

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

**SEPTEMBER 8, 2015  
10:30 A.M.  
HHC BOARD ROOM  
125 WORTH STREET**

**AGENDA**

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

**II. ADOPTION OF JULY 14, 2015  
STRATEGIC PLANNING COMMITTEE MEETING MINUTES** **JOSEPHINE BOLUS, RN**

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

**IV. INFORMATION ITEM:**

**i. WORLD TRADE CENTER ENVIRONMENTAL HEALTH CENTER UPDATE**

**TERRY MILES**  
EXECUTIVE DIRECTOR, WORLD TRADE CENTER ENVIRONMENTAL HEALTH CENTER

**JOAN REIBMAN, MD**  
MEDICAL DIRECTOR, WORLD TRADE CENTER ENVIRONMENTAL HEALTH CENTER

**V. OLD BUSINESS**

**VI. NEW BUSINESS**

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



## **MINUTES**

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

**JULY 14, 2015**

The meeting of the Strategic Planning Committee of the Board of Directors was held on July 14, 2015 at 10:30am in HHC's Board Room, located at 125 Worth Street, Room 532, with Ms. Josephine Bolus, NP-BC, presiding as Chairperson.

#### **ATTENDEES**

##### **COMMITTEE MEMBERS**

Josephine Bolus, NP-BC, Chairperson of the Committee  
Ram Raju, M.D.  
Robert F. Nolan  
Bernard Rosen  
Steven Newmark, representing Deputy Mayor Lilliam Barrios-Paoli

##### **OTHER ATTENDEES**

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

##### **HHC STAFF**

C. Barrow, Associate Director, Lincoln Medical and Mental Health Center  
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations  
L. Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations  
V. Buccellato, Chief Operating Officer, Coney Island Hospital  
T. Carlisle, Associate Executive Director, Corporate Planning Services  
D. Cates, Chief of Staff, Office of the Chairman of the Board of Directors

D. Collins, Senior Associate Director of Facilities, Coney Island Hospital  
M. Cooper, Director of Community Outreach, Office of Intergovernmental Relations  
E. Davis, Senior Associate Director, World Trade Center Environmental Health Center  
S. Fass, Assistant Vice President, Corporate Planning Services  
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations  
T. Hamilton, Assistant Vice President, Corporate Planning Services  
S. James, Assistant Director, Harlem Hospital Center  
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations  
S. Kleinbart, Director of Planning, Coney Island Hospital  
D. Lee, Intern, Office of the President  
Z. Liu, Senior Management Consultant, Corporate Planning Services  
P. Lockhart, Secretary to the Corporation, Office of the Chairman of the Board of Directors  
K. Madej, Director of Marketing, Office of Communications and Marketing  
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  
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness  
S. Penn, Senior Director, World Trade Center Environmental Health Center  
S. Ritzel, Associate Director, Kings County Hospital Center  
S. Russo, Senior Vice President, Office of Legal Affairs  
L. Sainbert, Assistant Director, Office of the Chairman of the Board of Directors  
W. Saunders, Assistant Vice President, Office of Intergovernmental Relations  
K. Whyte, Senior Director, Corporate Planning, Community Health and Intergovernmental Relations

## **CALL TO ORDER**

Ms. Josephine Bolus, NP-BC, Strategic Planning Committee Chairperson, called the July 14, 2015 meeting of the Strategic Planning Committee to order at 10:35 A.M. The minutes of the June 9, 2015 Strategic Planning Committee meeting were adopted.

## **SENIOR VICE PRESIDENT REMARKS**

### **Federal Update**

#### Supreme Court Ruling on King vs. Burwell

Ms. Brown explained the Supreme Court's decision on the King vs. Burwell case in which, plaintiffs challenged the Obama Administration on language that was included in the Affordable Care Act (ACA) concerning health care subsidies. Plaintiffs argued that the ACA limited health care subsidies to enrollees who reside in states that have established their own health exchanges, and not the federal exchanges. Ms. Brown stated that, on June 25th, the Supreme Court of the United States ruled, by a vote of 6-3, that the Affordable Care Act can provide federal tax credits to individuals under both state and federally run health exchanges. She explained that an adverse ruling would have jeopardized the future of "Obama Care" because only 16 states and Washington D.C. have established state run exchanges. Three states including Nevada, New Mexico and Oregon have state exchanges but use the federal website for enrollment. Moreover, such a ruling would have prohibited approximately 8 million people who reside in the 34 states that use federally run exchanges from receiving federal tax credits. A key finding that supported the Supreme Court's decision was that the Internal Revenue Service (IRS) has properly interpreted that the wording of the ACA implied that tax credits would be available to those "enrolled through an exchange established by the state" and the federal health exchange. The decision was written by Chief Justice John Roberts. He argued that any significant differences between state and federal exchanges would have been clearly delineated by the statute; and that an adverse ruling would have led to a 'death spiral' in the insurance markets in those states, which was clearly not the intent of Congress. Ms. Brown commented that this was the last major legal challenge to the ACA; and opponents of the ACA had been struggling to preserve subsidies if the Court had sided with the plaintiffs.

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

Ms. Brown reported that, at an April 2, 2015 meeting, the Medicare Payment Advisory Commission or MEDPAC made a recommendation that Congressional lawmakers should push for repealing the Two-Midnight Rule in its entirety. The passage of the SGR bill has postponed the Two-Midnight Rule until September 2015. In a proposed payment rule posted on July 1, 2015, the Centers for Medicare and Medicaid Services (CMS) has documented that it planned to allow physicians to exercise judgment to admit patients for short hospital stays on a case-by-case basis. Moreover, CMS would also remove oversight of those decisions from its administrative contractors, but would instead engage quality improvement organizations to enforce the policy. Recovery audit contractors, meanwhile, would be directed to 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 that were attributable to hospitals' fear that Medicare audit contractors would challenge their admissions. As a result, many patients became ineligible for skilled nursing care after spending days in the hospital because their stays were considered observation visits. Ms. Brown informed the Committee that CMS had reported that the number of observation visits lasting more than two days had decreased by 11% in fiscal year 2014 compared to fiscal year 2013. The American Hospital Association (AHA) and the Greater New York Hospital Association (GNYHA) are also advocating for CMS to drop the 0.2% hospital payment reduction that was adopted to balance the expected increase in higher-paying inpatient stays.

Mrs. Bolus asked how well this information is explained to patients regarding their status, observation versus admission. Ms. Brown deferred the question to Dr. Raju who reassured Mrs. Bolus that a follow-up response would be provided concerning her inquiry. **NOTE:** Ms. Brown followed up on Ms. Bolus' inquiry. Her response is that all patients who are placed under observation for up to two midnights are provided with a letter regarding their status.

#### GAO Report on 340B Drug Discount Program

Ms. Brown reported that, on July 6, 2015, the Government Accountability Office (GAO) had released a study which evaluated hospitals' participation in the 340B Drug Discount and Medicare programs. Key findings of that report include that 40% of all hospitals participate in the 340B program; and Medicare Part B per beneficiary spending was more than twice as high at 340B hospitals than other hospitals. The American Essential Hospitals, 340B program and other health care advocates underscored problems with the reports' methodology in accounting for socio-economic and health differences in the populations served by DSH-340B hospitals and other hospitals. The GAO recommended that Congress should consider eliminating the incentive to prescribe more drugs "than necessary" to Medicare Part B beneficiaries at 340B hospitals but advocates reject this finding as unwarranted by the data. Ms. Brown commented that this report puts pressure on the 340B program which is so important to HHC and other DSH hospitals. Notably, the report did find that 340B hospitals provide more uncompensated care than non-340B hospitals.

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

Ms. Brown reported that, without Congressional action, the James L. Zadroga 9/11 Health and Compensation Act for injured and ill 9/11 survivors and responders would expire in less than a year and a half. Support for a permanent extension of the Act reached a critical milestone last week with 102 Members of the House of Representatives, including 24 Republicans, providing support for this effort. The Reauthorization Act (H.R. 1786) introduced in the House by New York Representatives Carolyn Maloney, Jerrold Nadler and Peter King, just three months ago, is rapidly gaining co-sponsors as the 14<sup>th</sup> anniversary of the 9/11 attacks approach. Reauthorization in the Senate is being led by New York Senator Kirsten Gillibrand along with Senator Chuck Schumer, with 23 Senate supporters. Four of these supporters are Republicans – the same four who had initially signed on in April when reauthorization was introduced. They are Mark Kirk of Illinois, Susan Collins of Maine, Lisa Murkowski of Alaska and Tom Cotton of Arkansas, who all pledged to garner more Republican support. The James L. Zadroga Act funds HHC's World Trade Center Environmental Health Center, legislatively known as the Survivor Program. The Survivor Program provides health care services to individuals who lived, worked or attended school in the affected neighborhoods who

became ill on or after 9/11 from exposure to WTC dust. The program has 8,600 enrollees and is fully funded by the Act until the end of 2016. HHC along with the City of New York supports the law's permanent reauthorization.

## **City Update**

### New York City's Budget

Ms. Brown reported that the "handshake" between the Mayor and the Council Speaker in the Rotunda of City Hall occurred on the June 22nd. The remaining details were then hammered out and the Council voted to approve the budget on Friday, June 26<sup>th</sup>, which capped weeks of negotiations. Funding was added for numerous programs to address income inequality, food insecurity, protecting seniors, ending veterans' homelessness and extending the beach season by one week past Labor Day. Major highlights of the spending plan includes the following:

- \$137 million was added for Correctional Health in FY 16. This grows to \$155 million in FY17 and \$156 million in FY19. Additional funds were added for collective bargaining settlements. This includes \$38 million for FY15, \$7 million in FY16, \$11 million in FY17 and FY18 and \$12 million in FY19
- Council Discretionary funds of more than \$150,000 were added for Lincoln's Guns Down Life Up program including minor equipment and furniture for Gouverneur Healthcare Services
- \$1.5 million was added by the Council to create programs focused on increasing access to healthcare services for immigrants. HHC's IGR staff will be talking to the Council about how HHC might be able to tap into those funds to support HHC's health equity initiatives.

### HHC Capital Funding Highlights

The Mayor and Council added \$23 million for HHC's capital projects. The Administration provided capital funding to expand primary care capacity in certain existing clinics and to build new clinics in underserved areas. Ms. Brown reminded the Committee that the Council allocated capital funding varied each year but would typically range from \$10-\$12 million depending on the total amount of funding that the Council was allowed to spend on capital, the level of facility requests, and competing capital demands (parks, libraries, etc.). Similarly, funding from Borough Presidents vary each year. She reported that the Brooklyn Borough President provided \$3.1 million in funding as a placeholder while discussions ensue on the establishment of a potential burn unit in Brooklyn. The Queens Borough President provided \$1 million in previously unallocated funding for FY15 to expand the pharmacy department at Queens Hospital Center. Council Members Lancman and Miller each contributed \$250,000 to fund the project's \$1.5 million price tag. The Brooklyn Borough President added \$211,000 for Coney Island Hospital to purchase a new Echocardiograph Machine. The Manhattan Borough President provided \$65,000 to Harlem Hospital for the purchase a new Anesthesia Monitoring System.

Ms. Brown reported that facility specific funding also varied each year. This year, Kings County Hospital Center (KCHC) did very well. KCHC received nearly \$5 million. Of that total, \$2.5 million will be used to fund a new Nurse Call Station. The remaining funds will be used to purchase ventilators along with endoscopy, echocardiograph, and radiology equipment. Ms. Brown reported that Council Member Eugene and the Brooklyn Delegation were to be commended. The pharmacy department expansion received \$1.5 million in

total with the funding added from the Borough President. Funding was also provided for projects on Sea View's campus including the new Meals on Wheels (\$250,000) and Grace Foundation buildings (\$170,000).

Ms. Brown summarized the \$11 million Council allocated capital funding for HHC facilities as the following:

- Nearly \$5 million for Kings County Hospital
- \$1.7 million for Coney Island Hospital for Cardiac Cath
- \$1.25 million for Elmhurst Hospital for clinical monitoring systems
- \$951,000 for Woodhull's Gamma Nuclear Medicine Camera
- \$650,000 for Roberto Clemente Center Renovations
- \$500,000 for Queens Hospital to expand the Pharmacy Department
- \$300,000 for the Judson Health Center Roof
- \$185,000 for equipment purchases at Bellevue Hospital
- \$90,000 for Harlem Hospital to purchase a Bariatric Table
- \$40,000 for Gouverneur Healthcare Services to purchase an Ophthalmology System

At the request of Mr. Nolan, Board Member, Ms. Brown stated that she would provide a copy of her presentation, which highlighted the Council allocated capital funding for HHC facilities. Mrs. Bolus commented that the information on Mrs. Brown's presentation slide could be used by HHC facilities in their advocacy efforts with City Council Members.

## INFORMATION ITEMS

### **Presentation: Key Updates from 2015 New York State Legislative Session**

Wendy Saunders, Assistant Vice President, Office of Intergovernmental Relations

Ms. Brown introduced Ms. Wendy Saunders, Assistant Vice President, and invited her to present key highlights from the 2015 New York State Legislative Session.

Ms. Saunders began her presentation by stating that, although the Legislative Session was scheduled to end on June 18<sup>th</sup>, it did not adjourn until June 25<sup>th</sup> due to ongoing negotiations on controversial issues including the extension of mayoral control of New York City schools, rent regulation, the 421-a Real Estate Tax Incentive program and others. In addition, despite significant upheaval, including new leaders in both houses, the Legislature had passed more bills this year than at any time since 2008. Ms. Saunders summarized the activities of the Legislative Session as the following:

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

Ms. Saunders reported on the Staffing Ratios legislation **A.1548 (Gottfried)/S.782 (Hannon)** which would:

- Impose mandatory nurse staffing ratios for hospitals and nursing homes
- Require HHC to hire 3,200 new nurses at a cost of more than \$388 million just for hospitals



**This bill did not pass EITHER house.** This legislation is the top priority for the NYS Nurses Association. The NYS Nurses Association will continue to push hard for it next year. It would be the most costly health care mandate in memory, with a statewide cost for hospitals at more than \$3 billion.

Ms. Saunders reported on the proposed Medical Malpractice legislation, **A.285 (Weinstein)/S.911-A (Libous)**, which would:

- Extend New York's statute of limitations from thirty months from the date of the alleged malpractice, to thirty months from whenever the alleged malpractice is discovered

Ms. Saunders stated that the Medical Malpractice legislation was amended to clearly apply to HHC and other public facilities. **This bill passed the Assembly only.** Ms. Saunders explained that this bill, dubbed "Laverne's Law" received a great deal of attention during the last weeks of the Legislative Session. Senate Majority Leader John Flanagan announced that he would hold a series of roundtables to discuss the many issues surrounding medical malpractice reform, rather than acting on one bill in isolation. This bill has been the main focus of the Trial Bar over the past few years. Ms. Saunders added that HHC would have to continue to be vigilant on this and other bills related to malpractice.

Mr. Nolan asked why the bill had only passed the Assembly. Ms. Saunders responded that there was a lot of support and media attention for it, which was different compared to previous years. Ms. Saunders added that the Assembly is a different body than it was a few years ago. One third of the Assembly are new members.

Ms. Saunders reported on two HHC specific legislation that were both sponsored by Senator Lanza and Assembly Member Cusick. These bills **A.5222 (Cusick)/S.3326 (Lanza) and A.5221 (Cusick)/S.3322 (Lanza)** would respectively require HHC to spend 10% of its operating budget on Staten Island (\$670 million); and finance the operation of the two Emergency Departments on Staten Island. Bill **A.5222 (Cusick)/S.3326 (Lanza) passed the Senate ONLY.** Bill **A.5221 (Cusick)/S.3322 (Lanza) did not pass EITHER House.**

Ms. Saunders reminded the Committee that these bills were introduced every year. In recent years, the Senate has passed the bill requiring HHC to spend 10% of its operating budget in Staten Island, while the Assembly moves the other bill to the Ways and Means Committee, where it dies. Notwithstanding, Ms. Saunders cautioned that HHC has to remain attentive to the possibility that either house could do something unexpected.

Ms. Saunders provided the Committee with updates on a variety of bills that would impact HHC facilities and nursing homes including:

1. **A.1323B (Rosenthal)/S.676B (Hannon) CARE Act:** This bill would require hospitals and nursing homes must provide discharge information to patient-designated informal caregivers. Both houses passed legislation that would put in place new requirements for contacting and coordinating the discharge of hospital and nursing home patients with any informal caregivers the patient designates. This is known as the Caregiver Advise Record and Enable – or CARE – Act and was the AARP's top priority. It is anticipated that the Governor will approve this legislation.
2. **A.7791A (Mayer)/S5892 (Valesky) - Discharge Information for the Elderly:** This bill would require providers to provide patients 60 or older with a list of senior services and programs. Another

bill that passed both houses require hospitals and nursing homes to provide all patients 60 or older with a list of services and programs offered by their local area agency on aging. Seniors would also be provided with contact information for the agency. The State Office for the Aging is responsible for developing the information to be provided.

3. **A.7465, Gottfried /S.4874, Hannon) - Sepsis Data Collection:** This bill would delay the public release of hospital-reported information until validated and analyzed. Both houses also passed legislation that would provide up to a two-year delay on the public release of data related to Sepsis incidents in hospitals, which the New York State Department of Health (SDOH) began collecting last year. The delay provides NYSDOH time to validate and analyze the data so they can provide accurate and meaningful information to the public.

**All bills passed BOTH Houses.**

Ms. Saunders provided the Committee with an update on proposed bills that focused on professional issues. These bills included:

- **A.123B (Paulin)/S.4739 (Hannon) - Pharmacist Immunization Administration:** This bill would allow pharmacists to vaccinate for acute herpes zoster, meningococcal, tetanus, diphtheria and pertussis. Pharmacists can now provide these vaccines in addition to influenza and pneumococcal.
- **A.1034A (Gunther)/S.3621 (Funke) - Assault on Direct Care Workers:** This bill would make assault on direct care workers a Class D felony. The Legislature passed this bill to add direct care workers to the list of professionals who are protected from assault by enhancing penalties. Assault on Registered Nurses is already a Class D felony.
- **A.2150 (Gottfried)/S.1153 (Hannon) - Surrogate Decisions for Hospice:** This bill would allow physicians to make decisions for incapacitated patients who do not have anyone who qualifies as a family healthcare decision-maker.

**All bills passed BOTH Houses.**

Mr. Nolan referred back to the bill concerning pharmacist immunization administration (A.123B/S.4739) and asked if the bill was pushed by retail pharmacies like Rite Aid, CVS and Walgreens or by the Pharmacy Association. Ms. Saunders responded that, while the retail pharmacies may have supported the bill, it was the Pharmacy Association that took the lead. Ms. Saunders added that there were other retail clinic legislation that were slightly different than this one that did not pass both houses. They would rather expand the ability of the retail pharmacies to provide healthcare services in the pharmacies themselves. Mr. Nolan further inquired if New York State was heading in the direction where the mega giants like CVS and Walgreens would turn into full healthcare facilities. Ms. Brown responded that, in other states, these retail giants have primary care clinics within their mega stores. Moreover, they are providing extensive healthcare services to their employees. While it is a business strategy, these mega giants have also acknowledged the change in the environment from the consumer's perspective. Consumers like to get their services in the retail clinics. The services are open and have non-traditional hours, with around the clock access in some instances.

Ms. Saunders reported on other bills that were presented that are of importance to HHC. These bills included:

- **A.7208 (Gottfried)/S.4893 (Hannon) - Prescriber Prevails:** This bill would require the Medicaid program to pay for certain drugs that were not included in the formulary. Although the Legislature passed a bill to implement “prescriber prevails” for Medicaid Fee for Service patients, it is likely that Governor Cuomo will veto the legislation. The initiative was rejected as being too costly during State Budget negotiations because the prescriber prevails process would ensure that patients are provided certain drugs deemed medically necessary, regardless of whether it is on the preferred list of drugs for the Medicaid program. The pharmaceuticals that would be covered include expensive anti-depressants, anti-retroviral, anti-rejection and atypical anti-psychotics, among others.

Mrs. Bolus asked if medications were included on the formulary for the transgender population. Ms. Saunders and Ms. Brown reassured Mrs. Bolus that they would make inquiries to find out if those drugs were covered. Mrs. Bolus also asked about the impact of the Hepatitis C medications and treatments on HHC. Ms. Brown clarified that the Hepatitis C treatments were separate and apart from medications for transgender patients, which have already had a financial impact on MetroPlus Health Plan as well as HHC. Mr. Nolan asked Ms. Saunders to clarify the term “formulary”. Ms. Brown responded that the State’s Medicaid program had an extensive list of drugs included in the formulary that the provider must adhere to in providing prescriptions to Medicaid beneficiaries. Ms. Brown explained that this legislation would allow providers to make an exception to the formulary for certain drugs that are not listed for certain patients because the doctor/prescriber perceived that off-formulary drugs would be more efficacious, more effective or have a less negative impact and effects on patients. Ms. Brown also clarified that the list of drugs, or formulary, is controlled by the State Department of Health. Ms. Saunders added that the current process entails the State Department of Health making the decision regarding whether or not a patient qualifies for an off-formulary drug. This legislation would allow the provider to make that decision.

- **A.8172 (Morelle)/S.5883 (Robach) - Limited Medicaid Claim Extension:** This bill would allow an exemption from the 90-day submission requirement due to computer-related problems. The Legislature passed this bill to codify the current 90-day timeframe for submission of a claim under the Medicaid program, but included a new exemption for computer or systems issues beyond the provider’s control. The amended legislation adds a one-year expiration of the initiative.
- **A.1327A (Cahill)/S.4922A (Hannon) - Coverage for Court-Ordered Behavioral Health Services:** This bill would create an expedited process by commercial insurers to review coverage decisions for court-ordered mental health and substance abuse services. This bill was passed by both houses.

#### **All bills passed BOTH Houses**

#### **Presentation: Ida G. Israel Community Health Center Update Presentation**

Daniel Collins, Senior Associate Director of Facilities, Coney Island Hospital

Ms. Bolus introduced Mr. Daniel Collins, Senior Associate Director of Facilities at Coney Island Hospital, and invited him to provide a status update on the Ida G. Israel Community Health Center. Mr. Collins began his presentation by informing the committee that Coney Island Hospital has operated the Ida G. Israel

Community Health Center since the mid 1980's in the Coney Island community of Brooklyn. Mr. Collins shared images of the damage that the former Ida G. Israel Community Health Center had sustained as a result of Super Storm Sandy.

Mr. Collins described the former Ida G. Israel Community Health Center's service utilization as the following:

<b>Utilization of Services Pre-Sandy Annual Visits</b>	
<b>Chemical Dependency</b>	<b>17,632</b>
Dental	10,637
Adult Medicine	7,368
Pediatrics	2,477
OBS	337
<b>Total</b>	<b>38,451</b>

Mr. Collins described the communities served by the Ida G. Israel Community Health Center (the Center). He reported that a large majority of the patient population served by the Center resided in zip code 11224. He added that the Coney Island peninsula had been designated as a Health Professional Shortage Area (HPSA) for services including primary care, mental health services and dental care. Ms. Brown explained that HPSA or health professional shortage area is a federal designation for certain communities, neighborhoods, and zip codes throughout the country. It is recognized that those neighborhoods/communities may not have adequate numbers of primary care, mental health or dental professionals. If that designation is received, the federal government would provide a little bump in the Medicare payments of all the providers who are serving that zip code not only as an incentive to those providers but also for others to move into those neighborhoods to provide care. Ms. Brown informed the Committee that the Coney Island peninsula is one of many neighborhoods in which HHC provides care that have received HPSA designation. Ms. Brown also added that the Coney Island peninsula has held this designation for quite some time, which is periodically renewed because of the shortage of providers in that area.

Mr. Collins described the race and ethnic make-up of the patient population served by the Center as the following:

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

He described the age make-up of the Center's patient population as the following:

- Less than age 20: 22%
- Between ages 20-44: 27%
- Between ages 44-64: 28%
- Ages 65 and over: 23%

Mr. Collins reported that the Center's new location at 2925 West 19<sup>th</sup> Street was less than a mile from its former location at 2201 Neptune Avenue. Ms. Brown reminded the Committee that the Board had made a commitment to restore Ida G. Israel Community Health Center in the neighborhood. She added that Mr. Arthur Wagner, Coney Island Hospital's Executive Director and his team did not only listen to the Board, but most importantly, they listened to the voices of the people in the community. Mr. Collins added that the

Center' new location was accessible to public transportation and the accessible subway lines included the F, N, Q and D. The bus lines include the B36 and B74.

Mr. Collins presented the Center's initial hours of operation but explained that extended hours would be established post ramp-up.

### **Ida G. Israel Community Health Center (Initial Hours of Operation\*)**

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

\* Extended hours will be established post ramp-up.

Mr. Collins described the floor plan of the new facility. The 13,500 sq. ft. floor plan includes six dental exam rooms, six medical exam rooms and other necessary support space. The chemical dependency area has offices for counseling and two large group rooms.

Mr. Collins shared with the Committee the new Ida G. Israel Community Health Center's timeline as outlined below:

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

Mr. Collins informed the Committee that the community had been kept abreast of the progress of the new Ida G. Israel Community Health Center and that promotional/advertisement efforts within the community included:

- Rendering of new facility stating "Coming Soon Summer 2015" posted at construction site and on the homepage of CIH Intranet
- Two half page advertisements posted for two weeks in April 2015 and during the last week of June 2015 in the *Brooklyn Spectator*
- Flyer with rendering of new facility distributed to CIH Health Fair attendees on September 7, 2014
- Broadcasted on social media via *Twitter*
- Staff attendance at a number of Community Board and community service meetings to discuss the progress and the location of services to be offered at the center

Mr. Collins clarified that HHC owned the facility but leased the land from the Housing Preservation Department (HPD).

## **ADJOURNMENT**

There being no further business, the meeting was adjourned at 11:25 AM.



# WTC Environmental Health Center Update

Presentation to the Strategic Planning Committee

Joan Reibman, MD – Medical Director

Terry Miles – Executive Director

September 8, 2015

## Overview

- Administrative
  - The Zadroga Act – federal funding for 9/11-related care
  - The World Trade Center Health Program and HHC's role
  - Revenue and expenses
- Scientific/Clinical
  - Destruction of the World Trade Center as an environmental disaster
  - Chronic exposures of the Survivor population
  - Exposure doses and chemical composition of WTC dust
  - Community and Academic/Medical Coalitions
  - HHC's WTC Environmental Health Center
  - What we have learned

# Administrative

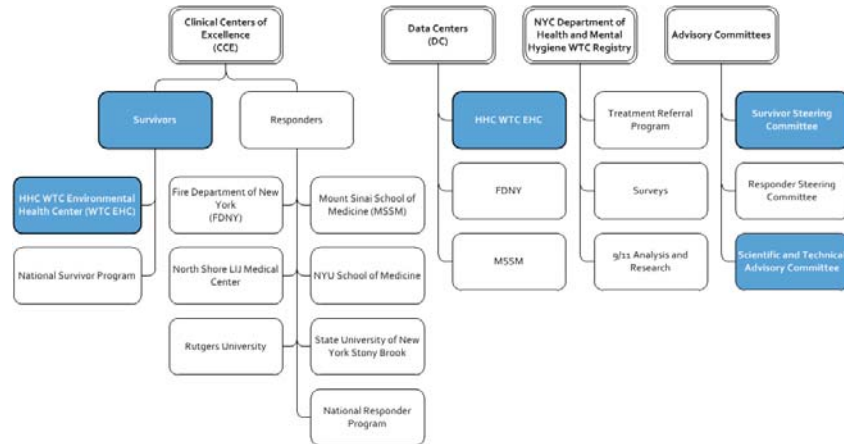
Terry Miles  
Executive Director  
World Trade Center Environmental Health Center

## The Zadroga Act

- The World Trade Center Health Program (WTCHP) was congressionally established by the James L. Zadroga 9/11 Health and Compensation Act of 2010 and became operational on July 1st of 2011
- Administered by the National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control (CDC)
- The WTCHP provides medical and mental health services for WTC responders, and community members still sick from the aftermath of 9/11
- The WTCHP includes:
  - 6 Clinical Centers of Excellence (CCEs) in the New York City Area
  - National Program serving individuals who live throughout the United States including responders to the Pentagon and Shanksville, PA
  - 3 Data Centers (DCs)
  - HHC operates one of the 6 CCEs and one of the 3 DCs



# World Trade Center Program Structure



September 8, 2015

WTC Environmental Health Center Update

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## WTC EHC Description

- HHC's World Trade Center Environmental Health Center (WTC EHC) is the only WTCHP Center of Excellence for Non-Responders
- Community "Survivor" program provides health care for local workers, residents, children, passersby and clean-up workers below Canal Street in Manhattan and the Brooklyn Heights waterfront
- WTC EHC is located at Bellevue, Elmhurst, and Gouverneur
- The WTC EHC is a multidisciplinary treatment program for individuals with WTC-related illnesses
- Medical and Mental Health conditions need to be "certified" by NIOSH for a patient to continue treatment
- WTC EHC patients incur no out-of-pocket expenses for treatment at the WTC EHC

Bellevue



Elmhurst



Gouverneur



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# Comparison Between Responder and Survivor Programs

## Responder Program

- Direct care and monitoring is billed only to the WTCHP
- All Responders are eligible for monitoring – even without a certified WTC-related condition
- The WTCHP does not support services for children of Responders

## Survivor Program (WTC EHC)

- HHC must bill third party payers for direct care before billing WTCHP
- WTC EHC services are available only to patients with certified WTC-related conditions
- The WTC EHC serves a pediatric/adolescent population

# FY 15 Revenue and Expenses July 1, 2014 – June 30, 2015\*

## Revenue

Item	Amount
CCE Contract	\$5,490,791
DC Contract	\$1,252,577
Fee for Service Revenue‡	\$1,121,073
<b>Total FY15 Revenue</b>	<b>\$7,864,441</b>

## Expenses

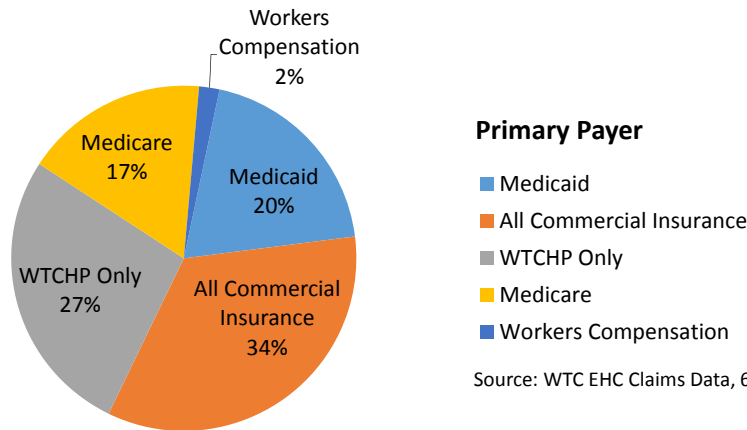
Item	Amount
All CCE Services	\$4,603,196
All DC Services	\$1,252,577
Direct Care	\$1,798,434
<b>Total FY 15 Expenses</b>	<b>\$7,654,207</b>

The Clinical Centers of Excellence (CCE) Contract supports member services (e.g., social work and case management) and administrative services (e.g., program management and claims processing)  
The Data Center (DC) contract supports data gathering, analysis, and reporting

\*Figures are preliminary as of 8/22/2014

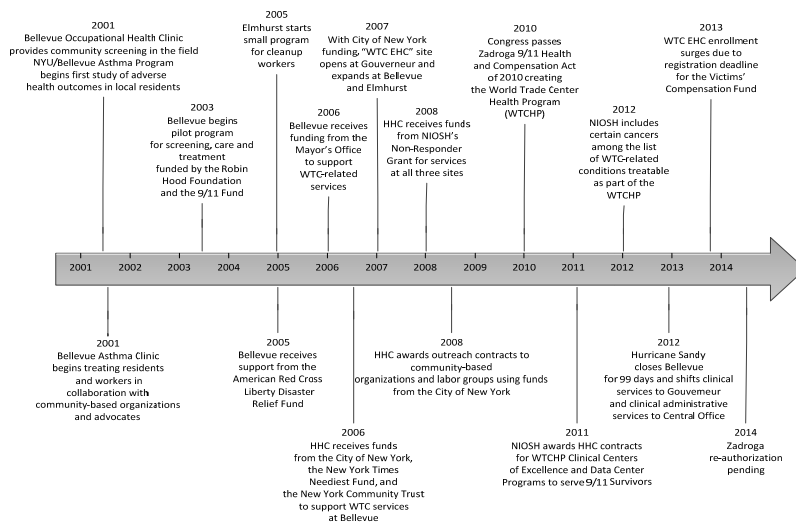
‡Based on date of service

# WTC EHC Primary Payer Mix



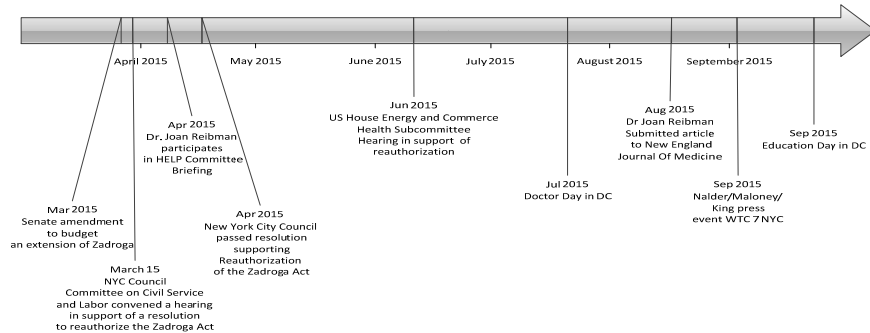
Source: WTC EHC Claims Data, 6/1/14 through 5/31/15

# Timeline of WTC-Related Care and Funding



# Zadroga to be Reauthorized

- The reauthorization bill includes original components plus:
  - Becomes a permanent program without expiration, with budget-neutral funding sources, and exemption from sequestration;
  - Increases funding for the Scientific and Technical Advisory Committee; and
  - Corrects technical issues (e.g. the WTCHP's own administrative funding vs from general NIOSH budget)



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## Scientific/Clinical

Joan Reibman, MD  
Medical Director, HHC World Trade Center Environmental Health Center  
Professor of Medicine and Environmental Medicine  
Bellevue Hospital Center  
New York University Langone Medical Center

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# Bellevue/NYU Efforts to Understand and Treat Environmental Health Issues from 9/11

- Environmental exposures
  - Response by Community/Hospital/Academic collaborations
  - History of treatment programs
  - James L. Zadroga Health and Compensation Act
- Adverse health findings in community members
- Medical findings
- Mental health findings

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# WTC Destruction as an Environmental Disaster

- Destruction of WTC Towers on 9/11/2001
- The immediate death of 2752 individuals
- Exposure to dust and fumes created from imploding towers
  - Firefighters and other arrived in droves to participate in rescue and recovery efforts
  - Local community



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60,000 residents  
south of Canal Street



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300,000 local  
workers/office workers,  
commuters, and  
teachers

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## 15,000 students and many children



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## Acute Exposures – Dust Cloud(s)



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An iconic 9/11 image  
known around the world  
“The Dust Lady”



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## Press Statement of EPA Administrator Christine Todd Whitman, September 21, 2001

- “I am glad to reassure the people of New York and Washington, DC, that their air is safe to breath[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.”
- This statement was made before there was a single test of indoor air quality conducted by any governmental entity



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## Chronic Outdoor Exposures

Local workers  
returned to work  
September 17, 2001



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## Chronic Indoor Dust Exposures



- Dust settled inside buildings/ventilation systems and was resuspended from incompletely cleaned ventilation systems
- Chemical composition of indoor dusts similar to outdoor – smaller particles
- Few residents evacuated

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# Chronic Exposures: Gases and Fumes



Fires burned through  
December 2001

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## Exposure Dose – Structure of Composite Exposure Scales Generated by Principal Components Analysis

	Component Variables	Composite scale
Acute	Personal appearance after thickest part of cloud Visibility in thickest part of cloud Time first caught, relative to WTC collapses	Dust cloud - Density
	Duration of time in dust cloud Prop. of time in thickest part of cloud	Dust cloud-Time
Chronic	Extent of dust coverage at home or workplace Depth of thickest dust layer at home or workplace Proportion of home or workplace most affected	Dust - Home/Workplace
	Smelled smoke inside, outside, both Duration of time during which smelled smoke	Smoke - Home/Workplace
	Time at home or workplace Month first at home or workplace after 9/11	Time - Home/Workplace
	Participated in cleaning of home or workplace Number of items cleaned by subject*	Involvement in cleaning - Home/Workplace
	Time spent cleaning home or workplace	

Maslow et al. Am J Public Health. 2012

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## Collapse of Two 107 Story Buildings



- 1.2 million tons of building materials
- 90% of settled particles >10  $\mu\text{m}$  diameter
- 11,000 tons of particles < 2.5  $\mu\text{m}$  diameter

\*Lioy et al. Environmental Health Perspectives Vol 110, July 2002

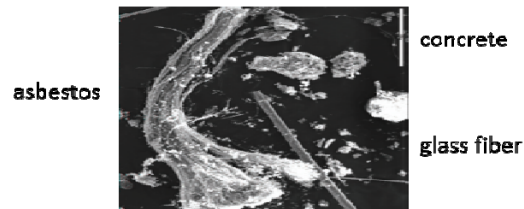
## Chemical Constituents of WTC Dust

- 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

Banauch et al. Curr. Opinion Pulm Med 2005, 11:160

## Characteristics of Settled WTC Dust

- Alkaline (pH9-11)
- Construction materials
  - Cement
  - Concrete
  - Wallboard
- Particulate matter
  - Calcium sulfate (gypsum)
  - Calcium carbonate
  - Crystalline silica
- Fibers
  - Fibrous glass
  - Gypsum fibers
  - Chrysotile asbestos



Banauch et al. Curr. Opinion Pulm Med 2005, 11:160  
USGS Environmental Studies of WTC

## Community and Academic/Medical Coalitions

- October 11, 2001 – Pace University Community Forum
- Academic-community coalitions
  - FDNY – longstanding health program
  - Rescue workers - Organized labor/Occupational clinics/local politicians
  - WTC Workers Medical Screening/Monitoring/
- Community coalitions – disparate groups



**Cough and Bronchial Responsiveness in Firefighters at the World Trade Center Site**

David J. Prezant, M.D., Michael Weiden, M.D., Gisela I. Banauch, M.D.,  
Georgeann McGuinness, M.D., William N. Rom, M.D., M.P.H., Thomas K. Aldrich,  
M.D., and Kerry J. Kelly, M.D.

## Adverse Respiratory Health Effects in the Community - WTC Residents' Respiratory Health Study

- Collaborative effort with New York State Department of Health and local community
- Cross-sectional study of sampled "exposed" and "control" residential population
- Designed, implemented and completed the study 16 months after 9/11/01
- Responses analyzed from 2,812 individuals



## WTC Respiratory Health Study - Findings

- 3.5 fold increase in new-onset respiratory symptoms (cough, wheeze, shortness of breath) increased in previously normal exposed residents compared to a control group  
Reibman et al. Environ Health Perspect. 2005 Apr;113(4):406-11
- Increase in medical consultation and asthma medicine use in previously normal residents  
Am J Epidemiol. 2005 Sep 15;162(6):499-507
- Conditions associated with exposure to dust and fumes  
J Asthma. 2007 May;44(4):325-32
- Findings subsequently confirmed by NYC DOHMH WTC Registry

## Health Findings in WTC Community Members - WTC Environmental Health Center

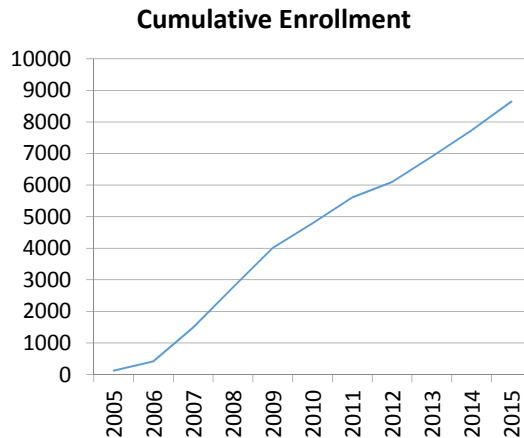
- Bellevue Hospital – treatment program
  - 2002 community collaborative pilot program for treatment of residents/area workers in the Bellevue Hospital Asthma clinic
- WTC Environmental Health Center – treatment program
  - 2005 American Red Cross Liberty Disaster Relief Fund
  - 2006 funding from City of New York
  - 2008 first Federal funding (CDC-NIOSH)
  - 2011 James Zadroga 9/11 Health and Compensation Act

# HHC WTC Environmental Health Center's Current Patients

- 8,649 patients currently enrolled
- 3,853 active\* patients
  - Bellevue 67%
  - Elmhurst 11%
  - Gouverneur 22%

\*Active = at least one visit within the past 3 years

Source: WTC EHC Database Application, 8/10/2015



## Patient Characteristics\*

<b>Sex, n (%)</b>			
	Male	2708	(50)
	Female	2701	(50)
<b>Current age, median (range)</b>			
		56, 11 - 96	
<b>Race, n (%)</b>			
	White	2661	(49)
	Black	1053	(19)
	Asian	509	(9)
	No answer	988	(18)
	Other	198	(4)
<b>Ethnicity, n (%)</b>			
	Hispanic	1691	(31)
<b>Income, n (%)</b>			
	< 30K	3031	(56)
<b>Exposure category, n (%)</b>			
	Local worker	2689	(50)
	Resident	1227	(23)
	Clean-up worker	732	(14)
	Other	761	(14)
<b>Dust cloud, n (%)</b>			
	Yes	2715	(50)

\*based on data from Bellevue Hospital, n = 5409, accessed 08/19/15

## Current Certified Conditions

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

- Conditions are not mutually exclusive
- 64% of patients have more than one Certified Condition

Source: WTC EHC Certification Report, 8/10/15

## Current Cancer Certifications

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%

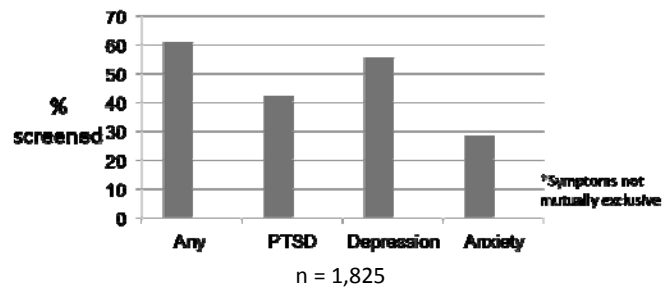
- Certification for cancer began in 2012
- 452 patients have at least 1 cancer certification
- 49 patients are certified for more than 1 cancer

Source: WTC EHC Certification Report, 8/10/15



## PTSD, Depression or Anxiety Symptoms\* in WTC EHC Patients Enrolled for Medical Symptoms

- High rates of PTSD, depression, anxiety in cohort enrolled for medical conditions
- Symptoms persistent 4-7 years after 9/11



Levy-Carrick et al. manuscript submitted

## What Have We 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
  - Severity associated with exposures, lung function, 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

## What Have We Learned – 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

## What Have We learned – Cancers

- Because we lack a screening population for denominator, and patients are self-referred, cannot assess incidence
- Despite this, enrollment for cancers continues to increase
- Currently performing a case series analysis to understand characteristics of hematologic cancers and solid tumors

## Other Lessons Learned

- 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
- Comorbid conditions impact response to treatment and chronicity of disease
- Multidisciplinary approach needed for disaster programs - model for general medical programs?

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### WTC Residents Study

Linda Rogers, MD  
Shao Lin, PhD  
Syni-An Hwang, PhD  
James Bower  
Mridu Gulati, MD.  
Kenneth Berger MD  
Roberta Goldring, MD

### Community organizations

Beyond Ground Zero Network  
9/11 Environmental Action  
Battery Park Residents Coalition  
Independence Plaza Tenants  
Org  
Southbridge Tenants Org

### Biostatistics/Epi/Data

Mengling Liu, PhD  
Yongzhao Shao, PhD  
Michael Marmor, PhD  
Qinyi Cheng  
Meng Qian  
Maria Elena Fernandez-  
Beros, PhD

### NYC DOHMH

Steven Friedman, MD  
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