

**STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS**

**OCTOBER 13, 2015
10:30 A.M.
HHC BOARD ROOM
125 WORTH STREET**

AGENDA

- I. CALL TO ORDER** **JOSEPHINE BOLUS, RN**
- II. ADOPTION OF SEPTEMBER 8, 2015
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**
- III. SENIOR VICE PRESIDENT'S REPORT** **LARAY BROWN**
- IV. INFORMATION ITEM:**
- i. GOTHAM HEALTH FQHC UPDATE**
- WALID MICHELEN, MD
CHIEF EXECUTIVE OFFICER & CHIEF MEDICAL OFFICER**
- V. OLD BUSINESS**
- VI. NEW BUSINESS**
- VII. ADJOURNMENT** **JOSEPHINE BOLUS, RN**

MINUTES

STRATEGIC PLANNING COMMITTEE MEETING OF THE BOARD OF DIRECTORS

SEPTEMBER 8, 2015

The meeting of the Strategic Planning Committee of the Board of Directors was held on September 8, 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
Robert F. Nolan
Bernard Rosen
Steven Newmark, representing Deputy Mayor Lilliam Barrios-Paoli

OTHER ATTENDEES

J. Cassidy, Analyst, Office of Management and Budget
E. Kelly, Analyst, New York City Independent Budget Office

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
J. Bender, Assistant Director, Media Relations, Communications and Marketing
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
L. Chang, Data Center Administrator, World Trade Center Environmental Health Center
E. Davis, Data Center Director, World Trade Center Environmental Health Center

M. Elivert, Senior Associate Executive Director, Queens Hospital Center
S. Fass, Assistant Vice President, Corporate Planning Services
E. Guzman, Chief Operating Officer, Metropolitan Hospital Center
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
S. James, Assistant Director, Harlem Hospital Center
L. Johnston, Senior Assistant Vice President, Medical and Professional 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
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
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
L. Robinson, Funded Project Administrator, World Trade Center Environmental Health Center
S. Russo, Senior Vice President, Office of Legal Affairs
L. Sainbert, Assistant Director, Office of the Chairman of the Board of Directors
P. Slesarchik, Assistant Vice President, Labor Relations

CALL TO ORDER

The Strategic Planning Committee Chairperson, Ms. Josephine Bolus, NP-BC, called the meeting of the Strategic Planning Committee to order at 10:35 A.M. The minutes of the July 14, 2015 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS**Federal Update**

Ms. Brown reported on the following:

CMS' Anticipated Modification of Two-Midnight Rule for Short Stays

Ms. Brown reported that, on August 12, 2015, CMS had announced that it would extend the partial delay of the enforcement of the Two Midnight Rule Policy through December 31, 2015. Under this extension, Recovery Audit Contractors would only conduct post-payment patient status reviews of claims for admissions after December 31, 2015. In an April 2nd meeting, the Medicare Payment Advisory Commission or MEDPAC recommended that Congressional lawmakers should push for repealing the Two-Midnight Rule in its entirety. Passage of the Sustainable Growth Rate (SGR) repeal law in April 2015 postponed the Two-Midnight Rule until September 2015.

In the proposed Outpatient Prospective Payment System (OPPS) rule that was posted on July 1, 2015 (comment period concluded on August 31st), the Obama Administration (CMS) said it planned to allow physicians to exercise judgment to admit patients for short hospital stays on a case-by-case basis. Ms. Brown explained that if the rule is implemented as it is currently written, HHC's impact could be a loss of up to \$38 million in Medicaid revenue every year. CMS also said it would remove oversight of those decisions from its administrative contractors and would use quality improvement organizations to enforce the policy. Recovery Audit Contractors would focus only on hospitals with unusually high rates of denied claims.

Ms. Brown reported that these rule changes were outlined in the 2016 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Payment Rule. This rule was conceived to address a spike in observation stays, which were attributable to hospitals' fear that Medicare audit contractors would challenge their admissions. As a result, many patients were deemed ineligible for skilled nursing after spending days in the hospital because their stays were billed as observation. CMS reported that the number of observation visits lasting more than two days decreased by 11% in fiscal year 2014 compared to fiscal year 2013. AHA and GNYHA would still like CMS to eliminate the 0.2% reduction to hospital payments that was adopted to balance the expected increase in higher-paying inpatient stays.

340B Drug Discount Program Guidance

Ms. Brown reported that HRSA had been working on a comprehensive 340B guidance since 2007. On August 28, 2015, comprehensive 340B Drug Discount Program guidance was published. Ms. Brown reported that there were no major changes to the 340B program in spite of intense lobbying by the pharmaceutical industry. Areas of concern for HHC include the exclusion of pharmaceuticals in bundled Medicaid

payments, which could cost HHC \$5-10 million/year; and the exclusion of discharge drugs from 340B Drug Discount Program, which could cost HHC \$2-4 million/year. HHC saves \$30 million off of the GPO prices and gains an additional \$9 million through the use of contract pharmacies.

Medicare Reform Bills

Ms. Brown reported that, on July 29, 2015, members of the House Ways and Means Committee had released bills that would change both Medicare Indirect Medical Education (IME) and Medicare Disproportionate Share Hospital (DSH) payments from per discharge add-ons to lump sum payments. It is still too early to ascertain the impact of these bills on HHC. These bills- the Medicare IME Pool Act of 2015 (HR 3292) and the Strengthening DSH and Medicare through Subsidy Recapture and Payment Reform Act of 2015 (HR 3288) are part of a reform effort by the Committee's leadership.

Ms. Brown reported that the Medicare Crosswalk Hospital Code Development Act of 2015 was also introduced, which would create a crosswalk that maps outpatient and inpatient codes in what appears to be an attempt to enable site-neutral payment reform. Site-neutral payments would have a negative impact on HHC. The intent is to pay the same amount for a hospital outpatient clinic visit as a physician's office visit. Ms. Brown reported that she would share more on potential impact at the next Committee meeting. These bills will be on the Committees' agenda when Congress returns from its summer break on September 8th.

City Update

Ms. Brown reported that, last month, the City Council had approved and Mayor de Blasio signed legislation to prevent future cases of Legionnaires' disease in New York City by imposing new regulations on buildings with cooling towers. The new law will require that all cooling towers be registered with the City's Department of Buildings. Owners will be required to conduct quarterly inspections in accordance with Department of Health and Mental Hygiene regulations, and provide annual certification that cooling towers have been inspected, tested, cleaned and disinfected to the Department of Building (DOB). New York State is expected to follow suit with new regulations with similar requirements for buildings with cooling towers.

Mrs. Bolus asked if there was enough funding for the inspectors to conduct these quarterly inspections. Ms. Brown responded that she was unaware of the City's allocation to the Department of Buildings for these inspections. Mr. John Jurenko, Senior Assistant Vice President, clarified that the building owners were expected to pay for these inspections themselves. Ms. Brown added that there will be an increase in the industry growth for environmental experts to conduct private inspections of these buildings. Ms. Brown stated that HHC would absorb the cost of these inspections at its facilities. Mr. Martin added that these inspections, which were originally conducted every six months during the cooling season, would now be done quarterly because of the new law and would cost HHC approximately \$4 million/year.

Mrs. Bolus asked if the new law also included the 200 companies that partner with HHC through the Delivery System Reform Incentive Program (DSRIP). Ms. Brown explained that DSRIP is a major transformation strategy by the state and federal government. Those organizations that are part of HHC's One City Health Performing Provider System are still independent entities. Therefore, if those entities owned buildings with

cooling towers, those entities, DSRIP or no DSRIP, would be required to implement the city's new law regarding the cooling towers at their own expense.

Mr. Robert Nolan, Board Member, asked if the annual cost of \$4 million included follow-up and clean-up of the cooling towers in addition to the inspections. Mr. Martin responded affirmatively. He added that the number of cooling systems varied according to a facility's size. While a diagnostics and treatment center (D&TC) may only have one cooling tower, a hospital like Kings County Hospital Center may have four or five cooling systems.

INFORMATION ITEM

Presentation: World Trade Center Environmental Health Center Update

Terry Miles, Executive Director, World Trade Center Environmental Health Center
Joan Reibman, M.D., Medical Director, World Trade Center Environmental Health Center

Ms. Brown introduced Mr. Terry Miles, Executive Director, and Joan Reibman, MD, Medical Director of HHC's World Trade Center Environmental Health Center (WTC EHC) Program. She reminded the Committee that it was customary during the month of September to update Board members on this important program that HHC has been operating since the unfortunate attacks on the World Trade Center on September 11, 2001. Ms. Brown informed the Committee that the program had significantly grown and changed in terms of its funding, the range of services it provides and the population served. In addition to those changes, Ms. Brown explained that it was important to update Board members because the federal law that funds this program (the James L. Zadroga 9/11 Health and Compensation Act of 2010) was up for reauthorization. Ms. Brown added that there have been a lot of activities to support getting the Zadroga Act reauthorized as quickly as possible to ensure ongoing funding support of this program and others.

Mr. Miles began his presentation by first thanking the Committee for the opportunity to provide an update on HHC's World Trade Center Environmental Health Center (WTC EHC). He informed the Committee that his presentation would cover what the Zadroga Act meant administratively and how it supported HHC's WTC EHC. Mr. Miles added that Dr. Reibman's presentation would focus on the science of why these programs are needed and what is being done clinically. Mr. Miles introduced HHC's WTC EHC administrative staff, including Scott Penn, Deputy Director; Edith Davis, Data Center Director; Larry Chang, Data Center Administrator; and Lance Robinson, Project Administrator. Mr. Miles explained that the clinical administration component of the work that is led by Dr. Reibman's was also being supported by the following Assistant Medical Directors: Dr. Deepak Pradan at Bellevue Hospital, Dr. Judy Su at Gouverneur Healthcare Services and Dr. Elizabeth Awerbuch at Elmhurst Hospital Center.

I. WTC EHC PROGRAM ADMINISTRATION

The James L. Zadroga 9/11 Health and Compensation Act of 2010 (Zadroga Act)

Mr. Miles explained that the James L. Zadroga 9/11 Health and Compensation Act of 2010 was signed into law at the end of the year 2010 and was operationalized in July 2011. The Zadroga Act was named to memorialize an NYPD officer who died as a result of 9/11 related illnesses. Mr. Miles explained that,

while the Zadroga Act has both a health and a compensation component, his presentation would only focus on the health component.

Mr. Miles reported that the health component of the Zadroga Act was administered by the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control (CDC). The compensation component of the Zadroga Act is administered separately by the United States Department of Justice.

Mr. Miles explained that the Zadroga Act established a World Trade Center Health Program for both medical and mental health services for WTC responders and community members who became sick as a result of events on and after September 11, 2001. Mr. Miles explained that for the sake of this program, community members are legislatively defined as "survivors." The overall World Trade Center Health Program includes seven clinical centers of excellence (CCEs) in the New York City area; a national program which serves individuals who live throughout the United States – including responders at the Pentagon and at Shanksville, PA; and three data centers (DCs). Mr. Miles added that HHC operates one of the seven CCEs and one of the three DCs.

World Trade Center Health Program Structure

Mr. Miles stated that the WTC EHC is the clinical center of excellence (CCE) for WTC survivors. The WTC EHC has three clinical locations, which are sited at Bellevue and Elmhurst Hospitals and Gouverneur Diagnostic and Treatment Center. There is also a national program that serves responders and survivors. Mr. Miles explained that it was misleading to refer to the national program as a CCE because the national program functioned very differently compared to the WTC EHC program. He explained that the national program uses United Healthcare's provider network, which ensures that people would have access to WTC-related health care in their community, no matter where they live. Mr. Miles informed the Committee that Dr. Reibman and other medical directors have been working with Medscape to create clinical guidelines for providers throughout the country, which will build the capacity of providers across to serve WTC patients.

Mr. Miles stated that HHC's WTC EHC has a data center, which is part of the program. He emphasized that, by law, there must be a "Survivor Steering Committee" and a "Scientific Technical Advisory Committee." He added that community advocates and labor make up the Survivor Steering Committee. He added that, by law, survivors and physicians have to be included on the Scientific Technical Advisory Committee.

WTC EHC Program Description

Mr. Miles explained that the term "survivor" is a legislative term, which refers to workers, residents, children, passers-by, and clean-up workers below Houston Street in Manhattan and at the very northwest corner of Brooklyn Heights. Mr. Miles added that Canal Street is the northern boundary for the Victims Compensation Fund. He explained that the Houston Street definition for survivors was written into law. The Canal Street definition for the compensation fund was determined by an administrator who was named to oversee the compensation component of the Act. Mr. Nolan, Board Member, asked how much of Brooklyn Heights' waterfront was included within the boundaries. Mr. Miles responded that it was a very small area.

Comparison between Responder and Survivor Programs

Mr. Miles described the differences between the “survivor” and the “responder” programs. Mr. Miles explained that the responder program screened and provided direct care to affected first responders; and it also monitors healthy individuals. He informed the Committee that currently there are 37,000 individuals who are enrolled in the WTC Health Program. All responders are eligible for monitoring, even without a certified WTC-related condition. He added that there was no such monitoring program for survivors. While the responder program was primarily comprised of men, the survivor program was comprised of 50% men and 50% women. Moreover, the survivor program has a pediatric-adolescent population which is now aging out. Currently, there are approximately 70 children/adolescents who are enrolled in the program. Mr. Miles stated that the WTC Health Program is a payer of last resort, which means that enrollees’ personal health coverage plans must be billed first before the WTC Health Program is billed. Furthermore, WTC EHC patients must not only be sick, they must also have a certifiable WTC-related health condition.

FY 15 Revenue and Expenses: July 1, 2014 – June 30, 2015

Mr. Miles referred to the FY 15 Revenue and Expenses – July 1, 2014 – June 30, 2015 presentation slide. He explained that the figures were preliminary and that the program has both a CCE and DC contract. The CCE contract supports member and administrative services, while the DC contract supports data gathering, analysis and reporting. He added that there was also a fee-for-service component for care that is rendered.

Mr. Miles reported that the WTC EHC program’s revenue was \$7,864,441 and the program’s expenses was \$7,654,207. Mr. Miles explained that the figures were roughly the same and that the program pays for itself. Ms. Brown clarified that, in addition to the Central Office WTC EHC team, these expenses are distributed throughout the organization including the three program sites, which are supported by other departments. Ms. Brown explained that the administrative costs include data gathering, analysis and reporting, supporting the activity of the Central Office WTC EHC team as well as others within the organization. She added that because the program has a very complicated billing mechanism, the WTC EHC team works very closely with colleagues in Finance and Corporate Reimbursement. Mr. Miles added that overwhelmingly, the administrative costs also include non-clinical time for clinical staff such as doctors, social workers, etc.

WTC EHC Primary Payer Mix

Mr. Miles described the WTC EHC primary payer mix as the following:

- 34% of patients enrolled in commercial insurance
- 27% of patients with WTCHP coverage only
- 20% of patients enrolled in Medicaid
- 17% of patients enrolled in Medicare
- 2% of patients enrolled in Workers Compensation

Mr. Miles explained an unintended consequence of the bill. The language of the Zadroga Act stipulates that the WTC Health Program should serve as the payer of last resort for survivors; however, New York

State has a pre-existing agreement with the federal government that Medicaid would be the payer of last resort. As a result of this agreement, the difference between what Medicaid pays and what the WTC Health Program allows for patients (20%) who are enrolled in the Medicaid program, could never be billed to the WTC Health Program. Mr. Miles commented that, in spite of that, the program is able to sustain itself financially.

Timeline of WTC-Related Care and Funding

Mr. Miles reported that:

- Shortly after the actual event in 2001, patients started coming to HHC facilities with symptoms related to the events of September 11th. Initially, HHC developed a very small program to treat these individuals. The main source of funding was through philanthropy.
- In 2006 and 2007, the City of New York stepped in which helped to create a program site at Gouverneur, supported the pre-existing small program at Elmhurst, and expanded the program at Bellevue Hospital.
- In 2008, HHC began to receive some federal funding for the program.
- With the Zadroga Act taking effect in July 2011, HHC received ongoing funding to support the WTC EHC Program. Mr. Miles reminded the Committee that the Zadroga Act was about to expire.

Reauthorization of the Zadroga Act

Mr. Miles stated that the current law called for the Zadroga Act to be reauthorized after five years. The goal for reauthorization is to make the program permanent while keeping it budget neutral. Mr. Miles added that the Senate had already passed the budget neutral component of the Zadroga Act as a bill in March 2015, which was a key step for reauthorization. Mr. Miles explained that the reauthorization bill would expand funding and services for further research in a more enhanced way than the current law. It would also address some technical issues that need to be corrected. Mr. Miles stated that a large technical issue is the lack of funding for administering the WTC Health Program at the federal level. The federal government has been using National Institute of Occupational Safety and Health (NIOSH) and Center of Disease Control (CDC) funding to oversee the program. Mr. Miles acknowledged the City Council for passing a resolution in support of reauthorization in the early part of the year. A few weeks later, the bill was formerly introduced in both the Senate (S. 928) and the House (HR. 1786) using the same language unlike four years ago.

Mr. Miles reported that there hasn't been a lot of activities over the last several months, except for the following:

- April 2015 - Dr. Reibman participated in an advisory phone call with the Senate Health Committee.
- July 2015 - Dr. Reibman participated along with the medical directors of the Fire Department and the Mount Sinai Program in Doctor Day in Washington, DC
- Last Week - Press conference with the participation of WTC EHC patients

- Next Week - Education Day scheduled in Washington, DC. Congress Members Nadler and Maloney requested that WTC EHC members be present on that day to help educate Congress Members about the program.
- The Senate's Health Education, Labor and Pension (HELP) Committee is negotiating what has been presented to the Senate. The most heated issue that people are still optimistic about is whether the program will be permanent, or would they negotiate to a 25-year term or less.
- The House's Energy and Commerce Committee had a very positive meeting earlier this year. Since then, there has been no discussion, no mark-up on the bill, and no correction process that would normally happen after a committee meeting. The assumption is that these key steps would occur in early October.

Mr. Miles invited Committee members to review the WTC Health Program 2014-2015 Year in Review Annual Report, which was distributed during the meeting. Mr. Miles cautioned that some of the information in the document was slightly different than what Dr. Reibman would be presenting to the Committee. This is because the annual report/newsletter has data that is several months old. He highlighted that one of the patients that was interviewed for the annual report/newsletter was Ms. Florence Jones, who was a member of the WTC EHC program.

II. WTC EHC PROGRAM - SCIENTIFIC/CLINICAL UPDATE

Dr. Reibman began her presentation by praising HHC's support of the WTC EHC program. She specifically acknowledged the support of Ms. LaRay Brown, and all the members of the WTC EHC team. She noted that it had been an enormous endeavor for many people. Dr. Reibman re-emphasized that the program started and continues to be a collaborative community project since 2001. Dr. Reibman commented that the program is a beautiful illustration of what happen when physicians, community and HHC work all together.

Dr. Reibman informed the Committee that her presentation would cover the scientific and clinical aspects of the program including environmental exposures, the adverse health findings in community members, as well as the medical and mental health findings.

Environmental Exposures

Dr. Reibman stated that inasmuch as it is obvious now that the destruction of the World Trade Center resulted in the immediate death of 2,752 individuals and exposed a considerable amount of individuals (including firefighters and others who participated in the rescue efforts as well as local community members) to dust and fumes as the towers collapsed, this fact was not known at the time of the unfortunate event. Dr. Reibman stressed that it took a long time to comprehend that among the individuals who were exposed, there were approximately 60,000 residents living south of Canal Street; 300,000 local/office workers, commuters and teachers; 15,000 students; and many other children. Dr. Reibman stated that some individuals were completely covered in material from the dust cloud that formed when the towers collapsed. Among those who were exposed to the dust cloud were Stuyvesant High School students, many of the local workers who left the towers themselves, and those who lived in

the surrounding buildings. Dr. Reibman reported that one of these women, called the "Dust Lady" whose picture became an iconic 9/11 image known around the world, had recently passed away. Dr. Reibman explained that some individuals suffered from acute exposure not because they were responders but because they were local workers, school children, residents, even passers-by and tourists who were present in the area on that day.

Dr. Reibman reminded the Committee that before any testing of indoor air quality was conducted by any governmental entity, there was a press statement by EPA Administrator Christine Todd Whitman that was issued on September 21, 2001 stating:

- "I am glad to reassure the people of New York and Washington, DC, that their air is safe to breathe [sic] and their water is safe to drink. New Yorkers.... need not be concerned about environmental issues as they return to their homes and workplaces."

Subsequent to that statement, local workers returned to work on September 17, 2001 and few residents evacuated. It is to be noted that dust had settled inside buildings/ventilation systems and was re-suspended from incompletely cleaned ventilation systems. In addition, the chemical composition of indoor dusts was similar to the outdoor dusts – but with smaller particles. Dr. Reibman added that there was potential for chronic exposures to gases and fumes as the fires burned through December 2001. It was evident that people who lived and worked in the area were potentially exposed to the debris. Dr. Reibman noted that the collapse of the two 107 story buildings included 1.2 million tons of building materials, 90% of which were of settled particles >10 µm diameter and 11,000 tons of particles < 2.5 µm [micrometers] in diameter.

Dr. Reibman described the chemical constituents of the WTC dust as the following:

- Combustion of jet fuel
- Combustion products
 - Plastics
 - Metals
 - Woods
 - Insulation
 - Fluorescent lights
 - Computer and video monitors
- Organic pollutants
 - Polycyclic aromatic hydrocarbons
- Hydrocarbons
 - Naphthalene
 - Polychlorinated biphenyls (PCBs)
 - Dioxins
 - Benzene
- Heavy metals
 - Mercury
 - Lead

Dr. Reibman described the characteristics of settled WTC dust as the following:

- Alkaline (pH9-11)
- Construction materials

- Cement
- Concrete
- Wallboard
- Particulate matter
 - Calcium sulfate (gypsum)
 - Calcium carbonate
 - Crystalline silica
- Fibers
 - Fibrous glass
 - Gypsum fibers
 - Chrysotile asbestos

Dr. Reibman reported that Bellevue Hospital and NYU Medical Center had been jointly involved in a forum at Pace University on October 11, 2011. As a result, a number of academic community coalitions were developed, which included the Fire Department of New York City (FDNY), rescue workers, and community members. Dr. Reibman stated that the FDNY had a long-standing health program that continues to provide enormous important information.

Dr. Reibman informed the Committee that the *New England Journal of Medicine* had published a paper on September 12, 2002, stating that there were adverse health effects among firefighters at the World Trade Center site. Because of the academic interests of both Bellevue Hospital and NYU Medical Center, they were able to conduct a study through a collaboration with the New York State Department of Health and the local community. Dr. Reibman stated that the New York City Department of Health was not included at that moment. A comparison was made between an "exposed area" and a "control" area on the Upper West Side and lung function testing was also conducted. Dr. Reibman reported that the findings of the WTC Respiratory Health Study documented an increase in new-onset respiratory symptoms (i.e., cough, wheezing, and shortness of breath) in previously normal exposed residents compared to a control group; and an increase in medical consultation and asthma medicine use in previously normal residents. These conditions are associated with exposure to dust and fumes. These findings were subsequently confirmed in multiple reports from the New York City Department of Health and Mental Hygiene's WTC Registry.

Dr. Reibman reported that Bellevue Hospital's treatment program was developed as a result of the health findings in WTC community members. In 2002, community and advocacy groups showed up at Bellevue Hospital and requested treatment, which was provided at the Bellevue Hospital Asthma Clinic. Consequently, the WTC Environmental Health Center treatment program was created and supported with different sources of funding as listed below:

- 2005 – American Red Cross Liberty Disaster Relief Fund
- 2006 – City of New York
- 2008 – CDC-NIOSH (first federal funding)
- 2011 – James Zadroga 9/11 Health and Compensation Act

Dr. Reibman described the WTC Environmental Health Center's current patients. She reported that there are 8,649 patients currently enrolled in the program, 3,853 of whom have had a visit within the past three years and are considered active. Dr. Reibman re-emphasized that compared to the responder program, which monitors healthy individuals, every WTC EHC patient must have experienced a WTC-related symptom, such as shortness of breath, cough, wheezing, chest tightness and (most recently) mental

illness before being admitted to the program. Dr. Reibman noted that, while not all of these patients are seen every month, there are about 4,000 patients that are active at all three sites. Bellevue Hospital has the largest site. At the request of Robert Nolan, Board Member, Dr. Reibman explained that exposure plus a WTC-related symptom were two required conditions for any patient to be admitted to the WTC EHC program. She added that by definition, the WTC EHC Program has a sick population.

Dr. Reibman stated that every patient is screened for exposure, symptoms, and a temporal relationship between the exposure and the symptoms. She added that there have been a lot of discussions about the onset of asthma among individuals applying to the program. For example, if one develops asthma 10 years later, after the expiration of the exposure period, which was one year after 9/11, it would be difficult to state that the patient's condition is related to the exposure of the 9/11 chronic dust. Therefore, there has been a 5-year cut off for asthma or asthma-like symptoms after the last exposure. Ms. Brown added that, if the program is still in existence 10 years from now and an individual can prove at that time that he/she was exposed and that their current symptoms are related to 9/11, he/she would be able to enroll in the program.

Bernard Rosen, Board Member, asked about the remaining 4,800 patients who are not active. Specifically, he asked how often they visited the program. Dr. Reibman responded that they all had made at least one visit to the program. She stated that it is hopeful that they would come back. However, many of them have moved away, others have decided to go to their private physicians and others may simply feel well with no need to follow-up.

Mrs. Bolus asked if there were any babies born afterwards. Dr. Reibman responded affirmatively and added that this has been a hot topic. It was initially said that babies born nine months after the exposure, would be included in the program; however, there have not been a lot of them. Dr. Reibman informed the Committee that there were a number of studies done by Columbia and also at Mount Sinai on health defects in babies. She reported that unfortunately, while the study at Mount Sinai was an excellent one, it was not funded by the government and subsequently ended. The Columbia study, however, had a longer duration and may still be ongoing. Dr. Reibman stated that little is known about any health defects in this group. Dr. Reibman stated that there is a need to really focus on kids and their in utero exposures but unfortunately, the program did not do it. Mrs. Bolus asked if the other sites were able to focus on the kids' exposures. Dr. Reibman stated no and emphasized that the program was only staffed to delivery pediatric care at the Bellevue Hospital site.

Mr. Rosen asked if some first responders were part of the active patients. Dr. Reibman clarified that the WTC EHC program served only non-responders/survivors. Dr. Reibman described the WTC EHC patients' characteristics. Unlike the responders' program with 90% male patients, there is a 50/50 split of male and females including children who are severed by the WTC EHC. Dr. Reibman reported that currently, most of the active WTC EHC population are local workers who were either working in offices or retail, or had stands in the street as well as a small number of residents. Dr. Reibman explained that the program started with a major group of clean-up workers, with 50% of these workers reporting as being in the dust cloud on 9/11 and having had acute exposure on that day.

Dr. Reibman presented the current WTC EHC certified conditions as the following:

| <u>Certified Condition</u> | <u>% of Patients with Certified Conditions</u> |
|--------------------------------------------|------------------------------------------------|
| Medical Conditions | |
| • Obstructive airway disease (asthma-like) | 51% |
| • Upper respiratory disease | 39% |
| • Gastroesophageal reflux disease | 37% |
| • Cancer | 9% |
| • Interstitial lung disease | 1% |
| • Sarcoidosis | 1% |
| Mental Health Conditions | |
| • Post-traumatic stress disorder | 23% |
| • Adjustment reaction | 19% |
| • Depression | 19% |
| • Anxiety | 12% |
| • Substance Abuse | 5% |

These conditions are not mutually exclusive. Sixty-four (64%) of the WTC EHC patients have more than one certified condition. Dr. Reibman explained that sarcoidosis is a disease of unknown cause that usually starts in the lungs by forming granuloma tight little clusters of inflammatory cells. The disease could be mild or extremely debilitating. Thanks to the pre-existing medical program of the firefighters showing that there was a peak of new cases of sarcoidosis, the WTC EHC program was able to link the new sarcoidosis cases to the list of WTC-related symptoms. Dr. Reibman admitted that it can only make sense that a foreign body exposure would cause an immune response in the lung. Dr. Reibman reported that there were a number of these cases.

Dr. Reibman reported on the current cancer certifications as listed below:

| Cancer Type | #of Patients with this Cancer Certification | % of Patients with any Cancer Certification |
|-----------------------------------|------------------------------------------------------------|------------------------------------------------------------|
| • Breast | 86 | 19% |
| • Prostate | 57 | 13% |
| • Trachea, Bronchus and Lung | 44 | 10% |
| • Thyroid | 42 | 9% |
| • Lymphoma | 38 | 8% |
| • Skin (Non-Melanoma) | 34 | 8% |
| • Leukemia (Lymphoid and Myeloid) | 27 | 6% |
| • Head and Neck | 23 | 5% |
| • Kidney | 23 | 5% |
| • Multiple Myeloma | 20 | 4% |
| • Colon and Rectum | 19 | 4% |
| • Esophagus and Stomach | 13 | 3% |
| • Hodgkin's Disease | 9 | 2% |
| • Other | 70 | 15% |

Dr. Reibman reported that certification for cancer began in 2012 because it was not possible to get the data on cancers from the beginning. This is because it was not expected that cancers would show up right away. Cancers were identified after reviewing firefighters' and New York City Department of Health data. Because 50% of the program's population is female, a common cancer that has been identified is breast cancer. In addition, an increase of prostate cancer has been reported by the firefighters and by the NYC Department of Health. Dr. Reibman stated that lung cancers were not as prevalent as they had expected. However, there is a fair number of lymphomas, leukemia, multiple myelomas and Hodgkin's Diseases. Dr. Reibman stated that people are coming in every single day with a variety of cancers and it is unclear if these cases are regular cancers, if there is something different about them, or if they are responding the way cancers are expected to respond. Dr. Reibman explained that it has been a huge endeavor for the program as these patients were not being cared for by the program but referred out for case-based management. She added that Ms. Sheila Smyth-Giambanco, RN, who serves as the WTC EHC's Cancer Clinical Coordinator is to be commended for ensuring that every single one of these cases is appropriately followed and cared for.

Mental Health Findings

Dr. Reibman reported that there were high rates of PTSD, depression and anxiety in the cohort enrolled for medical conditions and these symptoms are persistent 4-7 years after 9/11.

Lessons Learned

Respiratory Disease

- Standard measures of lung function may not completely reflect symptoms – may need measures of small airways
- Standard measures of lung function show improvement over time – those with abnormal lung function do not return to normal
- Lower respiratory symptoms have remained chronic and uncontrolled in many because of the following:
 - Severity associated with exposures, lung functions, presence of mental health symptoms
 - Chronicity associated with exposures, abnormal lung function measurement, presence of mental health symptoms
 - Measures of inflammation (eosinophils, c-reactive protein) are frequently elevated and associated with disease

Mental Health

- High rates of PTSD, anxiety and depression in overall population of "survivors" and in those presenting just for medical complaints
- PTSD associated with exposures (dust cloud) and respiratory symptoms
- PTSD, anxiety and depression can be chronic
- Chronic PTSD, anxiety and depression associated with exposures, lower respiratory symptoms and decreased functional status
 - Anxiety further associated with low-income

Cancers

- Cannot assess incidence because the program lacks a screening population that would serve as a denominator, and patients are self-referred
- Enrollment for cancers continues to increase
- Currently performing a case series analysis to understand characteristics of hematologic cancers and solid tumors

Other

- High rates of co-morbid medical and mental health conditions in community members with environmental disaster exposure
- Medical and mental health conditions are improved in some, remain chronic in others
- Co-morbid conditions impact response to treatment and chronicity of disease
- Multidisciplinary approach needed for disaster programs – model for general medical programs?

Ms. Brown emphasized that the HHC's WTC EHC program grew out of a coalition of community residents, community health advocates, and union/labor. This is extremely important because the WTC EHC is the kind of program that requires a level of advocacy that is unparalleled vis-à-vis Zadroga, the interactions between the responders' program, the Fire Department with Mount Sinai, the WTC Health Program and the federal government. Ms. Brown emphasized that the program has been serving many individuals with very low-income who cannot afford to get the kind of private care that their conditions would require.

Mrs. Bolus applauded the team for their hard work. Ms. Brown added that the applause should also go to other team members at Bellevue Hospital, Gouverneur Healthcare Services and Elmhurst Hospital.

ADJOURNMENT

There being no further business, the meeting was adjourned at 11:39 AM.



gotham
HEALTH

Walid Michelen, MD
CEO/CMO

This Presentation will Cover:

- 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 20-20?

What is a Federally Qualified Health Center (FQHC)?

A health center that is:

- Established under Section 330 of the federal Public Health Services Act
- Overseen/regulated by the Department of Health and Human Services' (DHHS) Health Resources Administration's Bureau of Primary Health Care
- Required to serve a medically underserved area (MUA) or medically underserved population designated by DHHS
- Mandated to provide care to anyone seeking health care (with emphasis on those with incomes below the poverty level)
- Required to be a charitable, tax-exempt non-profit organization

What is a Federally Qualified Health Center (FQHC)?

- A health center that is:
 - Required to be a charitable, tax-exempt non-profit organization
 - Eligible to receive “wrap-around payments” (i.e., difference between FQHC Medicaid FFS rates and Medicaid HMO payments) and higher than state Medicaid FFS rates
 - Eligible for 330 grants for serving special populations or providing targeted programs
 - Eligible for participation in federal malpractice program
- FQHC Look-Alike Status enjoys most of the benefits, application is more streamlined

Why did HHC seek Federally Qualified Health Center Look-Alike status for its 6 Diagnostic & Treatment Centers (D&TCs)?

- 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

The Strategy: Public Entity & Co-Applicant Model

- In 1997, the federal government issued its first guidance related to granting FQHC designation to public entity health centers
- A more recent, more expansive guidance concerning the public entity FQHC model was issued in 2014
 - 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
- 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

Public Entity Nuts and Bolts

- Public Entity (HHC) and Co-Applicant (Gotham Health FQHC, Inc.) apply together for FQHC Look-Alike 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

What is Gotham Health FQHC, Inc.?

- Gotham Health FQHC, Inc. is the Co-Applicant Board with which HHC (Public Entity) applied to HRSA and NYS for designation of the 6 D&TCs as Federally Qualified Health Center Look-Alikes
 - It is a NY not-for-profit corporation governed by a Board that meets the composition requirements of Section 330 of the Public Health Services Act
 - At least 51% must use the D&TCs as their principal source of primary care

Gotham Board Members

| 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 |



Gotham Executive Team

| 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 |
| John Rabbia | Director of Quality and Population Management |

What is Gotham Health?

- We received FQHC-LA designation February 1, 2015 (it took nearly 3 years!)
- Gotham Health is the “umbrella” name of the FQHC-LA designated sites and their satellites
 - Segundo Belvis, Morrisania, East New York, Cumberland, Gouverneur, Renaissance and 34 satellite locations
- Gotham Health is still part of HHC
 - It follows all HHC policies and procedures
 - Gotham Health employees are hired and paid by HHC and fall under HHC personnel policies
 - All operations are run by HHC

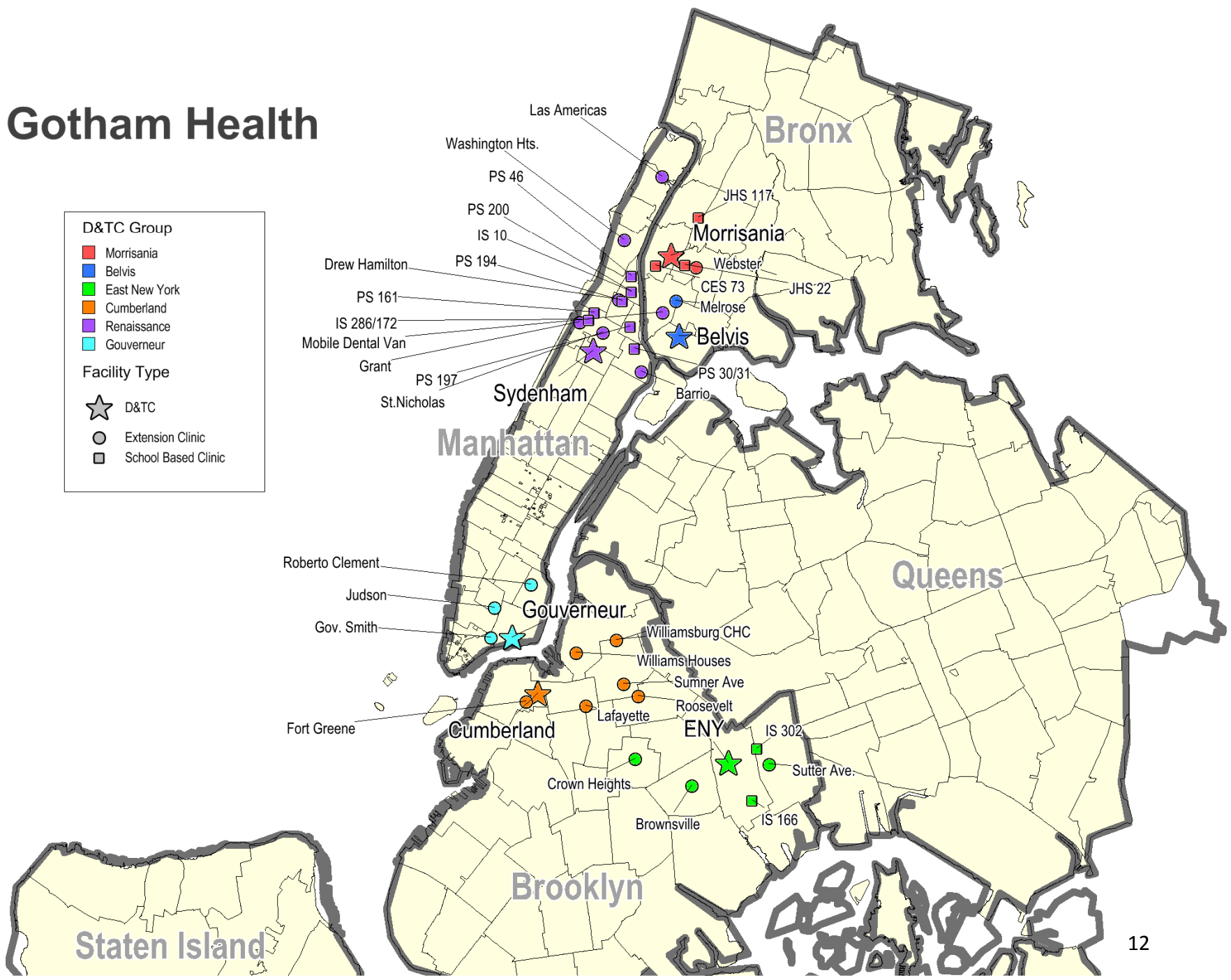
Gotham Health

D&TC Group

- Morrisania
- Belvis
- East New York
- Cumberland
- Renaissance
- Gouverneur

Facility Type

- ★ D&TC
- Extension Clinic
- School Based Clinic



Where are we Headed?

- Cumberland is now a Federally Qualified Health Center because it received a HRSA New Access Point Grant
 - Grant is for \$650,000 per year grant to provide greater access to public housing residents
 - Care management and community outreach services to several NYCHA developments in North Brooklyn
- 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)

What does Cumberland's designation mean for Gotham Health & HHC?

- 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

- HHC is transitioning 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 we will achieve that transformation

Gotham Health and The 2020 Vision: Improve the Patient Experience

- Improve Press Ganey score from 84% to 93%
- Improve staff engagement
- Transition from a provider-centered to a Patient-Centered Medical Home
- Decrease average flow time to 45 minutes
- Add select specialties

Gotham Health and The 2020 Vision: Increase Market Share

- Continuously assess each service area's needs to determine gaps and plan for additional services
- Add 60,000 new MetroPlus members by 2020
- Aggressive marketing campaign
- Expand Women's Health and select specialty services

Gotham Health and The 2020 Vision: Manage the Population

- Gotham Health performs much better than the state and national averages for FQHCs
- However, we need to continue to improve our performance in QARR and other HMO incentive programs

Expand our Community Engagement

- Expand our community partnerships
 - Including One City Health partners
- Become 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.)





Our Commitment

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