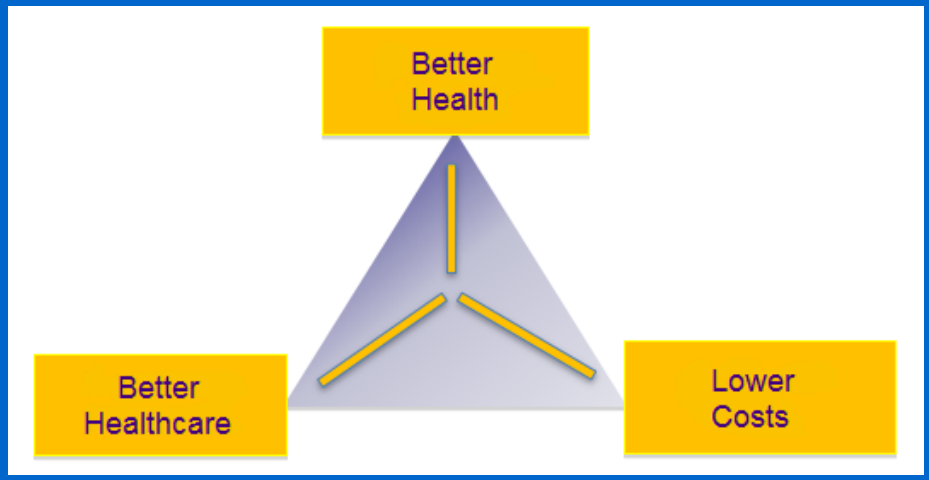
- Leveraging NYC Health + Hospitals Resources
- Risks and Challenges

3 Forces of Change: All Relate to the Triple Aim

In the face of this:



All seek to achieve this:



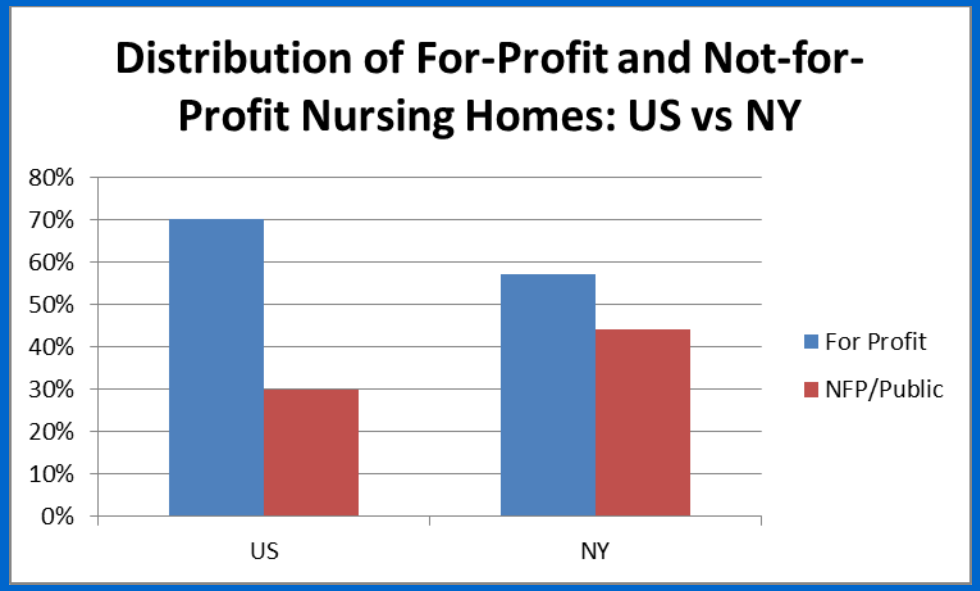
Source: Roth, M, **U**.S. health care costs for the aged are sky high**,** Pitt Post Gazette, Dec 2009. Fischbeck, P., Carnegie Mellon Univ accessed at http://www.post-gazette.com/news/nation/2009/12/13/U-S-health-care-costs-for-the-aged-are-sky-high/stories/200912130214#ixzz33Fib0dnh

CONTINUING CARE LEADERSHIP COALITION CCLC

Forces of Change: Three Buckets

5 Market Forces: A Snapshot of NYS Today

The Not-for-Profit and Public provider community has been essential to keeping the quality bar high in NYS



NY Performance on Selected Measures

- 6% better than the US on CMS Quality Measures
- 11% more facilities achieve 5 star status than in the US overall
- 11% better performance than the US on antipsychotic medication use

6 Market Forces: Four Key Trends

1. Shifting Demographics (Driving Demand for More Services)
   - Continued growth of an aging population
   - Changes in disease and disability prevalence
   - Persistent needs of a population in poverty
   - A worsening caregiver ratio
2. Changing Consumer Preferences
   - A more informed population is seeking greater control, more person-centered care models
   - Consumers want to receive care in their homes and communities for as long as possible
3. Demand for Efficiency in an Ever More Costly Care Environment
   - Labor costs – facing upward pressure – remain the preponderance of LTC service delivery costs
   - Resource needs will rise as patient needs become more acute at every level of care
   - Simultaneously, Medicaid payment levels remain well below actual costs

7 Market Forces: Four Key Trends (Continued)

4. A Shifting Mix of Provider Types in NYS

Table 1.
Number of Nursing Facilities by Year and Sponsorship, New York State

	1996	2000	2005	2010
For-Profit	312	313	310	310
Not-for-Profit	295	298	290	258
Public	48	51	49	44
Total	655	662	649	612

Source: RCF4 nursing facility cost reports filed with the New York State Department of Health, 1996-2010, obtained through HANYS/FACETS.

Source: United Hospital Fund: New York's Nursing Homes: Shifting Roles and New Challenges , 2013

Policy: Three Big Themes; Many Related Initiatives

Dominant Policy Themes:

- Moving financial risk downstream
- Managing health at the population level
- Shifting care delivery to the lowest cost, least restrictive sites

9 Policy: An Expanding Array of Initiatives

- Migration of the long term care population and benefit to managed care
  - Mandatory Managed Long Term Care (MLTC)
  - Expansion of the Medicare Advantage programs
  - Implementation of the Fully-Integrated Dual Advantage Program (FIDA) in NYS
- Organization of care for the Medicaid population through DSRIP Performing Provider Systems (PPSs)
  - Implications for payment
  - Implications for care delivery models and approaches
- Emergence of aggressive value-based purchasing agendas at the State and Federal levels

10 Policy: An Expanding Array of Initiatives

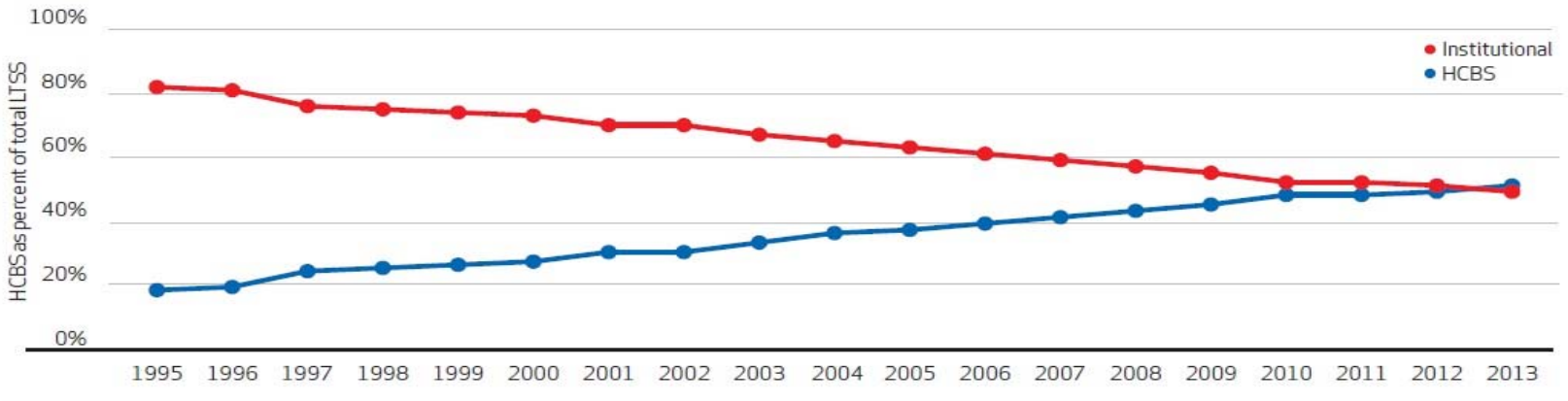
- Shifting Care to the Community; Cumulative Effect of Array of Factors:

ADA · Olmstead decision · Money Follows the Person

Balancing Incentive Program · Community First Choice Option

EXHIBIT 1

Medicaid Home and Community-Based Services (HCBS) Expenditures as a Percentage of Total Medicaid Long-Term Services and Supports Expenditures, FY 1995–2013



SOURCE "Medicaid Expenditures for Long-Term Services and Supports in FFY 2013," Truven Health Analytics, June 30, 2015, page 7.

"Health Policy Brief: Rebalancing Medicaid Long-Term Services And Supports," Health Affairs, September 17, 2015. http://www.healthaffairs.org/healthpolicybriefs/

11 Regulatory Forces

- Array of new regulatory actions will impose new expectations on providers, in tension with policy emphasis on transitioning greater risk and accountability to providers
  - CMS “Conditions of Participation Rule:” Sweeping changes for nursing facilities
  - CMS Rule on “Changes to discharge planning regulations for hospitals, LTCHs and home health”
  - New overtime pay expectations for home care
  - Minimum wage changes, also with implication for home health sector
- Other regulatory actions will reinforce the direction of current policy thinking
  - CMS Final Rule on Bundled Payment for Joint Replacement
  - In-process changes to the NYS nursing home bed need methodology
- Further observations:
  - Environmental regulations continue to challenge providers (e.g., sprinkler regulation, smoking and e-cigarettes)
  - Providers are challenged by overlapping and duplicative regulations for providers and managed care plans

12 Steering a Path to Success

- Leveraging NYC Health + Hospitals Resources
  - Unique alignment between Health + Hospitals Experience and Assets and the demands of the emerging health environment
    - Experience operating as a “true system”
    - Expertise in dealing with prevalent chronic diseases of the population
    - Leadership in the patient-centered medical home model
    - Engagement with the community, through communication, collaboration
    - Leadership position in delivery of behavioral health services
    - Deep experience with home health and telehealth services
    - Award-winning system-wide palliative care program
    - Documented track record of attaining superior quality outcomes

13 Steering a Path to Success

- Risks and Challenges:
  - Sustaining effective communications across system elements
  - Measuring what works; tweaking practices based on experience
  - Ensuring a strong voice for the system's long term care components in planning, decision-making, in the PPS context and beyond
  - Remaining both "entrepreneurial" and attentive to the regulatory/compliance environment simultaneously