STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

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

AGENDA

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

II. ADOPTION OF OCTOBER 13, 2015 STRATEGIC PLANNING COMMITTEE MEETING MINUTES — **JOSEPHINE BOLUS, RN**

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

IV. INFORMATION ITEM:

i. **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

V. OLD BUSINESS

VI. NEW BUSINESS

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

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

OCTOBER 13, 2015

The meeting of the Strategic Planning Committee of the Board of Directors was held on October 13, 2015 in HHC's Boardroom located at 125 Worth Street, Room 532, with Ms. Josephine Bolus, NP-BC, presiding as chairman.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, NP-BC, Chairman, Strategic Planning Committee
Ram Raju
Lilliam Barrios-Paoli, Chairman of the Board
Robert F. Nolan
Anna Kril
Bernard Rosen

OTHER ATTENDEES

J. Agrawal, Office of Management and Budget
J. Cassidy, Analyst, Office of Management and Budget
J. DeGeorge, Analyst, New York State Comptroller
M. Dolan, Senior Assistant Director, DC 37
E. Kelly, Analyst, New York City Independent Budget Office
J. Wessler, Guest

HHC STAFF

S. Abbott, Assistant Director, Corporate Planning Services
C. Barrow, Associate Director, Lincoln Medical and Mental Health Center
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
S. Blundi, Deputy Counsel, Legal Affairs
L. Brown, Senior Vice President, Corporate Planning, Community Health and

Intergovernmental Relations
E. Casey, Director, Corporate Planning, HIV Services
D. Cates, Chief of Staff, Office of the Chairman of the Board of Directors
S. Fass, Assistant Vice President, Corporate Planning Services
M. Guerdy, NP Student, Elmhurst Hospital Center
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
J. Haberlin, Senior Counsel, Legal Affairs
M. Hartman, Senior Counsel, Legal Affairs
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
S. Kleinbart, Director of Planning, Coney Island Hospital
Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman of the Board of Directors
A. Marengo, Senior Vice President, Communications and Marketing
I. Michaels, Director, Media Relations, Communications and Marketing
W. Michelen, Chief Executive Officer and Chief Medical Officer, Gotham Health
T. Miles, Executive Director, World Trade Center Environmental Health Center
N. Peterson, DSRIP Facility Manager, Woodhull Medical and Mental Health Center
S. Ritzel, Associate Director, Kings County Hospital Center
S. Russo, Senior Vice President, Office of Legal Affairs
P. Slesarchik, Assistant Vice President, Labor Relations
P. Swamy, Associate Counsel, Legal Affairs
D. Thornhill, Associate Executive Director, Harlem Hospital Center
L. Villalon, Deputy Chief Financial Officer, Coler Rehabilitation and Nursing Care Center and Henry J. Carter Specialty Hospital and Nursing Facility
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 October 13, 2015, Meeting of the Strategic Planning Committee (SPC) of the Board of Directors to order at 10:35 A.M. The minutes of the September 8, 2015 SPC meeting were adopted. Ms. Bolus introduced Ms. Lilliam Barrios-Paoli, the newly appointed Chairman of the New York City Health and Hospitals Corporation's Board of Directors.

SENIOR VICE PRESIDENT REMARKS

Federal Update

Two-Midnight Rule Update

Ms. Brown reported that, on September 21, 2015, a federal judge rejected CMS' argument that it met the legal requirements for rule making when CMS promulgated its rule to reduce hospitals' inpatient payments by .2% in conjunction with its Two-Midnight Rule policy. She informed the Committee that the reduction was included in the FY 2014 Inpatient Prospective Payment Systems (IPPS) Rule, which took effect on October 1, 2013. Moreover, CMS was ordered by the court to provide further justification, which would provide hospitals with an opportunity to comment on CMS' actions. Ms. Brown added that, if CMS cannot robustly justify its .2% cut, the court could order that withheld funds be retroactively restored to hospitals starting from October 1, 2013.

Ms. Brown informed the Committee that Dr. Raju, who is a Board Member of the American Hospital Association (AHA), along with herself and her staff have engaged in discussions with the AHA, the Greater New York Hospital Association (GNYHA), the Healthcare Association of New York State (HANYS) and the American Essential Hospitals (AEH) concerning this issue. Dr. Raju acknowledged that Ms. Brown had been very instrumental to this success. He explained that the Two-Midnight Rule helps hospitals to keep patients for more than two days, which is the opposite intention of the Two-Midnight policy. Moreover, 80% of patients' costs are incurred in the first day when all tests are conducted before a diagnosis is reached. Consequently, this rule seeks to replace 80% of hospitals' inpatient rate with a very minuscule outpatient rate. Dr. Raju added that the Two-Midnight Rule is a cost saving measure, which is going to create a different mindset for the patient.

340B Drug Discount Program Update

Ms. Brown reminded the Committee that the 340B Drug Discount Program Mega Rule was promulgated by CMS at the end of August 2015. The 340B Drug Discount Program was specifically designed for safety net hospitals and federally qualified health centers (FQHCs). She explained that the definition of safety net hospital had grown from just public and governmental hospitals to include children and critical access hospitals in rural areas. She added that, because of the high cost of certain drugs, there have been a greater uptake on the part of providers who meet the definition to participate in 340B Drug Discount Program. She explained that this new guidance was the Health Resources and Services Administrations' (HRSA) attempt to

tighten up the rules on how and when the 340B Drug Discount Program could be used. The new mega guidance:

- Changes the definition of patients tied to "billable" outpatient service
- Changes the definition of covered inpatient drugs
- Excludes discharge drugs from the 340B Drug Discount Program
- Excludes the use of 340B discounted drugs for observation and ED visits that lead to inpatient stays
- Excludes infusion only services
- Excludes pharmaceuticals in bundled Medicaid payments (which could cost HHC $5-10 million/year)

Ms. Brown commented that there had been a great deal of advocacy particularly from the American Essentials Hospitals on pushing back on the greater stringency that HRSA had been inclined to make regarding the 340B Drug Discount Program. Notwithstanding, the new mega guidance is not as bad as it could have been since earlier draft language were even more restrictive.

Dr. Raju highlighted that public hospitals would be affected more than other hospitals. If the program goes away, the delivery of health care services that require some of the most expensive medications such as HIV, chemotherapy, anti-psychotic and Hep C would be tremendously affected. Moreover, Dr. Raju added that the fact that HHC would not be able to provide discharge medications to patients so that they do not have to go to a pharmacy in order to follow-up with their care, especially if it is snowing outside, is problematic. Dr. Raju stated that more advocacy efforts are needed around this issue, while keeping in mind that the fight will be against Big Pharma, one of the most powerful lobbying groups in the country. Dr. Raju commented that patients will be affected by this new guidance.

Re-authorization of Zadroga Act

As reported at prior Committee meetings, Ms. Brown stated that the James L. Zadroga 9/11 Health and Compensation Act for injured and ill 9/11 survivors and responders would expire in 2016. Ms. Brown added that, as challenging as that timeframe is, some recent media reports misstated or simply got wrong important facts that were disconcerting to both patients and staff. She clarified that HHC's World Trade Center Environmental Health Center was fully funded and budgeted through December 31, 2016. Notwithstanding, it is true that, as of October 1, 2015, the clock started ticking to require congressional reauthorization of the Zadroga Act. Ms. Brown informed the Committee that Senate and House, Republicans and Democrats alike, have assured that reauthorization of the health program would occur by early to mid-2016, if not sooner.

Ms. Brown stated that support grew significantly after September 16th when dozens of responders, survivors and their advocates, including staff and patients of HHC's WTC Environmental Health Center, visited the offices of over half of all Congress Members. As of October 13th, a total of 58 Senators and nearly 200 House Representatives have signed on in support of reauthorization. It is anticipated that those numbers will steadily grow. HHC joins the City of New York in thanking the key legislative leaders, New York Senators Gillibrand and Schumer and Congresspersons Nadler, Maloney and King, for continuing their push for a permanent reauthorization of the bill. In the meantime, the program is fully functioning and proceeding in the usual, expected and necessary ways.

Mr. Robert Nolan, Board Member, asked if the health component of the Zadroga Act had already expired. Ms. Brown clarified that the health component of the Zadroga Act did not expire. She stressed that it was

authorized through December 31, 2016. She explained that the National Institute for Occupational Health Services (NIOSH), the federal agency that is responsible for the entire Zadroga program has to begin program phase out activities so that by December 31, 2016, they would not have any obligations such as contractual issues, etc.

Ms. Brown commented that purposefully the proponents of permanent reauthorization wanted to peak people's interest and wanted folks to get excited about the possibility that if the Act expired that many people would no longer have the level of support that pays for their very expensive and extensive healthcare needs. Ms. Brown reassured Mr. Nolan that the reauthorization of the Zadroga Act had gained the support of legislators throughout the country because there are many responders who came from Middle America to New York who have been affected in terms of their health. It appears that there is a groundswell of congressional support from both aisles and that there will be a permanent reauthorization.

Council Awards $300,000 to HHC and NYLAG

Ms. Brown informed the Committee that the City Budget and negotiations with the Council normally occurs over the summer and would conclude by the end June in order to meet a July 1st effective date. Ms. Brown reported that this year there were some programmatic and policy issues that the Council wanted to spend more time on before making a final determination particularly in the area of funding community- based organizations and funding efforts related to immigrants. Ms. Brown informed the Committee that, HHC had put forward a couple of projects to be funded and was also solicited by the Council to put forward programs, particularly those that serve immigrant patients. She reported that one of these programs is an enhancement of an existing partnership HHC has with the New York Legal Assistance Group (NYLAG). She informed the Committee that NYLAG, which started at Elmhurst Hospital, now has a presence at several HHC facilities. Ms. Brown clarified that NYLAG does not represent patients in malpractice cases but helps patients to resolve critical issues that would enhance their lives including housing, citizenship, qualifying for support services, custody, employment issues, etc. Ms. Brown added that patients and their family members present many concerns. In particular, there are patients who are immigrants who have questions concerning their eligibility for certain services. These individuals need help with clarifying what their status is because there are many people who think that their status is such that they are not eligible. In fact, with some work on the part of attorneys who have a particular expertise and who can focus on these issues, many patients are able to take advantage of key benefits that are beneficial to them and to HHC, like reimbursement for healthcare services. These attorneys can also help patients to retain their eligibility for financial support beyond emergency Medicaid for their healthcare services.

Ms. Brown reported that HHC had put together a proposal with NYLAG and submitted it to the City Council. The proposal entailed a request for additional funds for 2.2 FTE staff attorneys and 1.5 FTE paralegals to augment the legal staff who are already stationed at HHC facilities. This team would be mobile and would specifically focus on patients who are undocumented. Ms. Brown presented an example of such a case that had a very positive outcome for a patient and HHC.

Ms. Brown read the following case:

> "In the early hours of October 7, 2012, Mr. "P" was found at the bottom of a staircase at the entrance of a subway, apparently beaten badly with severe injuries. Mr. "P" was taken to Wyckoff Medical Center, the nearest emergency room, where

he was medically stabilized but he was then transferred to Kings County. He suffered from broken ribs, a fractured sternum, numerous broken vertebrae and subsequent paralysis and paraplegia. After his acute needs were addressed, Mr. "P" required long term rehabilitative services. HHC's long term care facilities had no available bed at that time so Mr. "P" stayed at Kings County. Mr. "P", by the way, is an immigrant. Because Mr. "P" was undocumented, from Honduras, he was unable to receive rehabilitative care that would have been available by a non-public facility. Instead, he remained a long term and, what we call an "alternate level of care patient" at Kings. He was referred to Legal Health staff to determine whether there was any immigration remedies that could allow him to be eligible for Medicaid. After a comprehensive intake, Legal Health filed a deferred action application with the United States Citizenship and Immigration Services Office for discretionary relief. In doing so, Legal Health, and after many, many months, was able to establish Mr. P's eligibility for regular non-Medicaid. After multiple tests to process Mr. "P"'s Medicaid application, and a fair hearing in front of an administrative law judge, Legal Health and Medicaid settled the matter and Mr. "P" was approved after many, many months, meanwhile he is still in hospital bed. Mr. "P" has been transferred because he now has Medicaid to the Far Rockaway Rehabilitation facility (HHC's beds were all filled), where he is receiving physical therapy and is able to interact with others in a more appropriate setting. There are many Mr. "Ps" in HHC. There are many Mr. "Ps" in both our acute hospitals and our long term care facilities. So, in addition to providing the direct benefits to Mr. "P" Legal Health Services have enabled HHC to recover Medicaid dollars for the services we provided him. In his case, and two others, all at Kings County Hospital, alone we recover more than $300,000 in Medicaid revenue."

Ms. Brown concluded her remarks by stating that Council funds would be used to expand legal services for immigrants who get their healthcare at HHC facilities. Attorneys will work to obtain assistance on immigration matters, healthcare access, public benefits and housing. Patients, like Mr. "P" would benefit from expanded services. It is hopeful that the $300,000 Council award will help thousands of Mr. "Ps" and provide HHC with additional revenue opportunities.

INFORMATION ITEM

Presentation: Gotham Health FQHC Update

Walid Michelen, Chief Executive Officer & Chief Medical Officer
Gotham Health

Ms. Brown introduced Walid Michelen, MD, Chief Executive Officer and Chief Medical Officer of Gotham Health. Ms. Brown announced that Gotham Health is a new entity within the HHC family. She stated that it was timely to provide the Committee with some background information around Gotham Health to enhance the Committee's understanding of this very important effort that was undertaken by HHC to strengthen the viability of HHC's ambulatory care services.

Dr. Michelen greeted Committee members and invited guests. He stated that his presentation would cover the following topics:

- Definition of a Federally Qualified Health Center (FQHC)
- Why HHC sought FQHC Look-Alike designation for its six D&TCs
- HHC's strategy to obtain designation
    - Public Entity and Co-Applicant Model
- What is Gotham Health?
- How does Gotham Health align with Vision 2020?

Dr. Michelen began his presentation by providing the Committee with an overview of what is a Federally Qualified Health Center (FQHC). He explained that there was a movement that was started by Jack Geiger in New York to develop health centers to address the needs of the poor and uninsured across the country. Dr. Michelen stated that the Federal Government had established a health center under Section 330 of the federal Public Health Services Act, which is overseen/regulated by the Department of Health and Human Services' (DHHS) Health Resources Administration's (HRSA) Bureau of Primary Health Care. This health center is required to serve a medically underserved area (MUA) or medically underserved populations designated by DHHS. It is mandated to provide care to anyone seeking health care (with emphasis on those with incomes below the poverty level) and is required to be a charitable, tax-exempt non-profit organization. In addition, the health center is to be eligible to receive "wrap-around payments" (i.e., difference between FQHC Medicaid fee-for-service (FFS) rates and Medicaid HMO payments); higher reimbursement than state Medicaid FFS rates; eligible for Section 330 grants for serving special populations or providing targeted programs; and eligible for participation in the federal malpractice program. Dr. Michelen stated that FQHC Look-Alikes enjoy most of these benefits, except for certain Section 330 grants and participation in the federal malpractice program.

Ms. Brown clarified that HHC had strategically sought the FQHC Look-Alike (FQHC-LAL) designation because the application process was more streamlined and designation could be achieved more quickly. Dr. Michelen added that as healthcare is moving toward more primary care, becoming an FQHC-LAL aligned HHC well with that national mission.

Dr. Michelen described the driving forces for HHC to seek FQHC-LAL designation for its six diagnostic and treatment centers (D&TCs) as the following:

- To ensure the viability of vital primary care, dental and behavioral health services in 40 service delivery sites
    - 130,000 patients served in FY'13
- To access new revenues through higher FQHC payment rates and federal grants
    - Estimated $25 - $30 million in additional patient revenues to offset losses of $70 million in FY'13
    - Opportunities for 330 grants
- To increase access to primary care for low-income New Yorkers over the long term

Ms. Brown added that in 2013, HHC was engaged in a strategy to reduce its structural deficit through "the Road Ahead." Becoming an FQHC-LAL was one of many strategies that were contemplated to avoid closing some of the smaller clinics in order to address HHC's operating deficit. Ms. Brown commented that these clinics are never going to be self-sustaining. Therefore, because the federal government supports

ambulatory care and HHC is the single largest public healthcare provider in the country, FQHC-LAL status would enable these smaller clinics to become move viable and have a sustainable source of funding.

Dr. Michelen added that, in the past, public hospitals were not allowed to seek FQHC designation. However, the federal government has changed the rules. First, it was recognized that given the federal requirements around governance, capital assets and financial controls that a public entity could not meet those requirements. A more recent, more expansive guidance concerning the public entity FQHC model was issued in 2014. This guidance(s) explicitly recognized that it would be impossible for public entities to meet all FQHC governance requirements (e.g., community controlled Board) as public entities are subject to laws and regulations regarding personnel, capital assets and financial controls. A new public entity FQHC model allows a public entity to co-sponsor an FQHC with a Co-Applicant that has a community-controlled Board. This arrangement allows the public-entity (HHC) to maintain its statutory arrangements regarding personnel and financial controls and to comply with requirements of bond covenants regarding capital investments.

Dr. Michelen reported that 50% of Gotham Board Members are patients from the health centers. Together with HHC, that Board submitted an application to HRSA to obtain FQHC-LAL designation. The application process is described below:

- Public Entity (HHC) and Co-Applicant (Gotham Health FQHC, Inc.) apply together for FQHC-LAL status
- Both parties sign a Co-Applicant Agreement that sets forth respective responsibilities and duties
    - Co-Applicant retains final approval of HRSA (federal agency) mandated policy and programmatic aspects of health center operations
    - Public Entity retains ownership of properties, continues employment of staff, maintains responsibility over fiscal and personnel policies, and is responsible for day to day operations of the center sites
- The Co-Applicant forms a community-controlled Board
    - At least 51% must use the D&TCs as their principal source of primary care
- A Liaison Committee is formed with representatives from the Public Entity and Co-Applicant to work through issues that arise

Ms. Brown added that she and George Proctor are the two corporate officers who serve on the Liaison Committee along with the Board's Chair and Vice Chair. The responsibilities for each party are outlined in the Co-Applicant Agreement that was signed by the Gotham FQHC, Inc. Board and by HHC. This Agreement was reviewed and had to be approved by the federal government.

Dr. Michelen defined Gotham Health FQHC, Inc. as the Co-Applicant Board with which HHC (Public Entity) applied to HRSA and NYS for designation of the six diagnostic and treatment centers (D&TCs) as FQHC-LALs. It is a New York, not-for-profit Corporation that is governed by a Board that meets the composition requirements of Section 330 of the Public Health Services Act. At Mr. Rosen's request, Ms. Brown clarified that 51% of Board members must use the D&TCs as their principal source of primary care.

Dr. Michelen presented to the Committee the names of the Gotham Health FQHC, Inc.'s Board Members as outlined below:

NAME	TITLE
Dr. Dolores McCray	Chairperson
Ms. Elissa Macklin	Vice Chairperson
Ms. Antoinette Brown	Treasurer
Ms. Vivian Bright	Secretary
Mr. Paul Covington	Board Member
Mr. Moises Perez	Board Member
Ms. Michelle Morazán	Board Member
Ms. Denitra Johnson	Board Member
Mr. Herman Smith	Board Member
Ms. Ana Lee	Board Member

Dr. Michelen emphasized that members do not function as community advisory board members, but as Board Members who make significant policy and financial decisions.

Dr. Michelen presented the members of Gotham's Executive Team as the following:

NAME	TITLE
Dr. Walid Michelen	Chief Executive Officer / Chief Medical Officer
Ms. Anita Lee	Chief Operating Officer
Ms. Karen Dudek	Chief Nursing Officer
Mr. Ollie Worthy	Director of Finance
Mr. Ching Min Yuan	Director of IT
Mr. John Rabbia	Director of Quality and Population Management

Dr. Michelen reported that HHC received FQHC-LAL designation on February 1, 2015 (it took nearly 3 years!). He explained that **Gotham Health is the "umbrella" name of the FQHC-LAL designated sites and their satellites.** There are a total of six diagnostic and treatment center sites (D&TCs), which include Segundo Belvis, Morrisania, East New York, Cumberland, Gouverneur, Renaissance and 34 satellite locations, which include school-based health centers. Mr. Rosen asked if outpatient clinics are also included. Ms. Brown explained that Gotham Health includes all outpatient clinics that are not inside an HHC hospital. She reminded the Committee that all of the extension clinics or satellites of the D&TCs are part of Gotham Health. Ms. Brown stressed that Gotham Health FQHC, Inc. is the tax-exempt entity that was the Co-Applicant. However, Gotham Health is the name HHC is using to help people who work in those sites to form as a team. They are still part of the HHC family and also part of Gotham Health. Dr. Michelen added that, since Gotham Health is still part of HHC, it followed all HHC policies and procedures. Gotham Health employees are hired and paid by HHC and fall under HHC's personnel policies. All operations continue to be run by HHC.

Dr. Michelen reported that Gotham Health sites are located in the Bronx, Manhattan and Brooklyn. At the present time, there are no sites in Queens and Staten Island. HHC and Gotham Health FQHC, Inc., will seek approval to integrate all community primary care sites under Gotham umbrella in the near term (e.g., Vanderbilt D&TC on Staten Island)

Dr. Michelen reported that in spring 2015, Cumberland D&TC became a Federally Qualified Health Center (FQHC) because it received a HRSA New Access Point Grant. This grant provides funding in the amount of $650,000 per year to provide greater access to health care services for public housing residents. In addition to care management and community outreach services to several NYCHA developments in North Brooklyn. Cumberland's designation means that:

- We can apply for other FQHC-LAL sites to become a fully designated FQHC
- We can apply for more federal grants, including grants for renovations and construction
- We must increase Board representation (e.g., tenants of the NYCHA housing developments who are also patients of Cumberland)

Gotham Health and The 2020 Vision

Dr. Michelen stated that as HHC transitions to a health care system that promotes health and wellness and manages the health of its patient populations primarily through an ambulatory care delivery system, Gotham Health is one of the main vehicles by which, HHC will achieve that transformation. Dr. Michelen also stated that Gotham Health is aligned with Dr. Raju's 2020 vision of improving the patient experience, increasing its market share, and managing the population in the following ways:

Improve the Patient Experience

Dr. Michelen stated that Gotham Health will work to improve patient experience by:

- Improving Press Ganey score from 84% to 93%
- Improving staff engagement
- Transitioning from a provider-centered to a Patient-Centered Medical Home
- Decreasing average flow time from 60 to 45 and 30 minutes
- Adding select specialties

Dr. Michelen explained that Press Ganey is an organization that HHC contracted with to determine patient satisfaction. Every two weeks, Press Ganey receives a list of patients who received inpatient and outpatient services at the health centers. Press Ganey sends to patients an extended questionnaire (available in different languages) to be filled out and to be returned to Press Ganey with their feedback about their experience. The questionnaire covers the overall experience as well as other specific details about the waiting time, nurse treatment and clinical efforts. Press Ganey's scores are used to compare HHC's performance against the national, state and city levels. Dr. Michelen added that, in the future, CMS would either award or penalize hospitals and health centers based on their performance. He added that these scores are very important from a revenue perspective.

Increase Market Share:

Dr. Michelen reported that Gotham Health plans to increase its market share by:

- Continuously assessing each service area's needs to determine gaps and plan for additional services

- Adding 60,000 new MetroPlus members by 2020
- Implementing an aggressive marketing campaign
- Expanding Women's Health and select specialty services

Manage the Population

Dr. Michelen stated that we are already taking risks with DSRIP, MetroPlus and HealthFirst. He reported that, considering the indicators provided by HRSA, Gotham Health performed much better than the state and national averages for FQHCs. He noted, however, that there is a need to continue to improve our performance in QARR and other HMO incentive programs.

Dr. Michelen reported that Gotham Health needs to expand its community engagement by:

- Expanding its community partnerships
    - Including One City Health partners
- Becoming more integrated into communities' infrastructures (e.g., open our doors to community meetings, hosting CBOs', Chambers' of Commerce, faith-based organizations', and local educational organizations' activities, etc.)

Mrs. Bolus stated that at Cumberland D&TC it was suggested to post all related information/events taking place at the facility within the NYCHA developments. Dr. Michelen responded affirmatively. Mr. Rosen thanked Dr. Michelen for his presentation and confirmed with Ms. Brown that all his questions were answered.

Mrs. Bolus announced that there is a plan to have an open house at Cumberland D&TC in the near future to focus on bringing in NYCHA residents. With funding from the grant, there is a plan to buy some items and do a raffle to attract new residents. Dr. Michelen informed the Committee that Gotham Health held a focus group that included the participation of residents of the NYCHA developments. They have shared some great ideas on how to reach out to potential patients in the community.

Mrs. Bolus stated that Cumberland's community is also changing with the advent of newly built condominiums whose residents do not use our services. Dr. Michelen reassured Mrs. Bolus that, "if we do it right," they too will be able to use our services.

Dr. Michelen concluded his presentation by sharing with the Committee Gotham Health's commitment. It reads that "Gotham Health is committed to providing a caring, value-added outpatient experience that anticipates patient and community needs and exceeds expectations through a highly engaged patient-centered workforce."

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:19 AM.

HHC Primary Care Expansion Initiative

Presentation to Strategic Planning Committee of the Board of Directors

November 10, 2015

Contents

HHC Primary Care Expansion Initiative Work Groups and Key Staff

Project Owner and Intergovernmental Affairs

- LaRay Brown

Project Manager

- Steven Fass

1. **Operations and End User**
   - Mari Millet
2. **Community Needs Assessment**
   - Christopher Philippou
3. **Real Estate and Legal**
   - Dion Wilson
   - Jeremy Berman
4. **Regulatory**
   - Elena Russo
5. **Finance and Capital**
   - Fred Covino
   - Alice Berkowitz
   - Dean Moskos
6. **Design, Engineering, and Construction**
   - Roslyn Weinstein
   - Louis Iglhaut
   - Tamika Campbell, D&C Project Manager
   - Mahendranath (Menji) Indar
   - Jacobs Engineering
   - MJCL Architects
   - Workspace Consulting Group
7. **Information Technology**
   - Robert Hinton, IT Project Manager

Problem Statement

Unequal access to quality, affordable, primary and preventive health care has contributed to wide disparities in the health of NYC communities.

Goals

- Support the Mayor's "Caring Neighborhoods" Initiative to expand primary care capacity in underserved areas across NYC
- Expand and create new primary care access to achieve Vision 2020
  - At least 11 new community health centers across the City in high need areas by 2017
    - Develop at least 5 new health centers, and expand capacity and services at 6 existing sites
  - Health centers will be:
    - Located in highest-need communities
    - Serve all patients regardless of insurance status, income or immigration status
    - Provide accessible and convenient hours of operation
    - Employ patient-centered medical home model of care (PCMH)
    - All health centers will be open by 2017

Identifying and Prioritizing NYC High Need Neighborhoods

- Population health
- Demographics
- Primary care expansion opportunities

Sources: HHC DSRIP Community Needs Assessment, 12/2014. New York State DOH Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012; NYS Official Health Plan Market Place Zip Code Level Enrollment Data, 2014; 2008-2012 US Census American Community Survey.

Identifying and Prioritizing NYC High Need Neighborhoods

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)

Sources: HHC DSRIP Community Needs Assessment, 12/2014. New York State DOH Office of Quality and Patient Safety Bureau of Health Informatics, Medicaid Claims Extract, 2012; NYS Official Health Plan Market Place Zip Code Level Enrollment Data, 2014; 2008-2012 US Census American Community Survey.

CHCANYS High Need Neighborhoods

2013

Bronx

1. Fordham – Bronx Park
2. Crotona – Tremont
3. High Bridge – Morrisania
4. Hunts Point – Mott Haven

Brooklyn

1. Bedford Stuyvesant – Crown Heights
2. East New York
3. Sunset Park
4. East Flatbush - Flatbush
5. Williamsburg – Bushwick

Manhattan

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

Queens

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

2015

Bronx

1. Fordham – Bronx Park
2. Crotona – Tremont
3. High Bridge – Morrisania
4. Hunts Point – Mott Haven
5. Pelham-Throgs Neck

Brooklyn

1. East New York
2. Sunset Park
3. East Flatbush - Flatbush
4. Williamsburg – Bushwick
5. Borough Park
6. Coney Island-Sheepshead Bay

Manhattan

- Washington Heights – Inwood
- East Harlem

Queens

- West Queens
- Flushing – Clearview
- Jamaica

Sources: A Plan for Expanding Sustainable Community Health Centers in New York", April 2013, and Oct. 2015. CHCANYS, NYS Health Foundation.

Primary Care Expansion Opportunities

1. Identify potential candidates for expansion at existing sites and lease sites
2. Project the service area
   - 12 to 18 minute distance by foot, bus, or subway
3. Quantify the target market population within the projected service area
   - Income less than 200% Federal Poverty Level
   - New immigrants
   - NYCHA development residents
4. Proximity to existing article 28 primary care providers within projected service area and identify any gaps in services
   - HHC facilities
   - Non-public facilities
5. HHC and MetroPlus market share
6. Neighborhood demand for additional primary care (unmet need)
   - Percent of Medicaid beneficiaries that do not use ambulatory care services
   - Percent of Medicaid beneficiaries that use an ambulatory care provider outside of their neighborhood
7. Infrastructure of projected service area
   - Foot traffic
   - Visibility and signage opportunities
   - CBO linkages opportunities
   - Pharmacies
8. Derive market potential based on estimated market share penetration by primary, secondary, and tertiary service areas
9. Forecast primary care providers that can be supported by site

Anticipated Expanded and New Sites

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

Note: These 11 sites were included in the Mayor's announcement

Patient Centered Medical Home

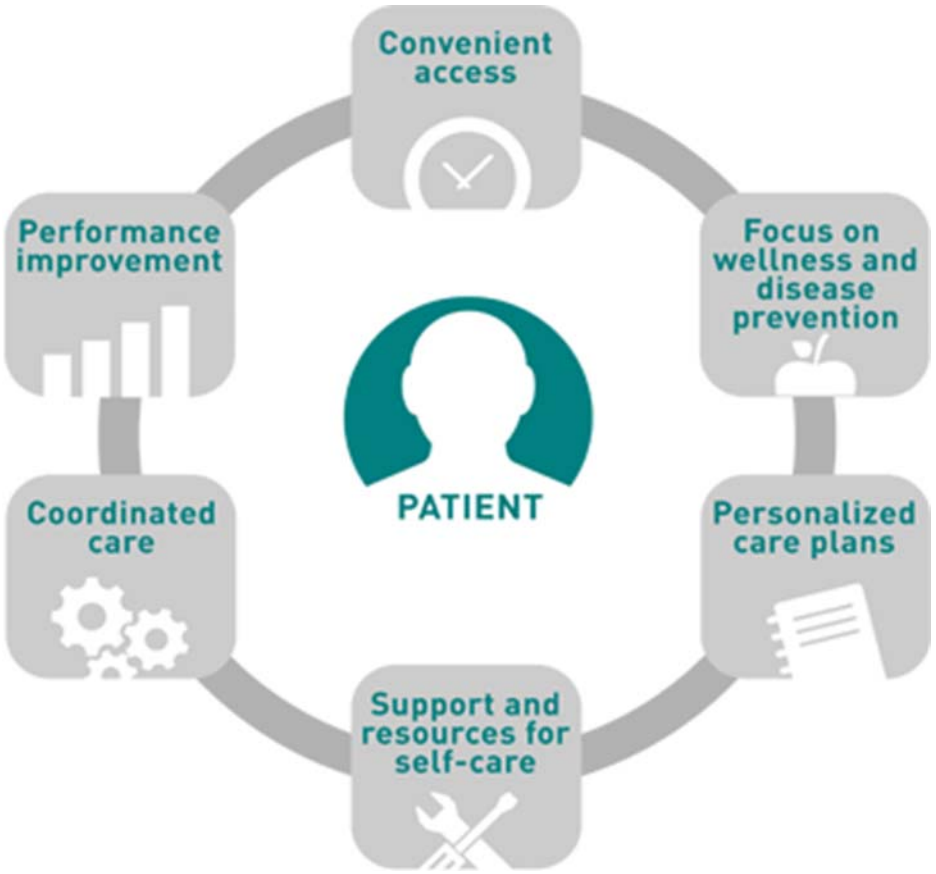
The objective of the Patient Centered Medical Home is to create a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

Certification:

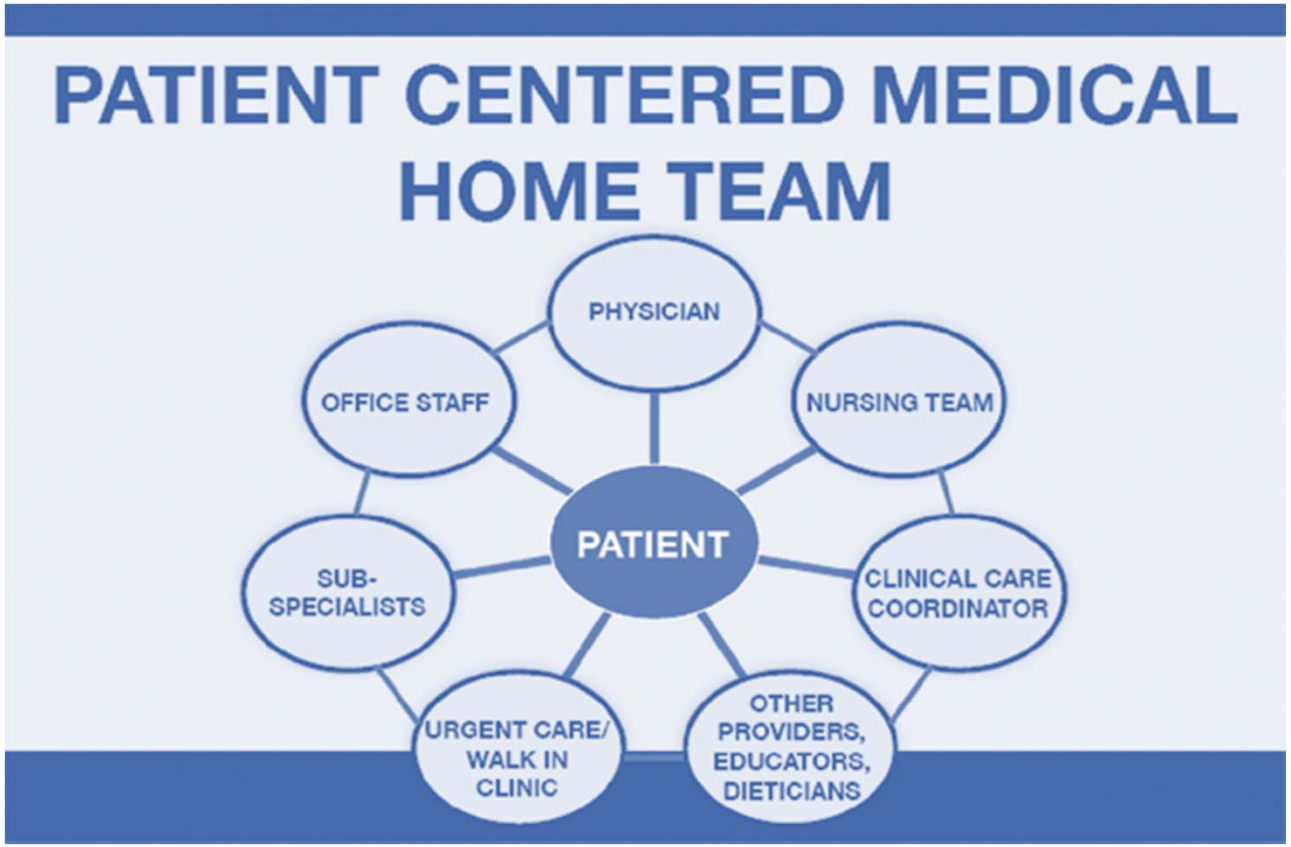
Level 3 *PCMH Certification for all Gotham Health D&TC's in process.*

PCMH Model of Care

- Comprehensive Care
- Patient Centered
- Coordinated Care
- Accessible Services
- Quality and Safety



PCMH Care Team



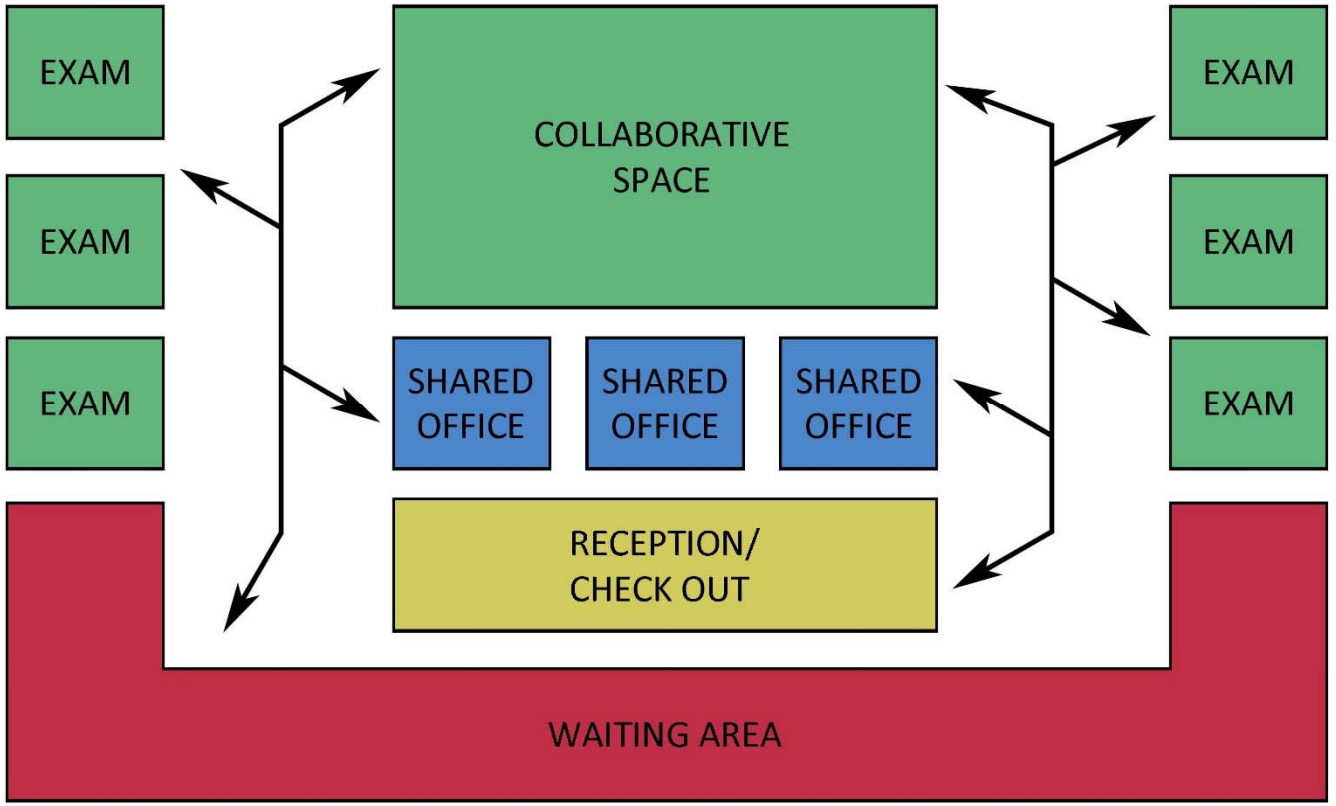
PCMH Healthcare Facility Design
Pod Configuration

Benefits to the Pod configuration in health centers 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 prevalently

http://www.daviswince.com/2012/how-does-the-patient-centered-medical-home-care-concept-translate-to-healthcare-design-for-architects/

PCMH Healthcare Facility Design
Pod Configuration



Anticipated Services Provided

* Hours at all sites will be Mon. through Sat., and include evening hours a minimum 3 days per week.

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)

Financial Projections

Methodology and assumptions

- Ramp up strategy
  - Volume trends will be monitored and additional staff added as volume ramps up.
  - Financial projections assume staffing and patient volume at full ramp up. These projections are based on Year 3 of operations, and expenses are inflation adjusted accordingly.
- Patient volume and revenue
  - Projections assume 3,500 visits per medical provider year, and 3.2 visits per patient per year at full ramp up.
  - Each site's payer mix is assumed to be equal to its nearest HHC DTC.
  - Potential non-direct patient revenue (e.g., grant revenue) is not included.
- Expenses
  - Total expenses exclude depreciation and interest expense.

Financial Projections

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)

Design and Construction

- 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)

Anticipated Schedule

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

Anticipated Capital Costs

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

Excludes 155 Vanderbilt Ave., S.I. Construction includes medical equipment, furnishings, and IT. 87-10 Northern Blvd build-out is included in lease