STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

JUNE 9, 2015
10:30 A.M.
HHC BOARD ROOM
125 WORTH STREET

AGENDA

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

II. **ADOPTION OF MAY 12, 2015**
STRATEGIC PLANNING COMMITTEE MEETING MINUTES   **JOSEPHINE BOLUS, RN**

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

IV. **INFORMATION ITEM**

   i. **IDENTIFYING FAIR, EFFECTIVE & SUSTAINABLE LOCAL POLICY SOLUTIONS:**
      UNDOCUMENTED IMMIGRANTS AND ACCESS TO HEALTH CARE IN NEW YORK CITY

                                                              CLAUDIA CALHOON, MPH
                       DIRECTOR OF HEALTH ADVOCACY, THE NEW YORK IMMIGRATION COALITION

                                                              NANCY BERLINGER, PHD
                              RESEARCH SCHOLAR, THE HASTINGS CENTER

V. **OLD BUSINESS**

VI. **NEW BUSINESS**

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

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

STRATEGIC PLANNING COMMITTEE MEETING
OF THE BOARD OF DIRECTORS

MAY 12, 2015

The meeting of the Strategic Planning Committee of the Board of Directors was held on May 12, 2015 in HHC's Board Room located at 125 Worth Street with Mr. Bernard Rosen, Board Member presiding on behalf of the Chairperson, Ms. Josephine Bolus, NP-BC.

ATTENDEES

COMMITTEE MEMBERS

Josephine Bolus, NP-BC, Chairperson of the Committee
Anna Kril
Robert F. Nolan
Bernard Rosen
Patricia Yang, representing Deputy Mayor Lilliam Barrios-Paoli

OTHER ATTENDEES

M. Dolan, Senior Assistant Director, DC 37
J. DeGeorge, Analyst, New York State Comptroller

HHC STAFF

S. Abbott, Assistant Director, Corporate Planning and HIV Services
C. Barrow, Associate Director, Lincoln Medical and Mental Health Center
M. Belizaire, Assistant Director of Community Affairs, Office of Intergovernmental Relations
D. Cates, Chief of Staff, Office of the Chairman of the Board
K. Feldman, AED Ambulatory Care, Gouverneur Healthcare Services
L. Guttman, Assistant Vice President, Office of Intergovernmental Relations
T. Hamilton, Assistant Vice President, Corporate Planning Services
J. Jurenko, Senior Assistant Vice President, Office of Intergovernmental Relations
N. Link, MD, Medical Director, Bellevue Hospital Center

Z. Liu, Senior Management Consultant, Corporate Planning Services
P. Lockhart, Secretary to the Corporation, Office of the Chairman
L. Lombardi, Chief Strategy Officer, Bellevue Hospital Center
M. Lopez, Associate Director, Women's & Children's Health, Gouverneur Healthcare Services
R. Malone, Chief Financial Officer, Queens Hospital Center
A. Martin, Executive Vice President and Chief Operating Officer, Office of the President
J. Omi, Senior Vice President, Organizational Innovation and Effectiveness
K. Park, Associate Executive Director, Finance, Queens Health Network
N. Peterson, Senior Associate Director, Woodhull Medical and Mental Health Center
C. Philippou, Assistant Director, Corporate Planning Services
V. Phillips, Senior Counsel, Office of Legal Affairs
M. Pressman, Deputy Executive Director, Bellevue Hospital Center
R. Ramphal, Ambulatory Care Facilitator, Queens Hospital Center
S. Ritzel, Associate Director, Kings County Hospital Center
L. Sainbert, Assistant Director, Office of the Chairman of the Board
H. Sapla-Coll, Ambulatory Care Nurse, Queens Hospital Center
C. Scholz, Senior Director, Organizational Innovation & Effectiveness
D. Thompson, Associate Executive Director, Kings County Hospital Center
D. Thornhill, Associate Executive Director, Harlem Hospital Center
T. Wei, Organizational Staff Development, Bellevue Hospital Center
W. Yung, Organizational Staff Development, Bellevue Hospital Center

CALL TO ORDER

Mr. Bernard Rosen, Committee Member, called the meeting of the Strategic Planning Committee to order at 10:37 A.M. The minutes of the April 14, 2015 meeting of the Strategic Planning Committee were adopted.

SENIOR VICE PRESIDENT REMARKS

City Update

Mr. John Jurenko, Senior Assistant Vice President, greeted committee members and invited guests. He reported that, last week, Mayor de Blasio released the New York City FY 16 Executive Budget. The $78.3 billion spending plan and $83.8 billion 10-year capital strategy included:
- Initiatives to boost reserves
- Addition of a new capital reserve fund
- More than half a billion in agency savings over two years ($300 million in HHC savings)
- Funding to expand mental health services
- Increased assistance to the New York City Housing Authority (NYCHA)

Mr. Jurenko informed the Committee that a portion of the funding targeted for the expansion of mental health services would be provided to HHC. Additional resources would also be provided to fund collective bargaining agreements. He announced that the City Council would hold hearings on the Executive Budget proposal starting next week; and HHC would be providing testimony on Wednesday, May 20th at 10:00 am. The public hearing session is scheduled to occur on Tuesday, June 9, 2015.

Mr. Jurenko reported that, on May 11, 2015, Senator John Flanagan was elected by his peers to serve as the new Majority Leader in Albany and would replace former Majority Leader Dean Skelos. Mr. Jurenko informed the Committee that Mr. Flanagan is a lawyer by training, who had taken over his father's seat. He was also an Assembly Member for several years. Most recently, Mr. Flanagan was chair of the Education Committee in the Senate. As an Assembly Member, Mr. Flanagan was the ranker on the Health Committee prior to being ranker on the Ways and Means Committee in the Senate.

INFORMATION ITEM

Presentation: Supporting Strategic Goals through On-Demand Training

Carlos Scholz, Senior Director, Organizational Innovation & Effectiveness
Nathan Link, MD, Medical Director, Bellevue Hospital Center
Marcy Pressman, Deputy Executive Director, Bellevue Hospital Center
Linda Lombardi, Chief Strategy Officer, Bellevue Hospital Center
Wendy Yung, Bellevue Hospital Center
Tian Wei, Bellevue Hospital Center
Kenneth Feldman, AED Ambulatory Care, Gouverneur Healthcare Services
Molly Lopez, Associate Director, Women's & Children's Health
Gouverneur Healthcare Services
Robert Malone, Chief Financial Officer, Queens Hospital Center
Helen Sapla-Coll, Ambulatory Care Nurse, Queens Hospital Center

Ms. Joanna Omi, Senior Vice President for the Division of Organizational Innovation and Effectiveness invited Mr. Carlos Scholz and the Bellevue Hospital Center team members to join her for the presentation. She informed the Committee that the First Lady, Mrs. Chirlane McCray, would be visiting Bellevue Hospital Center that morning; as such, the Bellevue staff members would be leaving the meeting immediately following their presentation.

Ms. Omi reminded the Committee that Breakthrough was first introduced at HHC nearly eight years ago. She explained that training had always been a large part of the Breakthrough program, and was used as a tool to initially educate and engage corporate staff.   Ms. Omi stated that the presentation would demonstrate that the training program was not being conducted only for the sake of training but served as a mechanism to achieve strategic goals and operational improvements. Ms. Omi stated that the presenters were unique in a number of ways. They have all done incredible work through the process of achieving Silver level certification. Furthermore, these individuals are also representatives of the leadership tier within HHC, who are beginning to take advantage of the training program. The Bellevue Hospital team members introduced themselves. Team members included Mr. Tian Wei and Ms. Wendy Yung of Organizational Staff Development; Ms. Marcy Pressman, Deputy Executive Director; Ms. Linda Lombardi, Chief Strategy Officer; and Dr. Nathan Link, Medical Director.

Mr. Scholz began the presentation by describing the Silver certification training program. He stated that Silver certification training was part of HHC's tiered Breakthrough certification training program. It includes very basic concepts ranging from how to identify waste, problem solving through the development of flow cells. He added that the most advanced Lean concepts and tools were being taught at the Gold and Platinum certification training levels.

Mr. Scholz reported that the Silver certification training level had been modified to align with Dr. Raju's strategic goals for HHC, which includes his 2020 vision to improve the patient experience, develop the workforce, increase enrollment in MetroPlus Health Plan, grow market share and improve financial viability. Mr. Scholz stated that Breakthrough was an essential tool for achieving that vision and would be deployed in the manner outlined below to support this strategic vision:

- HOW--Implement the Breakthrough operating system
    o Create internal expertise to adopt and lead Breakthrough
    o Create the structural elements for a system of bidirectional accountability and mutual respect that effectively supports continuous improvement

- WHAT--Support specific corporate initiatives
    o Achieve and sustain primary care access goals
    o Support corporate-wide operational model for reducing ED length of stay
    o Integrate HARP planning into existing Breakthrough value stream activity
    o Implement the Daily Management System into critical value streams
    o Support integration and rollout of DSRIP goals

Mr. Scholz described the Reason for Action. He reported that originally, Breakthrough training was delivered in a batch format. All of the training is conducted in one week followed by a rapid improvement event (RIE), which would occur eight weeks later. As a result of this format, group members were found to be disconnected. It was determined that the training was not directed to the staff who would benefit the

most. Furthermore, some participants were not members of the staff of the facility where the trainings were conducted, and trainings were not being delivered "on-demand."

Mr. Scholz described the Current State of the Silver certification training program as outlined below:
- Provides basic flow cell skills and competencies:
    - Standard Work
    - 6S
    - Simple Flow
    - Pull Systems
    - Visual Management
- Previously, training included one week of training and one week RIE "blitz"
- From 2010 to 2013:
    - 13 sessions
    - 107 staff members trained
- Most of the students were dedicated or part-time Breakthrough staff (Deployment Officers, Facilitators or Embedded Facilitators)

Mr. Scholz reported that the model was changed in order to ensure that the training was closer to where it was needed, when it was needed and that it was more connected to the work that the facilities were doing through their value streams and also directly connected to their value stream analysis. He added that there was a need to escalate the pace of that training. He described the assumptions for change management as the following:
- The effectiveness of training – how, when, what, to whom, can always improve
- Training effectiveness is enhanced:
    - When it is provided close to when and where it is needed
    - Adult learning principles, i.e., hands on, repeated instances, affects area of value to students, interactive
        - In the Gemba (where the work is done)
        - Team-based
        - Opportunities to learn from fellow students
        - Okay not to be an expert on Day 1
- Pace and depth of change must escalate
    - Must spread from existing improvements (don't remake the wheel)
    - While still creating opportunities for organic learning and recognizing local differences

Mr. Scholz described the Target State for the Silver certification training program as the following:
- Silver level certification aims to develop teams to conduct major improvement activities at facilities:
- Format change:
    - Group training, prep work and individualized coaching (3 days)
    - One week of multiple-team RIE blitz (reduced total training time by 2 days)
    - Multiple flow cells operationalized in the Gemba by week end
    - Promote area-wide standardization and best utilization of resources
    - Fully align to value streams critical to achievement of strategic goals
    - Provide on-demand, when and where needed
    - Students come from within the value stream or the facility where training is happening
    - Condensed schedule (from 10 to 7 days)

- o Significant customer and supplier input from students and Breakthrough staff from all facilities
        - o Focus on quantitative results: students able to use and teach tools, subject focus enables or directly affects value stream outcomes
- Since then:
        - o 8 training sessions conducted in one year (see chart below)
        - o 67 staff members trained
        - o Increasing pull from leadership groups, demand up 100%

Rapid Experiments and New Models Implemented – 8 sessions

Link to Strategic Initiative	Value Stream	Area	Facility
Access Patient Experience	Ambulatory Care	Adult Primary Care	Woodhull
			Queens
			Lincoln
		Women's Health	Gouverneur
Patient Experience	Perioperative Services	Central Sterile Services	Jacobi
			Bellevue
Patient Experience Financial Stability	Acute Care	Echo & Stress Labs	Bellevue
Patient Experience Financial Stability	Long Term Ventilation Patients	Unit 4 West	Carter

Mr. Scholz described the concept of the flow cell. He explained that the flow cell uses a visual management chart that makes normal versus abnormal visible. It supports transparency in terms of expectation and ongoing tracking and improvements.   He described the four elements of the flow cell, using the visual management chart on presentation slide #9, as the following:

1. **1 by 1 (Simple Flow)**
    - Only handle information once
    - Only move the patient once
    - No batching

2. **6S (Defect Free)**
    - Optimize the environment:
        - o Sort
        - o Set for flow
        - o Scrub
        - o Safety
        - o Standardize
        - o Sustain

3. **Standard Work (Lowest Cost)**
   - Reduce variation and errors:
     o Optimal work sequence
     o Produce at the pace of demand
     o Resource to demand

4. **Pull (On Demand)**
   - Produce only when the next step in the process is ready
     o No "pushing"
     o Tight connections between steps

Mr. Sholz invited the Bellevue Hospital team to share with the Committee their improvements in the Echo and Stress Labs on the 3rd Floor of the Hospital building and to discuss how these improvements were connected to their value stream work.

Mr. Tian Wei provided an overview of the Echo and Stress Labs area before the value stream work was implemented. He described the Reason for Action as the following:
   - Long wait times for inpatient patients to have echo tests done
   - Incomplete orders in physicians' queues at day's end
   - Outpatients scheduled in the morning, taking up time slots for pending inpatients
   - 47% of physicians dissatisfied with turnaround time for echo
   - 65% of physicians dissatisfied with turnaround time for stress
   - Long response time is a significant contributor to length of inpatient stay

Mr. Wei reported the test completion rate for the Echo Lab. He explained that, initially, 10-40% of echo tests were completed on time. However, at the end of the Silver certification training RIE, the completion rate drastically moved from 10-20% up to 80-90%. Mr. Wei explained that they were able to sustain these results 60 days after the RIE. In addition, these positive results were also achieved in the regular Stress Lab and the Nuclear Stress Lab.

Ms. Wendy Yung reported that all the aforementioned improvements were based on the elements of the flow cell. She added that a visual process control board was created to show the progress of the work. This visual management tool was used to highlight placement, to indicate patient status throughout the process and to measure the target result time. Ms. Yung described how they were able to deploy the flow cell tools/elements to make improvements in the Echo and Stress Labs:

1. **1 by 1 (Simple Flow)**
   - One by one flow, one-directional flow for inpatients
   - Patients transported in the appropriate transport vehicle to eliminate congestion
   - Pre-packaged gowns with inventory levels
   - Pre-packaged charts and optimized placement for clerical staff
   - Organizing files alphabetically instead of by date
   - Organized stress lab area

2. **6S (Defect Free)**
   - Pre-packaged gowns with inventory levels

- Pre-packaged charts and optimized placement for clerical staff
- Organizing files alphabetically instead of by date
- Organized stress lab area

3. **Standard Work (Lowest Cost)**
    Standard Work for:
    - Head sonographer handoff of inpatient orders
    - PCB huddles and upkeep
    - PCT/Escort retrieving patients from unit
    - Clerk filing new inpatient files
    - Clerk determining mobility status of inpatient for transport

4. **Pull (On Demand)**
    - Pull system to move patients and staff using green/red visual cards
    - Move outpatients to the afternoon hours so pending inpatient orders can be processed in the morning

Ms. Yung reported that the scheduling system was optimized by visually mapping out all the patients. The staff was able to create an improved schedule with a smoother work flow. In addition, Ms. Yung reported that before the RIE, there were two entry ways to the Echo Stress Lab area which led to stretcher congestion in the hallway. The patient care technicians (PCTs) and the transport staff were bringing patients in and out of the same doorway, which caused traffic jams. As a result of the RIE, one area was designated to be the "in" entry way to the lab and the other the "exit" area. In addition, red and green stations were implemented to indicate the status of patients so that staff members could easily know whether they were finished with the patients and to move the patients back to their respective floors. The clerical work was reduced by 50% by simply reorganizing the clerk duties and making pre-packaged forms. These actions helped to reduce the processing time for creating a chart. Ms. Yung added that, by reducing 50% of the clerical work for 40 patients a day, a lot of time and effort had been saved and ultimately the patient waiting time was reduced.

Ms. Yung reported that the process control board was instrumental for the front line staff to track their daily progress. They were able to determine if all of their cases were fulfilled or not. They also had a chance to discuss the reason why they did not accomplish their goal. Ms. Yung stated that, overall, the driving factors that have made this event really successful were: 1) all the candidates that were part of the project remained in the area; and 2) engagement of the front line staff members, who were there to observe and ask questions, and their involved in every aspect of the work. Ms. Yung added that staff members were very receptive to that kind of work and a lot of these changes have been sustained. She added that the Breakthrough team was still working with the staff to improve their daily work.

Mr. Nolan, Board Member, asked the Bellevue team to explain the difference between a stress test and a nuclear stress test. Mr. Wei explained that a nuclear stress test is similar to the exercise stress test that is conducted using a treadmill but it includes pictures that can show areas of low blood flow through the heart and damaged heart muscle.

Ms. Omi introduced Ms. Marcy Pressman who participated in the Silver certification training improvement event. She asked Ms. Pressman to share her experience with the Committee. Ms. Pressman stated that the RIE had been a great model in helping the department to achieve its strategic goal. She reminded the

Committee of Bellevue's role as a transferring and referring center for patients who suffer from cardiac diseases. Ms. Pressman added that, as a result of the work that was done in the flow cells, remarkable results were achieved. The two access beds days were reduced to .8 access days. Ms. Pressman explained that, even though the access beds days were bumped up a little bit in February, there were significant reductions in March and April. Ms. Pressman stated that, "This is definitely the way to go for flow events because we are not in a week for just thinking about the changes to be made, but we are actually thinking about what needs to be fixed ahead of time...the week is used to work in the area with the staff and to test those changes."

Ms. Linda Lombardi also shared her experience with the Committee. She stated that the feeling was transformative. Staff members were trained and they applied the training. She added that the process control board was a very active board. Staff members shared their goals for the day, tools for getting there, and accomplishments once it is done. That kind of continual communication, the application of continuous learning is really transformative in the culture. She added that students and learners felt a sense of respect, ownership and control as they experimented and tried something. Sometimes the experiments work and sometimes they decide against a certain approach. The whole process of learning together, trying things together and developing a process that is considerably better and sustainable is something that really makes the team feel good about their work.

Dr. Nathan Link added that, from his perspective, not only was it a great event because of the outcomes, but also because it was focused on learning. Dr. Link stated that, before the Silver training RIE, they had made several attempts on their own to fix the problem. Dr. Link informed the Committee that he had been working at Bellevue Hospital for 30 years, and for all those years they really did not know how to fix the problem in the Echo Stress Lab. Dr. Link stated that, what he liked the most about the process was learning the tools to fix the problem. As leaders, they will have more opportunities to use those tools to fix other issues. Dr. Link added that they did not see the light until they had to go through the work and learn all the steps, then doing and practicing it and see how it worked. The process control board was the key to success because the staff was able to track their work during the day and they knew exactly where they were every hour in achieving the goal of the day. Dr. Link also added that the team members were very proud of their work. They have been able to sustain the improvements.

Mr. Robert Nolan, Board Member, asked Dr. Link to explain the elements of the process control board. Dr. Link responded that the process control board was comprised of 5 rows, or categories of the different kinds of echocardiograms that needed to be done. The top row referred to inpatients. When they start in the morning, there are 8 inpatient orders to be completed by 1:00 p.m. That information is recorded in the first box. As each one is done, it is being checked off in the next box. A zero is recorded for the left over ones. By noon, they were all completed. Dr. Link added that different categories had different time goals. He added that the Lean process forces staff to think methodically. All the elements have to be addressed according to a rigorous process. He agreed with Mr. Nolan that, once done, in retrospect, it appeared so simple.

Ms. Omi referred to a phrase commonly used in Breakthrough, "slow down to go fast". She stated that the Bellevue Hospital team had spent three days in pre-work and the actual event was one week long. Ms. Omi highlighted that, by taking that time to learn, the tools can be used to coach other staff and can also be applied in other areas of the hospital. The spread and the diffusion of that learning and the staff experience would be much deeper at the facility because of the roles that they play and the credibility that they have going through the process. Ms. Omi stated, as Ms. Pressman noted, Bellevue is a referral center for the

entire corporation for certain cardiac services. As such, if there is a bottleneck at Bellevue, there is a citywide bottleneck. Therefore, it is critical to ensure that the system wide referral of patients to Bellevue is possible by making the patient flow possible and by ensuring that there is throughput for that service. Ms. Omi emphasized that there had been no mention of creating a new electronic information system to manage this process. It is simply using a white board with black tape and black markers on it. The board is erased every day. Ms. Omi added that lost revenue was stopped and cost savings increased by deploying this simple technology. By eliminating more than 50% of excess bed days, which are reimbursed at a lower level, Bellevue is achieving tremendous savings while reducing unnecessary costs. Ms. Omi added that the new Chief Financial Officer is working on adding values to those savings to monetize and to demonstrate this going forward.

Mr. Scholz invited the Queens Hospital Center and Gouverneur Healthcare Services staff to present their work. The team included Ms. Molly Lopez, Associate Director, Women's & Children Health, Gouverneur Healthcare Services; Mr. Kenneth Feldman, Associate Executive Director, Ambulatory Care, Gouverneur Healthcare Services; Ms. Helen Sapla-Coll, Ambulatory Care Nurse, Queens Hospital Center; Mr. Robert Malone, Chief Financial Officer, Queens Hospital Center and Mr. Ravi Ramphal, Ambulatory Care Facilitator, Queens Hospital Center.

Mr. Scholz stated that the Gouverneur Healthcare Services staff had conducted the same type of training in their Women's Health Clinic. Mr. Scholz stated that Ms. Alina Moran, Chief Financial Officer for Elmhurst Hospital Center also attended that training session.

Mr. Feldman provided the Committee with an overview of the Women's Health Clinic before the value stream analysis. His description is summarized below:
- Both patients and staff were often confused and frustrated by long waits, uneven work burdens, and a high degree of variation:
  - Excessive waiting
- Rework – multiple staff asking for the same information
  - Each provider or support staff did similar tasks differently
  - Poor visibility re the status of any one staff person or patient
- No standardized clinical protocol for the well woman visit, potentially extending cycle time and duplicating effort, while not providing a fail-safe for preventive services

Ms. Wendy Lopez reminded the Committee that, as part of the Silver certification training event, the goal was to improve the patient's experience by improving the way the team worked together. She added that they felt that having metrics/performance indicators were key to measure whether the team was working together for the patient from start to finish. Ms. Lopez shared the results for the following metrics:
- Patients seen within 60 minutes: Started with 30% of patients were being seen in 30 minutes and now 100%
- Percentage of daily briefs conducted: Daily briefs conducted was 100% from the beginning
- Contraception addressed in reproductive age female: Started under 20% and now at 100%
- Women 40-60 screened with mammography within 1 month: Started nearly at 80% and now at 100%

Mr. Feldman stated that the team was provided with the opportunity to align the Silver training process with both the process indicators and quality indicators. He described the activities that were included in the team's flow cell development process as the following:

1. **1 by 1 (Simple Flow)**
    • Geographic patient-centeredness in the clinic. Procedures done in the same exam room (pregnancy, HIV tests, etc.)
    • Clerical functions performed by the RNs minimized, more quality time spent with patients

2. **6 S Defect Free**
    • Standards for room organization. All supplies and equipment are where needed and fully functioning (LARC, microscope, fetal monitor, scales, thermometer)
    • Created procedure kits
    • WOWs located where needed

3. **Standard Work (Lowest Cost)**
    • Team members' roles and functions defined to maximize staff productivity and reduce patient flow time
    • Teams integrated to support department and patient-centered flow
    • Defined and staffed teams by demand

4. **Pull (On Demand)**
    • Patients brought to one room, staff members swing rooms using color triggers
    • Established supplies inventory standards, new par levels and replenishment system

Mr. Scholz reported that team members participated in daily morning briefs to discuss previous day and current day activities.   He reported that the process control board that they created had helped them to track the metrics. It also shows how they were able to bring people together. Operationally, it created a sense of pride within Women's Health, and a little bit of envy from the rest of the building. Mr. Scholz informed the Committee that the goal was to spread and to have stability for the rest of the organization. He added that Women's Health was the first value stream analysis (VSA) that was conducted and a second pass was initiated last month. He also announced that, most importantly, the Medicine VSA would start next month and that the goal was to create standardization and expertise within the building. The Women's Health area now has a sense of pride as the departments in the building rotate through their daily process board to see how they can be successful and how, if there is a push back, it can be handled successfully.

Ms. Lopez described some key changes that resulted from the Silver certification training. She informed the Committee that the most successful outcome of the event was the implementation of a patient-centered flow. As such, the staff comes to the patient in one exam room instead of moving the patient from the exam room to various waiting areas. She reported that, through that change, the patient steps were decreased from 176 steps to 103 steps, as confirmed by Ms. Alina Moran, who also walked the patients' walk.

Ms. Lopez explained the composition of the process control board. She stated that the metrics included:
    • Cycle time less than 60 minutes
    • Mammography screening
    • Contraceptive counseling
She described the target performance for each metric as the following:
    • 50% for the cycle time
    • 90% for mammography
    • 75% for contraceptive

Ms. Lopez reported that one of the issues that they had faced concerned the supplies and replenishment system. They wanted to make sure that there were enough long active reversal contraception (LARC) supplies. They instituted measures to ensure that there were adequate supplies at all times. For instance, whenever a PCA uses the last of any supply an orange tag with the words "out of stock" is placed in the mailbox of the person in charge of ordering supplies to prompt the placement of a new order. For a larger supply closet, if a bin is empty, that empty bin would be placed on top of the shelf. When the head nurse sees the empty bin, a new order would be placed.

Ms. Anna Kril, Board Member, asked Ms. Lopez to explain the notes at the bottom of the process control board. Ms. Lopez responded that these notes were parameter charts. She explained that, whenever a metric is not met, one of the PCAs would document the reason why on the X access and the date it occurred on the Y access. Ms. Lopez informed the Committee that the recurring issue of not meeting the cycle time goal of less than 60 minutes resulted from provider delays. She added that the right side of the board reflected monthly trend lines. Ms. Omi added that these were some of the methods that the team used to track the types of problems and re-occurring issues so that they can get back to where they want to be on cycle time and to problem-solve for that specific issue.

Ms. Omi highlighted that the Women's Health was established at Gouverneur over the last year. This department has been live in that area for only a year. The goal is to create a place where anyone in the facility can go to see what good looks like. Therefore, the team has created a level of excitement throughout the rest of the facility. The Adult Medicine area will stand on the shoulders of Women's Health and they will be able to show more quickly how to implement the work that has been done in Women's Health. Ms. Omi commented that this was a wonderful way to create a model for others to see and learn from. She thanked the Gouverneur staff for their presentation.

Mr. Sholz invited Mr. Robert Malone to present Queens Hospital Center's Silver certification RIE in the Adult Primary Care Clinic. Mr. Malone stated that the event focused on the cycle for patients. He explained that it was increasingly important because patients' experiences affect the hospital's Hospital Consumer Assessment of Healthcare Providers (HCAPH) scores and the hospital's financial shift from inpatient to outpatient. Mr. Malone added that initially, the cycle time in the Adult Primary Care Clinic was over three hours for a patient. He invited Ms. Helen Sapla-Coll to share with the Committee the previous state of the Adult Primary Care Clinic prior to the Silver certification training event.

Ms. Sapla-Coll reported on the pre-existing conditions of the Adult Primary Care Clinic as described below:
- No visual management guiding the process
- No pull systems for treatment process. Staff "pushed" patients from one process to the next regardless of readiness
- Dwell time of registration was extensive, the process was cumbersome and siloed
- Care was interrupted each time a new room was needed
- Staff had to leave exam rooms throughout the day to get basic supplies due to inefficient stocking of supplies in each treatment room, creating multiple interruptions and adding to total flow time
- Patient was moved multiple times to the waiting room between treatment phases
- Space was not optimized for flow

Ms. Sapla-Coll reported that the Silver event produced a reduction of the downtime from about 4 hours to 1 hour and 40 minutes. She added that the department was still improving and has been able to sustain these results over the past 6 months. The best ever downtime of 1 hour and 9 minutes was achieved last month.

She added that with the new results, both patients and staff were happy. Mr. Malone added that, while the goal is not always known right away and sometimes tends to go up a little bit in subsequent months, it is important to maintain and continue to enforce what was developed in the RIE as some results will ultimately show up. He emphasized that their downtime is now 1 hour and 9 minutes and that the goal is to reduce downtime to only 1 hour.

Ms. Sapla-Coll described the key activities of the team's flow cell development process as the following:

1. **1 by 1 (Simple Flow)**
    *   Cell concepts introduced in Green Team in which providers use swing room to provide care

2. **6S Defect Free**
    *   6S a "Model" Treatment room and 2 "model" RN room with everything labeled with pictures of what it should look like. Later introduced to the rest of the clinic
    *   End of shift replenishment system
    *   Process Control Board to understand and manage flow
    *   Soarian chart "ready" trigger included in the standard work and flag system installed in the model treatment rooms

3. **Standard Work (Lowest Cost)**
    *   Cross-trained all registration staff
    *   Standardized work was created for each discipline and posted where the work is being done (pilot: green Team)

4. **Pull (On Demand)**
    *   Room flag system to improve flow

Mr. Malone stated that the process control board had helped the team to understand and manage the flow. He added that the Soarian chart "ready" trigger was included in the standard work and a flag system was installed in the model treatment rooms.

Mr. Malone reported on the key changes that resulted from Silver certification training work. He explained that a colored flag system was developed to alert staff of the status of the patient. He explained that the different colors indicate certain information such as: who is in the room with the patient, the appointment time, time for the next patient, etc. He added that purple is for care; pink is for equipment; green meant that all disciplines were involved; and blue is for pull systems in place. This new approach is patient-centered and puts the patient in the middle.

Mr. Martin, Executive Vice President and Chief Operating Officer, asked the Bellevue, Gouverneur and Queens staff members if their Hospital Consumer Assessment of Healthcare Providers (HCAHP) scores had been impacted by the results of the Silver training. Mr. Malone responded affirmatively. He shared with the Committee that a call center was added in the clinic to make the appointments and that the clinic was seeing more patients than it previously had. He is expecting to see even more improvements over the next quarter based on the increased access.

Mr. Ramphal added that one of the major complaints was the cycle time. Patients were wondering why they had to wait so long, even with a scheduled appointment; and why they also had to be moved from room to

room when all they needed to do was to see a doctor. Mr. Ramphal reported that, after examining the causes, the process was streamlined and patients were able to go through their appointments a lot faster; while at the same time, simplifying the patient flow and increasing access for more patients. Mr. Nolan commented that, prior to the patient's visit, or even the day before, the proper supplies and equipment were in place in the room for the doctor. Mr. Ramphal responded that a system of pre-visit planning was non-existent before the Silver training.

Mr. Malone stated that one of the new requirements in managed care for diabetic patients is to have a retinal eye exam annually. He informed the Committee that, in addition to seeing patients on a regular basis, the patients can solely come for the eye exam, see a PCA and do not have to go to the Ophthalmology Suite for the exam, thereby, bringing more access to the eye clinic.

Ms. Lopez stated that Gouverneur's patient satisfaction scores were trending up. She informed the Committee that waiting room surveys were conducted before and after the event between June and March. She reported that one of their highest scores was for their ability to reach the patient on the phone. In addition, one of the metrics being watched, as it is also measured by the state is the percentage of women who receive contraceptive counseling. Ms. Lopez reported that there had been a dramatic improvement up to 65-70%, which is about the state's average.

Ms. Omi added that success brings success. She explained that, when a Silver training is put together, the team consists not only of students from the area that are called to learn the work, apply and sustain the improvements in that area, but also leadership staff. She highlighted that Mr. Malone is from the Finance Office and has a tremendous history with Breakthrough. He has been a longstanding champion of Breakthrough in his area. In addition, Mr. Malone has been asked to take on a lot more responsibilities to help spread Breakthrough at the facilities by being an expert process owner and helping other managers in other areas of the facility. Ms. Omi stated that Breakthrough is building the capacity of staff to train other staff, while developing leaders at the same time.

Mr. Sholz concluded the three presentations by sharing with the Committee some of the next steps, which include:
- Bringing more students to Silver earlier in their development
- Ensuring that all value streams include flow cell development and have opportunities for Silver
- Using Silver as a tool to achieve enterprise wide project outcomes more quickly
- Creating prescribed models to deliver flow improvement for different value streams
- Ensuring Silver improvements are sustained through the Daily Management System (DMS)
- Applying learning from Silver trainings to Gold and Platinum courses

Mr. Nolan thanked Mr. Sholz and the Breakthrough teams for their presentations.

ADJOURNMENT

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

Identifying Fair, Effective & Sustainable Local Policy Solutions:
Undocumented Immigrants and Access to Health Care in New York City

Claudia Calhoon, MPH
The New York Immigration Coalition
Nancy Berlinger, PhD
The Hastings Center

The Hastings Center

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December 2014 Convening

- Aimed to:
  - Create focused space to augment and deepen ongoing conversations in the Mayor's Task Force on Immigrant Health Access
  - Sharpen local stakeholders' understanding of gaps in access to health care for populations left out of the ACA—in particular, New York City residents who are both undocumented and uninsured
  - Identify proven or promising local solutions to closing these gaps in other cities, counties, and states and discussed applicability to NYC

December 2014 Convening

- Funded by a discretionary grant from the RS Clark Foundation
- Vera Institute for Justice provided space pro bono
- Convening, report, and recommendations were independent of City Mayor's Task Force process
- Aimed to complement it re: timing, utility
- Authors of report are responsible for recommendations
- All meeting participants had opportunities to provide insights via discussion and subsequent review of meeting summary

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Convening Participants

New York City government

- Department of Health and Mental Hygiene
- Health and Hospitals Corporation
- Human Resources Administration Office of Citywide Health Insurance
- Office of the Deputy Mayor for Health and Human Services
- Mayor's Office of Immigrant Affairs

Labor/Advocates

- SEIU
- Community Service Society
- Coalition for Asian American Children and Families
- Make the Road
- Vera Institute for Justice

Clinicians

- Primary Care (HHC Bellevue) and FQHC's (Community Health Care Association of New York State)
- Discharge Planning (Montefiore)
- Specialty Care (Memorial Sloan Kettering Cancer Center)

Funders

- Altman Foundation

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December 2014 Convening

- External Speakers:
  - Tangerine Brigham Deputy Director, Managed Care Services Division of Los Angeles County Department of Health Services (Healthy San Francisco and My Health LA)
  - Sherri Rice and Nikki King, President/CEO and Chief Operating Officer of Access to Healthcare Network, Nevada
  - Rajeev Raghavan, Assistant Professor of Medicine, Baylor College of Medicine and Ben Taub Hospital-Harris Health System of Houston, Texas
  - Andrew Cohen and Kate Bicego, Massachusetts' Health Law Advocates/Health Care for All

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2015 Report Overview

- Describes:
  - New York City's undocumented uninsured population
  - City's safety-net health care system
  - Specific gaps in coverage and financing that impede access to health care for this population
- Highlights special opportunities and challenges for health care system improvement in the City
- Compares models that are proven or promising as sustainable ways to improve access to uninsured populations
- Offers six actionable recommendations for City stakeholders, supported by guidance for ongoing planning, program development, and system improvement

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New York City's undocumented uninsured population

- Approximately 500,000 immigrants who live in New York City are undocumented
- About 250,000 are insured through employer sponsored coverage, private insurance purchased outside of ACA marketplace, or Child Health Plus
- About 250,000 remain uninsured:
  - 155,000 will be eligible for Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) or Deferred Action for Childhood Arrivals (DACA)
  - Of these, 40-50 percent will be income-eligible for Medicaid after enrollment in DAPA or DACA
  - As of May, 2015 DACA/DAPA delayed
- **TAKE HOME:** At least 200,000 of the currently uninsured are likely to remain uninsured

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Existing services and gaps for undocumented and uninsured

- **Safety-net health care systems in New York City**
  - HHC
  - Federally Qualified Health Centers (FQHCs)
  - Voluntary Hospitals (to limited degree)
- **Emergency Medicaid and its limits in New York State**
  - Functions as limited form of coverage
  - Gaps
- **Gaps in the New York City safety-net**
  - Chronic conditions
  - Life-threatening conditions
  - Discharge planning and post-hospital care
  - Efficiency and cost effectiveness

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Opportunities and Challenges

- **Opportunities**
  - DSRIP
  - Better linkages with voluntary hospitals
  - ID NYC or other sort of enrollment card

- **Challenges**
  - State coverage mechanism for all
  - Leveraging primary care workforce
  - Indigent Care Pool (ICP) and Disproportionate Share funding (DSH)

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My Health LA

- No-cost health care program launched in October 2014
- Offers comprehensive health care for low-income (at or below 138 percent of the FPL), uninsured county residents, regardless of immigration status or medical condition
- Does not require out-of-pocket payments or user fees
- Offers care through 164 community clinic medical home sites, where patients receive primary and preventive health care services and some diagnostic services
- Los Angeles County Department of Health Services facilities also provide County clinic medical home sites, plus emergency, diagnostic, specialty, inpatient services, and pharmacy services
- Of the estimated 400,000 remaining uninsured in Los Angeles County, 135,000 are now served, with capacity to reach another 145,000

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Healthy San Francisco

- Low-income program for San Francisco County residents with incomes up to 500 % FPL regardless of employment status, immigration status, or medical condition
- Charges participation fee & point-of-service fee to all patients except for those under 100 % FPL and those who are homeless; One set of fees for all public clinics; non-public clinics set their own fees
- Fee information provided at time of enrollment to help applicants select medical home
- Participants receive a card with the name of their medical home

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Healthy San Francisco

- Large, interconnected care network made up of different types of providers
- Predictable affordable participation fees decreases client fear of large bills
- Encourages preventive care and offers customer service, health education, care management
- Focus on primary care home to reduce duplication and improve coordination
- Centralized eligibility system to maximize public entitlement and centralized system of record to create accountability
- Non-insurance (care) model lowers costs and protects federal and state funds for counties

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Access Care, Harris County, Texas

- Financial assistance program of the Harris Health System, the hospital district that includes the city of Houston

- Open to uninsured Harris County residents

- Provides access to discounted health care at more than 20 community clinics, a dental clinic, and surgical and other sub-specialty clinics, one long-term care facility

- Scope of services exceeds that of most FQHCs in the area, although wait times for sub-specialty clinic appointments and for elective surgeries can be long

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Massachusetts

- One application for all available programs, including the insurance marketplace
- **Mass Health Limited**
  - State version of Emergency Medicaid
  - Available to undocumented immigrants and some immigrants who are PRUCOL
- **Children's Medical Security Plan**
  - Financed by the state and offers primary care and preventive services to low income children up to 200 % FPL
- **Health Safety Net**
  - Grew out of the state's ICP to pay for care at acute care hospitals and community health centers
  - For Massachusetts residents earning less than 400 percent of the FPL are eligible for HSN funds, which follow individuals rather than institutions
  - Patients with incomes between 200-400 percent of the FPL can apply once they incur a health care cost
- HSN's **Medical Hardship Program** can be applied up to a year retrospectively to cover medical debts

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Access to Healthcare Network

- Offers medical discount programs, specialty care coordination, a health insurance program, non-emergency medical transportation services, a pediatric hematology/oncology practice, and a toll free statewide call center
- 35,000 members, more than half of whom are presumed to be undocumented
- Members must be at 100-325 % FPL, live and/or work in Nevada, and be ineligible for public insurance such as Medicaid or Medicare
- Members pay $35 a month for deeply discounted medical services plus care coordination

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Common Elements of Existing Models

- Eligibility
- Financing
- Provider networks
- Care coordination
- Political support

Recommendations

1. Improve access to primary and preventive health care, and to specialty care and other services, through primary care medical homes in FQHCs and HHC ambulatory centers networked to specialists

2. Explore the potential for the City's municipal ID card to function as an enrollee card for a primary care medical home network for uninsured New Yorkers

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Recommendations

3. Acknowledge that a primary care oriented medical home solution, while important, will not resolve health care access for undocumented immigrants and other uninsured populations who have medical and related social service needs that significantly exceed the scope of a primary care medical home and that further efforts are needed to close these gaps.

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Recommendations

4. Describe explicitly the potential role of the City's major voluntary hospitals in supporting access to health care for the undocumented uninsured and other uninsured populations, with attention to their current role in emergency and inpatient care and to access problems that exist at the hospital/ post-hospital transition

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Recommendations

5. Integrate new efforts to improve access to primary care for uninsured New Yorkers into current efforts of New York City Performing Provider Systems to meet their DSRIP goal

6. Advocate for state-level policymakers to identify a mechanism that will provide health coverage to immigrant populations who remain uninsured

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Observations/Suggestions

- Improving public systems

- Anticipating emerging issues in organizational collaboration

- Promoting knowledge sharing and problem solving among public and voluntary hospitals

Reception/Next Steps

- Forum on meeting and report planned for once the Mayor's Taskforce Report is released

- Requests for technical assistance from:
  - Illinois Coalition for Immigrant and Refugee Rights
  - Public Citizens for Children and Youth (Philadelphia)

- Featured on CUNY TV's Informed Comment

- Cited in the NYC Comptroller's Report "Holes in the Safety Net"

- Invitation from Milbank Quarterly to submit article based on report

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April 2015

Undocumented Immigrants and Access to Health Care in New York City

Identifying Fair, Effective, and Sustainable Local Policy Solutions

Report and Recommendations to The Office of the Mayor of New York City

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The Hastings Center

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New York Immigration Coalition

Michael K. Gusmano
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The Hastings Center

This independent report is based on a meeting convened by the New York Immigration Coalition and the Undocumented Patients Project of The Hastings Center, which was hosted by the Vera Institute of Justice in New York City on December 11-12, 2014. The goals of this meeting were to sharpen local stakeholders' understanding of gaps in access to health care for populations left out of the Patient Protection and Affordable Care Act of 2010 (ACA)—in particular, New York City residents who are both undocumented and uninsured—and to identify proven or promising local solutions to closing these gaps in other cities, counties, and states. Although this report and its recommendations focus on challenges and solutions in New York City, it may also be useful to other New York State municipalities, and to other cities and counties in the United States.

This document describes New York City's undocumented uninsured population, the City's safety-net health care system, and the specific gaps in coverage and financing that impede access to health care for this population. It also describes special opportunities and challenges for health care system improvement in the City and compares models that are proven or promising as sustainable ways to improve access to health care for undocumented immigrants and other uninsured populations. It concludes with six actionable recommendations for City stakeholders, supported by guidance for ongoing planning, program development, and system improvement. The final draft of this report was provided to the Office of the Mayor of New York City, Task Force on Immigrant Health Access, Care & Coverage Subgroup, on February 28, 2015.

Contributors

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CONTENTS

INTRODUCTION
New York City's undocumented uninsured population:
current and projected access to health insurance coverage

This report is based on working estimates of the local undocumented population and summarized as follows:[1]

- Approximately 500,000 immigrants who live in New York City are undocumented. Of these, about half (250,000) are insured through employer sponsored coverage, private insurance purchased outside of the ACA marketplace, or Child Health Plus.

- The other half (250,000) are currently uninsured. Of these, 155,000 will be eligible for Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) or Deferred Action for Childhood Arrivals (DACA). This total includes 121,000 newly eligible as of the Obama Administration's Executive Action of November 2014 and 34,000 who have been DACA-eligible since the June 2012 Executive Action but remain unenrolled. (See note 1.) Of these, 40-50 percent will be income-eligible for Medicaid after enrollment in DAPA or DACA.[2]

- 200,000 or more of the currently uninsured are likely to remain uninsured. In this report, "undocumented uninsured" refers to this remaining uninsured population, which includes undocumented immigrants who are ineligible for DACA or DAPA; eligible for but unenrolled in DACA or DAPA, or enrolled in DACA or DAPA but income-ineligible for Medicaid.

A. Safety-net health care systems in New York City

Like other City residents who lack health insurance, New Yorkers who are undocumented and uninsured rely on local safety-net health care systems, defined by the Institute of Medicine (IOM) as those that "organize and deliver a significant level of health care and other related services to uninsured, Medicaid, and other vulnerable patients."[3] The City's two major safety-net systems are the New York City Health and Hospitals Corporation (HHC), the nation's largest local public hospital system, and Federally Qualified Health Centers (FQHCs, also known as community health centers), which are nonprofits that offer primary and preventive health care. Both systems rely on Medicaid (and to a lesser extent, Medicare) reimbursements. They also depend on federal Disproportionate Share Hospital (DSH) funding and other sources of state Indigent Care Pool (ICP) funding. Both systems have explicit provisions for uninsured patients who cannot afford to pay for needed care. Although patients are not asked directly about immigration status, both HHC and the Community Health Care Association of New York State (CHCA-NYS), whose members include FQHCs and migrant health programs, presume that many of their patients who are low income and are not enrolled in Medicaid are undocumented. Health care professionals may confirm that a patient is undocumented during the process of enrolling a patient in Emergency Medicaid (described in Section 1B) or determining whether a patient meets the requirements for Permanently Residing Under Color Of Law (PRUCOL; see note 2).

HHC receives funding from the City and operates with a structural budget deficit to accommodate services to uninsured patients. When an uninsured person presents at an HHC ambulatory center, a Certified Application Counselor (CAC) evaluates possible coverage options, which include Medicaid and Child Health Plus.[4] For those determined to be ineligible for coverage, HHC offers a fee scale for patients with incomes up to 400 percent of the Federal Poverty Level (FPL).[5] In addition to primary and preventive health care, HHC ambulatory centers offer uninsured patients access to on-site pharmacies and referrals to medical specialists and diagnostic and other services located in HHC medical centers.

FQHCs, which are federally designated by the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), receive federal grant funding to support care to the uninsured on a sliding scale. Their service delivery model is the medical home, which aims to include care coordination with providers outside of the FQHC.[6] Because an FQHC does not have access to the range of specialists and services available in HHC hospitals, finding affordable care is a significant problem when an FQHC patient is uninsured and needs specialty services. In many cases, these FQHC patients are referred to HHC facilities. Some FQHCs in the City have begun to offer more services in-house in response to this problem.

Other parts of the local safety-net include non-profit (also known as "voluntary") hospitals that have emergency departments (EDs) where uninsured patients may seek or be referred for health care. These hospitals also provide inpatient care to uninsured patients admitted to the hospital through the ED, with the cost of this care covered by Medicaid for the Treatment of an Emergency Medical Condition, often known as "Emergency Medicaid" (described in the next section) and/or a hospital's charity care funds.[7] Voluntary hospitals, including specialty hospitals that do not have EDs, may also have provisions for treating uninsured patients other than through ED admissions.[8] One-stop facilities such as free clinics, urgent care centers, and walk-in clinics in chain drug stores are part of the informal safety-net for uninsured patients. These facilities usually do not work in coordination with HHC, FQHCs, or voluntary hospitals, but may offer shorter wait times or hours that are convenient for undocumented uninsured patients.

B. Emergency Medicaid and its limits in New York State

Undocumented immigrants who are not PRUCOL (see note 2) are ineligible for Medicaid apart from

Emergency Medicaid, which covers "emergency" services to treat conditions that seriously jeopardize a patient's health, put the patient at risk of bodily dysfunction of a major organ, or cause severe pain. In New York State, Emergency Medicaid reimburses hospitals for the costs of providing inpatient care to uninsured patients who earn up to 138 percent of the FPL. Emergency Medicaid also functions as a limited form of insurance coverage. Once a condition defined as an "emergency" is documented, coverage can be authorized for a maximum of 15 months to cover certain treatments, such as some types of cancer treatment.[9] With the implementation of the ACA in New York State, undocumented immigrants can be pre-qualified for Emergency Medicaid through the New York State of Health web portal; pre-qualified individuals are issued a card confirming that they have this limited coverage should a medical emergency arise. Unfortunately, there are many gaps in Emergency Medicaid, which often does not cover the long-term consequences of initiating life-saving or life-sustaining treatment and excludes some treatments that would typically constitute appropriate medical care for specific life-threatening conditions. For example, Emergency Medicaid covers chemotherapy and radiation but does not cover many usual services associated with the delivery of these treatments, and does not cover bone marrow transplants, which would be standard treatment for some forms of cancer.

C. Gaps in the New York City safety-net

Safety-net clinicians and administrators familiar with the undocumented uninsured population in New York City describe a range of problems that typically arise when a patient's medical needs exceed the resources of an HHC or FQHC primary care setting or the temporary coverage provided by Emergency Medicaid. For example:

1. Effective management of chronic conditions

HHC ambulatory centers and FQHCs care for many patients with common chronic conditions such as diabetes. Treatments for some of these conditions are covered under Emergency Medicaid, while others are excluded or only partially covered. A particular problem is that Emergency Medicaid does not cover medical supplies, such as glucose test strips that diabetic patients use to manage their condition. If a primary care provider lacks a payment mechanism for the needed supplies and the patient cannot afford to pay for the supplies out of pocket, the patient lacks a re-

source needed for effective control of this disease. As a consequence, the patient's health may deteriorate, requiring expensive and preventable ED and possibly inpatient treatment. Also, some chronic conditions require regular consultation with a medical specialist, such as an oncologist, nephrologist, or ophthalmologist, to be managed effectively. As noted, access to specialty care may not be readily available in HHC ambulatory centers or in FQHCs, and wait times for uninsured patients to see specialists (who may be concentrated at HHC medical centers such as Bellevue) are typically long. Preliminary data from FQHCs suggest that uninsured patients with a diabetes diagnosis have a higher volume of charges compared to insured patients with the same diagnosis, which suggests unmet medical needs.[10] Behavioral health services, including treatment for chronic and persistent mental illness, are especially difficult for the undocumented uninsured population to obtain, due to long wait times for appointments with qualified providers in primary care settings, licensure restrictions on potentially qualified providers, and uneven geographic distribution of qualified providers who have the linguistic skills and cultural knowledge needed to serve the City's diverse undocumented community.

2. Effective treatment and management of life-threatening conditions

It is difficult to treat certain life-threatening conditions, such as Hepatitis C, advanced kidney disease, or cancer, when a patient is undocumented and uninsured. Emergency Medicaid does not cover the expensive but effective drug therapy for Hepatitis C. Emergency Medicaid covers dialysis but access to scheduled outpatient dialysis is difficult due to Emergency Medicaid's low reimbursement rate as compared to Medicare, the usual source of reimbursement for this treatment. Emergency Medicaid also does not cover medications associated with dialysis. Hospitals sometimes resort to admitting patients who need dialysis to ensure that they receive treatment and medications on schedule, although inpatient dialysis is much more expensive for the Medicaid system. While organ transplantation is a treatment option for conditions such as Hepatitis C or advanced kidney disease, it is extremely difficult for an undocumented immigrant to receive an organ transplant, even when a family member is willing to be a living donor, due to the lack of ongoing insurance coverage for post-transplant medical care.[11] Uninsured patients who have cancer may try to re-

duce their out of pocket costs by spacing out their treatments (therefore taking longer to complete treatment), or reducing their use of medications that are not covered by Emergency Medicaid.[12]

3. Discharge planning and post-hospital care

Undocumented uninsured patients face immense difficulties securing needed post-hospital medical and nursing care, again due to their ineligibility for Medicaid and Medicare. In addition to the gaps noted above, hospital social workers and other staff responsible for meeting the "safe and effective" discharge planning standard describe nursing home care, home care, physical therapy, durable medical equipment, and medical transportation (to scheduled outpatient dialysis, for example) as major barriers to discharge. HHC is the City's largest provider of skilled nursing and long-term acute care, and also provides short-term skilled nursing, but even when the needed services are available within the HHC system, the absence of a financing mechanism for appropriate post-discharge care creates barriers to discharge.

4. Efficiency and cost effectiveness

The efficient and cost effective use of limited resources, include staff time and expertise, is stymied by these coverage problems. A hospital discharge planner who is highly knowledgeable about the limited care and coverage options available to the undocumented uninsured will still need to plead for medi-cally appropriate resources that would otherwise be funded by public insurance. If these resources cannot be secured and the patient cannot be discharged safely, the hospital will retain the patient at high cost to the facility, which may no longer be able to use Emergency Medicaid as a source of reimbursement if the patient no longer requires this level of treatment. This situation also creates an equity problem when a patient who needs inpatient care cannot be admitted because a bed is being occupied by a patient who cannot be discharged. Other problems of efficiency and cost effectiveness arise when health care professionals have insufficient or inaccurate knowledge about care and coverage options for the undocumented uninsured. When health care professionals are misinformed about Emergency Medicaid eligibility, patients may delay initiating treatment that is covered or be billed erroneously for covered conditions. Also, chronically ill undocumented uninsured patients may present at HHC ambulatory centers or FQHCs after hospitalization with discharge plans that do not realistically reflect their ability to pay for the ongoing health care services they need. This burdens the primary care provider with the unresolved coverage problem. A coordinated approach, in which the discharge planner and the patient's primary care provider confer prior to discharge, would be more effective.

A. Opportunities presented by health system reform initiatives, specifically the Medicaid Delivery System Reform Payment Incentive Program (DSRIP), to improve access to health care for "residually uninsured" populations

In addition to expanding access to health care, an important goal of most state and local programs for the undocumented and other uninsured populations is to achieve the "triple aim" of access, cost, and quality through better care coordination. As part of New York State's Medicaid Redesign, there are several initiatives underway to improve care coordination for safety-net patients. For example, New York State is participating in the CMS-sponsored Comprehensive Primary Care Initiative (CPCI), a multi-payer demonstration project that supports the development of medical homes.[14] New York State has also created a Delivery System Reform Incentive Payment (DSRIP) program as part of a larger Section 1115 Medicaid waiver. DSRIP waivers provide Medicaid funds to hospitals and certain other providers if they pursue delivery system reform leading to measurable performance gains. The goal of the program is to achieve greater vertical integration in the health care safety-net and to improve care coordination. Under this program, New York State has established 25 Performing Provider Systems (PPSs), led by public or other safety-net hospitals (including HHC) that serve selected geographic areas. Providers are eligible to participate in a PPS if at least 35 percent of their patients are Medicaid beneficiaries, dually eligible for Medicaid and Medicare, or uninsured.[15] PPS participants in addition to hospitals include community health centers, behavioral health providers, and skilled nursing facilities, among others. At stake is over $8 billion in federal money—each PPS is at risk of losing DSRIP funds associated with improving care for safety-net patients in its geographic region—so any effort by New York City to improve care coordination for the undocumented uninsured should both build on and contribute to this broader effort.[16]

B. Opportunities and challenges concerning the role of voluntary hospitals in improving access to health care for the residually uninsured

The City's voluntary hospitals are part of the local safety-net through their ED services and the care they provide to acutely ill uninsured patients who are admitted through the ED or who gain access to hospital services in other ways. Like their colleagues in public hospitals, physicians, nurses, and social workers in these institutions face ethical and practical challenges in providing undocumented uninsured patients with medically appropriate care, especially when patients are approaching discharge.[17] Although voluntary hospitals are required by state law to provide charity care and financial assistance to low-income patients regardless of immigration status, the extent of their involvement in efforts to close gaps in care and coverage in New York City and elsewhere in the state is not fully understood.[18] Solutions or promising practices concerning frequently occurring problems that arise in this sector may not be shared broadly with public safety-net systems. When explicit discussion of these problems is discouraged within the voluntary hospital sector out of leaders' concern that to describe successes will make a hospital a magnet for undocumented uninsured patients, this hampers local efforts to understand the extent of the challenges hospitals face and how they are managing them. To overcome the problem of siloed problem-solving and promote sharing of knowledge and promising practices, the City should have a strategy to engage voluntary hospitals at all levels to ensure that their knowledge, experience, and resources are part of local policy solutions.

C. Opportunities and challenges presented by the municipal ID card (IDNYC) and associated outreach and enrollment strategies

The 2015 launch of IDNYC, a City-issued identification card available to all New York City residents over the age of 14, offers lessons for successful outreach to immigrant populations.[19] It also offers the opportunity to adapt lessons from other direct-access models and explore the potential for using IDNYC as an enrollee card. A frequent feature of programs to expand access to health care for the uninsured (see next section) is the use of an enrollment card that

provides information about enrollee benefits, the name of the enrollee's primary care medical home, and for programs that allow participating providers to charge fees, relevant information about fee scaling. In San Francisco, the use of the card is supported by a handbook and newsletters. In Nevada, the card identifies the enrollee as a member of a non-profit that provides access to low-cost services at pre-negotiated rates. Houston has also used an enrollee card that entitles income-eligible county residents to sharply discounted rates for services in public hospitals and clinics. Cards that identify the holder to participating providers as an enrollee in a program with transparent, predictable costs can function as a key to unlocking safety-net services across institutions that are available to uninsured individuals.

D. Challenges that require policy solutions above the local level

Three opportunities and challenges related to the specific context of New York State:

1. Improving existing state programs and closing remaining gaps

The number of uninsured immigrants in New York State would be higher were it not for important protections guaranteed by the state Constitution and affirmed by the 2001 *Aliessa v. Novello* decision, which requires New York State to "provide aid, care and concern" for lawfully admitted permanent residents and individuals who are "permanently residing under color of law" (PRUCOL).[20] This case law makes lawful permanent residents who have received green cards within the past five years and undocumented immigrants who are PRUCOL (see note 2) eligible for state funded Medicaid provided they meet income eligibility (138 percent of the FPL), even though these immigrant populations are excluded from federally funded Medicaid.[21] President Obama's Executive Actions in 2012 and 2014 granting deferred action for certain populations also offer important but proscribed coverage opportunities in New York State. Because they are considered to be PRUCOL, immigrants granted administrative relief through DACA and DAPA will be eligible for state funded Medicaid if they meet income eligibility. (See note 2.) Under the ACA, New York State legislatively approved and is now implementing a Basic Health Plan (BHP) to cover individuals whose incomes are too high for Medicaid and who cannot afford to buy private health insurance through the marketplace. Applicants who earn up to 200 percent of the FPL will be eligible for BHP coverage. This arrangement is projected to save the state $500 million annually because New York State will be able to draw down federal dollars for coverage rather than using state dollars.[22] However, despite the efforts of immigration and health care consumer advocates, the state is not currently contemplating the creation of a parallel state funded BHP that would cover undocumented immigrants who remain Medicaid-ineligible. Individuals who make more than the income limits for Medicaid will have no subsidized or public coverage options, as they are prohibited by CMS from purchasing marketplace coverage or being covered through BHP. In short, the state-level policy patchwork includes some promising developments for Medicaid-eligible immigrants. Undocumented and uninsured immigrants need a City mechanism to increase their access to health care, because there is no plan, at present, to guarantee them coverage through equivalent state-level reforms.

2. Expanding the primary care workforce

As demand for primary care increases due to the formerly uninsured entering the health care system as the result of the ACA, FQHCs are struggling to recruit sufficient numbers of primary care physicians and dentists. Experts in community health centers have identified 16 neighborhoods in the City as already in high need of expanded primary care, with potential for sustainable growth by local FQHCs.[23] Current state regulations defining scope of practice for nurse practitioners (NPs) and other non-physicians may prevent these clinicians from practicing at the "top of their license" so their skills can be applied to fill primary care gaps. Reforms to update scope of practice regulations to meet the current and projected primary care needs of low-income communities have been proposed by community health advocates in many states. These proposals could also be taken up by the City with reference to the need to strengthen the primary care workforce in FQHCs serving immigrant neighborhoods.

3. Indigent Care Pool (ICP) and Disproportionate Share Hospital (DSH) payments

In contrast to Massachusetts (see next section), where uninsured individuals apply for support from the state's ICP, payments from the comparable fund in New York State are directed in lump sums to health care institutions. The City's plan to improve access to health care for the remaining uninsured could include a proposal to restructure this state's ICP so

these dollars fund specific care and coverage gaps, or follow individual patients.[24] A related issue is the potential impact of scheduled reductions under the ACA of DSH payments to safety-net institutions and the effect of these reductions on the ICP.

Overview of state and local programs for the uninsured

Five prominent state and local programs for undocumented and other uninsured patients offer useful lessons for New York City. These include city-county programs for the uninsured in Los Angeles, Houston, and San Francisco, as well as state programs for the uninsured in Massachusetts and Nevada.

My Health LA (MHLA) is a no-cost health care program launched in October 2014 that offers comprehensive health care for low-income (at or below 138 percent of the FPL), uninsured county residents, regardless of immigration status or medical condition.[25] MHLA relies on a budget of $61 million per year and does not require out-of-pocket payments or user fees. It offers care through 164 community clinic medical home sites, where patients receive primary and preventive health care services and some diagnostic services. Los Angeles County Department of Health Services facilities also provide County clinic medical home sites, plus emergency, diagnostic, specialty, inpatient services, and pharmacy services. Of the estimated 400,000 remaining uninsured in Los Angeles County, 135,000 are now receiving services through County clinic medical homes, and approximately 145,000 additional patients could be served by MHLA through the community clinic medical homes, for a total of 280,000 potentially served.

Healthy San Francisco (HSF) is a low-income program for San Francisco County residents with incomes up to 500 percent of the FPL regardless of employment status, immigration status, or medical condition.[26] Unlike MHLA, HSF charges a participation fee and point-of-service fee to all patients except for those under 100 percent of the FPL and those who are homeless. (Since 1993, the San Francisco Department of Public Health has provided subsidized/sliding scale services to persons with incomes at or below 500 percent the FPL.) Point-of-service fees vary by medical home; there is one set of fees for all public clinics, while non-public clinics can set their own fees. Point-of-service fee information is provided at the time of enrollment to help applicants make decisions about selecting a medical home. As noted, HSF partici-

pants receive a card with the name of their medical home, plus informational materials. HSF includes a mix of public, nonprofit (voluntary), and for-profit providers, creating a large, interconnected care network. Participating hospitals are asked to document the level of charity care provided, although HSF is not a reimbursement source for hospitals. HSF was launched with the help of major investments by the managed care consortium Kaiser Permanente and other non-public sources. Investment by Kaiser in fiscal year 2013-14 totaled $12 million, for which they were reimbursed $4 million by HSF, contributing $8 million. Kaiser also paid for an actuarial analysis to help determine how to further expand access.

Access Care is the financial assistance program of the Harris Health System, the hospital district that includes the city of Houston.[27] It is open to uninsured Harris County residents and provides access to discounted health care at more than 20 community clinics, a dental clinic, and surgical and other sub-specialty clinics. (A separate, no-cost program provides health care for the homeless.) This scope of services exceeds that of most FQHCs in the area, although wait times for sub-specialty clinic appointments and for elective surgeries can be long. Harris Health System has also invested in a scheduled dialysis clinic for uninsured patients; because a Medicare entitlement covers this diagnosis and treatment for most patients, patients who lack Medicare coverage for dialysis tend to be undocumented. The system also includes one long-term care facility.

In Massachusetts, all immigrants are eligible for some form of health coverage. There is one application for all available programs, including the insurance marketplace. **Mass Health Limited** is the state version of Emergency Medicaid.[28] It is available to undocumented immigrants and some immigrants who are PRUCOL. The **Children's Medical Security Plan**, created by statute in 1996, is financed by the state and offers primary care and preventive services to low income children. The program includes premiums if a patient has an income greater than 200 percent of the FPL. The **Health Safety Net (HSN)** grew out of the state's ICP and was created in 1985

under hospital rate setting to pay for care at acute care hospitals and community health centers. Massachusetts residents earning less than 400 percent of the FPL are eligible for HSN funds, which follow individuals rather than institutions. Patients with incomes between 200-400 percent of the FPL can apply once they incur a health care cost; HSN's Medical Hardship Program can be applied up to a year retrospectively to cover medical debts.

In Nevada, the nonprofit **Access to Healthcare Network (AHN)** offers medical discount programs, specialty care coordination, a health insurance program, non-emergency medical transportation services, a pediatric hematology/oncology practice, and a toll free statewide call center.[29] AHN has 35,000 members, more than half of whom are presumed to be undocumented. To be eligible, members must be at 100-325 percent of the FPL, live and/or work in Nevada, and be ineligible for public insurance such as Medicaid or Medicare. Members pay $35 a month for deeply discounted medical services plus care coordination.

Similarities and differences

Eligibility: All of these programs are targeted to low-income, uninsured residents. HSF stands out as the most generous, with subsidies for people with incomes up to 500 percent of the FPL. (Most local programs for the uninsured are designed for people with incomes within 200 percent of the FPL.) None of the programs target undocumented immigrants explicitly but all are designed to cover uninsured patients who are not eligible for public insurance programs. Program eligibility is structured so it does not crowd out the use of other programs. Individuals must present proof of residence and income but in most cases are not required to provide information about their immigration status.[30]

Financing: All of these programs rely on multiple sources of revenue. The three local programs (MHLA, Access Care, and HSF) are supported by county taxes. HSF is unique because it draws on a fee imposed on businesses that do not provide health insurance

to their employees. The programs in Los Angeles, Houston, San Francisco, and Massachusetts all rely, to varying degrees, on DSH payments scheduled to be reduced under the ACA; this is a potential source of instability for all of these programs. All but one of the programs involves cost sharing, co-payments, and fees. MHLA does not require cost sharing, but is limited to those within 138 percent of the FPL.

Provider networks: All of these programs were launched using existing capital facilities. HSF expanded the public safety-net to establish a public-private partnership that includes private hospitals and physicians.[31] (Past efforts in Los Angeles to create public-private partnerships to care for the uninsured had been politically controversial because organized labor objected to expanding county contracts with private providers.) MHLA and Access Care rely exclusively on public safety-net systems. Nevada is distinctive as a discount program with a broader range of providers.

Care coordination: All of these programs emphasize care coordination. Most programs use some form of primary care medical home to accomplish this. MHLA, as noted, assigns enrollees to a medical home at one of the participating clinics. HSF uses eReferral, a web-based system developed at San Francisco General Hospital, to respond to primary care providers' requests for specialty consultation and identify when a patient should be referred to a specialist and when the issue can be resolved in the primary care setting. This prevents medically unnecessary appointments and as a result reduces wait times at specialty clinics.

Political support: Political support was crucial to creating and sustaining all of these programs. The creation of these programs depended on support from local political champions. In San Francisco, for example, a member of the Board of Supervisors, labor unions, and a host of community organizations formed a coalition that overcame opposition to HSF from the restaurant association and other employer groups.[32]

Based on our review, in collaboration with City stakeholders, of proven or promising models for improving access to health care, with attention to relevant opportunities and challenges, we offer the following recommendations.

The City's plan to improve access to health care for the undocumented uninsured and for other remaining uninsured populations in a fair, effective, and sustainable way should:

Recommendation 1

Improve access to primary and preventive health care, and to specialty care and other services, through primary care medical homes in FQHCs and HHC ambulatory centers networked with specialists and services available in HHC medical centers.

A plan featuring primary care medical homes with points of access in targeted neighborhoods throughout the City, offering linguistically and culturally competent health care and robust care coordination within and across these safety-net systems, will significantly support access to primary care and to some forms of chronic care and post-hospital care. Care coordination, including explicit attention to outreach, enrollment, logistics, and cost, is a shared feature of all proven or promising direct-access models we have reviewed.

Recommendation 2

Explore the potential for the City's municipal ID card to function as an enrollee card for a primary care medical home network for uninsured New Yorkers.

Other direct-access models use cards to link a patient to his or her medical home or to support access to health care in other ways. In view of the popularity of IDNYC among immigrants and the lessons already learned about successful local outreach to this population, taking advantage of the card's popularity and adapting lessons from other systems about the effective use of enrollee cards to promote access can be part of the City's plan.

Recommendation 3

Acknowledge that a primary care oriented medical home solution, while important, will not resolve health care access for undocumented immigrants and other uninsured populations who have medical and related social service needs that significantly exceed the scope of a primary care medical home and that further efforts are needed to close these gaps.

The United States lacks federal policy solutions for affordable access to long-term care and other forms of health care that are needed by people who are aging, disabled, or living with chronic progressive conditions in New York City and throughout the nation. The consequences of ACA-mandated cuts in DSH funding to safety-net providers is another example of a federal policy issue with serious local consequences for access to health care. Mindful of these realities, a City plan to improve access to health care for the undocumented uninsured, and for other uninsured populations, should include attention to transitions from hospital to non-hospital care for patients with chronic conditions who are enrolled in primary care medical homes. This effort could also aim to restructure available safety-net funds to cover certain medical supplies and equipment that are used in chronic care, or on a short-term basis, and for which no payment mechanism exists when a patient is uninsured. This would support the ability of primary care medical home providers and patients to collaborate in the aftermath of hospitalization to support the self-management of chronic conditions and potentially prevent rehospitalization. It would also support the development of hospital discharge plans that are medically and financially feasible, and contribute to the statewide goal of reducing avoidable hospitalizations.

Recommendation 4

Describe explicitly the potential role of the City's major voluntary hospitals in supporting access to health care for the undocumented uninsured and other uninsured populations, with attention to

their current role in emergency and inpatient care and to access problems that exist at the hospital/post-hospital transition.

New York City's highest-volume emergency departments include both HHC hospitals and voluntary hospitals, which means that the provision of health care to uninsured patients, and the challenge of financing this care when a patient's needs exceed the provisions of Emergency Medicaid, is a challenge for hospitals in both sectors. It is also a challenge for voluntary hospitals offering specialized services, such as cancer treatment, to uninsured patients under Emergency Medicaid provisions. Cases involving undocumented uninsured patients are frequently complex cases for hospitals to manage, and the City's plan to improve access to health care for this patient population should include ongoing, focused efforts to better understand how voluntary hospitals manage these cases and whether there are lessons that can be more broadly shared or adapted for a Citywide solution. Further suggestions on integrating these efforts into planning are included in the next section.

Recommendation 5

Integrate new efforts to improve access to primary care for uninsured New Yorkers into current efforts of New York City Performing Provider Systems to meet their DSRIP goals.

A City plan to expand access to health care for the undocumented uninsured should aim to be integrated with safety-net institutions' efforts to meet time-sensitive DSRIP goals. As a first step, New York City PPS governance committees and advisory structures should include representatives from any new program created by the City. The IT infrastructure and online platforms that PPSs will put into place are potential resources for improving care coordination for the undocumented uninsured. The City's primary care medical home plan, once implemented, may serve an important function as a consumer-friendly facet of a PPS, helping the public to better understand how this new structure helps people who are uninsured.

Recommendation 6

Advocate for state-level policymakers to identify a mechanism that will provide health coverage to immigrant populations who remain uninsured.

This report describes how Emergency Medicaid is necessary but not sufficient as a financing mechanism to support health care for uninsured populations, including undocumented immigrants and also other low-income immigrants who are currently ineligible for Medicaid. In the absence of universal coverage, restructuring ICP payments to follow individual patients, as in Massachusetts, is one option for using available safety-net dollars to provide coverage to the remaining uninsured, including those who will not benefit from a local solution because they live outside the City. Another option is to create better incentives for hospitals to account for the charity care they provide. Either option could encourage voluntary hospitals to expand access to health care for the remaining uninsured.

To support the implementation of a City plan during a time of continuing changes in the financing and delivery of safety-net health care, we offer these further observations and suggestions to City stakeholders responsible for program planning, evaluation, and improvement:

Improving public systems

The de Blasio Administration has recognized the need to rethink and reform how public institutions and public dollars are used with respect to legally marginalized populations with complex medical and social needs, such as the chronically mentally ill and the homeless. These ongoing efforts to redesign public systems can also inform the City's new efforts on behalf of undocumented immigrants, another legally marginalized population in need of access to the right systems for their needs.

Anticipating emerging issues in organizational collaboration

The City's plan to improve access to health care for the undocumented uninsured and other uninsured populations will include provisions for data collection, data analysis, and programmatic adjustments, aimed at understanding the effects of this initiative on access, health outcomes, and the cost of care. This plan involves new or deeper collaborations among currently distinct parts of the safety-net system and also involves outreach to a population whose access-related problems are related to factors such as language, culture, and work schedules as well as to lack of insurance. There will be continuing need for expert insight into this emerging model of care and its responsiveness to the population it aims to serve. An interdisciplinary advisory group, including immigrant community representatives and experts in areas such as immigrant health, safety-net health care and health policy, clinical and organizational eth-

ics, and health care advocacy may be helpful to City planners as a mechanism for identifying, discussing, and making recommendations concerning issues as they emerge.

Promoting knowledge sharing and problem solving among public and voluntary hospitals

Recruiting voluntary hospitals in New York City—in particular, academic medical centers with concentrations of specialties and services—as part of the local solution to the unmet health care needs of undocumented uninsured New Yorkers involves encouraging clinicians, administrators, and leaders in these institutions to discuss these challenges openly, so that the scope of the problems different institutions are confronting is better understood by City stakeholders. An invited facilitated meeting could start this process, by providing a forum for discussion of how individual hospitals manage typical and rarer problems in the care of undocumented uninsured patients and whether there are more efficient and/or cost-effective ways of managing these problems collaboratively. Issues that would benefit from discussion among a range of voluntary and public hospitals would include: negotiating discounts on medical equipment from suppliers; negotiating with home care agencies and hospice programs to offer charity-care services to undocumented patients; paying nursing homes directly to accept uninsured patients with short-term needs when discharge to home is not possible; collaborating with legal services organizations and with foreign consulates to determine if an undocumented patient is PRUCOL or to clarify immigration status; and clinical and organizational decision-making concerning retaining patients in the hospital to meet sub-acute and chronic-care needs when discharge is feasible but the potential for deterioration and readmission are high.

NOTES

1. These estimates reflect data provided by City officials to the New York Immigration Coalition (NYIC) and The Hastings Center/Undocumented Patients Project and included in the summary of the December 11-12, 2014 meeting convened by these organizations. These estimates have been cross-checked against the Preliminary Assessment Summary prepared by the Care & Coverage Subgroup of the Mayor's Task Force on Immigrant Health Access. They do not reflect the legal delay in implementing the November 2014 Executive Action; this delay creates a barrier to subsequent enrollment in Medicaid by immigrants who are eligible for DACA or DAPA, and so could increase the estimated number of remaining uninsured. Sources: Meeting Summary, "Undocumented Immigrants and Access to Health Care in New York City: Identifying Fair, Effective and Sustainable Local Policy Solutions," convened by the New York Immigration Coalition (NYIC) and The Hastings Center/Undocumented Patients Project, New York City, December 11-12, 2014 (unpublished working paper reflecting participants' corrections, January 27, 2015); Preliminary Assessment Summary, Care & Coverage Subgroup, Mayor's Task Force on Immigrant Health Access (unpublished draft, February 3, 2015). Estimates are based on previous estimates of the New York City undocumented population and the New York State uninsured population.

2. In New York State, people who are known to the immigration system, do not have status in that system, and meet the requirements for Permanently Residing under Color of Law (PRUCOL) are eligible for state-funded Medicaid.

3. Marion Lewin and Stuart Altman, US Institute of Medicine (IOM), *America's Health Care Safety Net: Intact But Endangered.* Washington, DC: Institute of Medicine, National Academy Press, 2000.

4. A certified application counselor (in HHC, and similarly in FQHCs) or a "navigator" in an organization that receives state funding to offer this service, are both "In-Person Assistors" (IPAs) who help people complete insurance applications. Certified application counselors can target low-income and other specific populations and are paid by the organization they work for. Navigators are required to serve all income levels and are compensated by the state/federal marketplaces.

5. For some procedures, there is a financial benefit to being uninsured in the HHC system versus having insurance with a high co-pay/deductible. For example, an uninsured patient will pay $400 out of pocket for an MRI, while an insured patient will pay $2000.

6. This report's use of the term "medical home" (sometimes known as a primary care medical home, a patient-centered medical home, or a PCMH) corresponds to this standard definition of a model designed to meet "the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care." See: Agency for Healthcare Research and Quality (AHRQ), "Defining the PCMH," Webpage: http://pcmh.ahrq.gov/page/defining-pcmh Accessed March 26, 2015. This report's use of the term "care coordination" corresponds to this standard definition: "Care coordination in the primary care practice involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care." See: Agency for Healthcare Research and Quality (AHRQ), "Care Coordination," Webpage: http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html Accessed February 27, 2015.

7. Voluntary hospitals in New York State have also received Indigent Care Pool (ICP) funds, which they have used to cover uncompensated (charity) care and their losses from unpaid bills (bad debt). See discussion of Massachusetts approach (Section 3); see also Recommendations (Section 4).

8. For example, Memorial Sloan Kettering Cancer Center does not have an ED that is open to the public and so does not admit patients through an ED. It does have provisions for uninsured patients.

9. Emergency Medicaid is not available to individuals who exceed the income limit for Medicaid.

10. The NYS Center for Primary Care Informatics (CPCI) data warehouse, established by CHCANYS, supports the targeting, design, and implementation of improvements within FQHCs. It builds on FQHCs' electronic health record (EHR) systems and includes clinical, operational, and financial data from participating FQHCs. More than half of the state's FQHCs are part of this ongoing effort.

11. Undocumented immigrants are not explicitly ineligible for organ transplants due to their immigration status. Because there are limits on organ transplants to "foreigners" to discourage medical tourism, transplant centers often perceive that putting undocumented immigrants and other noncitizens on waiting lists for organs may expose centers to risk during audits. This is another barrier to organ transplantation for this population, in addition to their lack of coverage.

12. Memorial Sloan Kettering Cancer Center is documenting this problem.

13. This report reflects the scope of the Care & Coverage Options subgroup of the Mayor's Task Force on Immigrant Health Access. It does not address in detail the challenges of linguistic and cultural competency as these relate to access to health care for the undocumented uninsured, as these important issues were addressed by the subgroups on Barriers to Health Care for Immigrants and on Language Barriers to Health Care for Immigrants.

14. New York State Department of Health, *The Patient-Centered Medical Home Initiative in New York State Medicaid.* Report to the Legislature, April 2013. Available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/pcmh_initiative.pdf Accessed February 15, 2015.

15. Of particular relevance to uninsured populations are the "11th Projects," which will support outreach to and engagement of Medicaid enrollees and uninsured individuals who are infrequent users of health care. Public hospitals are offered the first right of refusal for implementing an 11th Project.

16. The 11th Project was the most significant addition to the DSRIP project list, and was announced in August 2014. See: Greater New York Hospital Association, "DOH Adds 11th Project to DSRIP Options," Press release, August 11, 2014. Available at: http://gnyha.org/PressRoom/Publication/0ced3dfa-d37e-409a-b380-c7ef83a0735c/ Accessed February 26, 2015; Kate Breslin, "Overview of the Delivery System Reform Incentive Payment Program (DSRIP)," Presentation, September 10, 2014. Available at: http://www.scaany.org/wp-content/uploads/2014/09/DSRIP-PowerPoint_091014.pdf Accessed February 26, 2015.

17. Nancy Berlinger and Rajeev Raghavan, "The Ethics of Advocacy for Undocumented Patients," *Hastings Center Report* 43, no.1 (2013): 14-17.

18. Alan Sager, "Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients," Report, August 31, 2011. Available at: http://www.cphsnyc.org/cphs/reports/paying_new_york_state_hospitals/Sager_Paying_New_York_StateHospitals_More_Fairly_for_Their_Care_of_Uninsured_Patients_FINAL31Aug11A.pdf Accessed February 26, 2015.

19. See: "About IDNYC," Webpage: http://www1.nyc.gov/site/idnyc/about/about.page Accessed February 26, 2015.

20. *Aliessa v. Novello*, 96 N.Y.2d 418, 422 n.2 (2001).

21. On immigration status and corresponding benefits, see: Empire Justice Center, "Health Coverage Crosswalk: Eligibility by Immigration Status," Report, March 2013. Available at: http://www.empirejustice.org/assets/pdf/publications/reports/health-coverage-crosswalk.pdf Accessed February 27, 2015.

22. New York State Senate Majority, "Finance Committee/Counsel Staff Analysis of the FY 2016 Executive Budget," Report, January 2015: 56. Available at: http://www.nysenate.gov/files/pdfs/Whitebook%20FY%202016%20FINAL%20with%20cover3.pdf Accessed February 26, 2015.

23. These neighborhoods are: Fordham/Bronx Park, Crotona/Tremont, High Bridge/Morrisania, and Hunts Point/Mott Haven in the Bronx; Bedford-Stuyvesant/Crown Heights, East New York, Sunset Park, East Flatbush, and Williamsburg/Bushwick in Brooklyn; East Harlem, Central Harlem/Morningside Heights, and Washington Heights/Inwood in Manhattan, and Long Island City/Astoria, West Queens, Flushing/Clearview and Jamaica in Queens. Source: CHCANYS.

24. Alan Sager, "Paying New York State Hospitals More Fairly for Their Care to Uninsured Patients," August 2011. Available at: http://www.cphsnyc.org/cphs/reports/paying_new_york_state_hospitals/Sager_Paying_New_York_StateHospitals_More_Fairly_for_Their_Care_of_Uninsured_Patients_FINAL31Aug11A.pdf Accessed March 25, 2015; see also Richard Daines "A Report on the Hospital Indigent Care Pool As required by Chapter 58 of the Laws of 2007," January 2008. Available at: http://www.health.ny.gov/facilities/hospital/indigent_care/docs/indigent_care_report.pdf Accessed February 26, 2015.

25. Health Services for Los Angeles County, "My Health LA," Webpage: http://dhs.lacounty.gov/wps/portal/dhs/mhla Accessed February 26, 2015.

26. Healthy San Francisco, "About HSF," Webpage: http://healthysanfrancisco.org/ Accessed February 26, 2015.

27. Harris Health System, "Access Care," Webpage: https://www.harrishealth.org/en/patients/access-care/pages/default.aspx Accessed February 28, 2015.

28. These programs are described on the website of Health Care For All (HCFA), "Who We Are," Webpage: https://www.hcfama.org/who-we-are Accessed February 26, 2015.

29. Access to Healthcare Network (AHN), "Access to Healthcare Network," Webpage: http://www.accesstohealthcare.org/ Accessed February 26, 2015.

30. Harris County's Access Care requires applicants to "show current or expired documents from the U.S. Citizenship and Immigration Services" if these documents exist. (See Access Care website, under "Eligibility.") The program's policy manual states that "Persons who claim to be undocumented and who have no USCIS documents to prove their legal residence in the United States are eligible for assistance if all other verifications are provided and if they are permanent resident[s] of Harris County." (4) Available at: https://www.harrishealth.org/SiteCollectionDocuments/eligibility/policies/ineligible-residents.pdf Accessed February 28, 2015.

31. Dennis Andrulis and Michael Gusmano. *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?*, New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, 2000.

32. Quynh Nguyen and Michael Miller, "Healthy San Francisco: A Case Study of City-Level Health Reform," Report by Community Catalyst, August 2008. Available at: http://www.communitycatalyst.org/docstore/publications/healthy_san_francisco_sept_2008.pdf Accessed February 27, 2015.

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The Center's Undocumented Patients Project provides analysis, commentary, and resources on issues of access to health care for this population. www.undocumentedpatients.org

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NEW YORK IMMIGRATION COALITION

The New York Immigration Coalition, which includes nearly 200 member groups, is an independent nonprofit organization founded in 1987 to promote immigrants' full civic participation, foster their leadership, and provide a unified voice and a vehicle for collective action for New York's diverse immigrant communities. www.thenyic.org