

BOARD OF DIRECTORS MEETING
THURSDAY, SEPTEMBER 24, 2015
A•G•E•N•D•A

<p><u>CALL TO ORDER - 4 PM</u></p> <p>Call for a Motion to Convene in Executive Session</p> <p><u>Executive Session / Facility Governing Body Report</u></p> <ul style="list-style-type: none"> ➤ Woodhull Medical and Mental Health Center <p>Semi-Annual Governing Body Report (Written Submission Only)</p> <ul style="list-style-type: none"> ➤ Lincoln Medical and Mental Health Center ➤ Gouverneur Healthcare Services <p>Diagnostic & Treatment Center Annual Quality Assurance Plan / Evaluation 2014 (Written Submission Only)</p> <ul style="list-style-type: none"> ➤ Cumberland Diagnostic & Treatment Center 	<p>Mr. Campbell</p>
<p><u>OPEN SESSION – 5 PM</u></p> <p>1. Adoption of Minutes: July 30, 2015</p>	<p>Mr. Campbell</p>
<p><u>Acting Chair’s Report</u></p> <p><u>President’s Report</u></p> <ul style="list-style-type: none"> ➤ Information Items: ✳ The Joint Commission Multi-Facility Survey of HHC - 2015 Presenter: Caroline Jacobs, Senior VP, Safety & Human Development <p>>>Action Items<<</p>	<p>Mr. Campbell Dr. Raju</p>
<p><u>Corporate</u></p> <p>2. RESOLUTION adopting the Corporation’s Mission Statement and Performance Measures as required by the Public Authorities Reform Act.</p>	<p>Mr. Campbell</p>
<p>3. RESOLUTION amending a previously adopted resolution in order to increase the authorization for one or more borrowings in an aggregate not to exceed amount from \$60,000,000 to \$120,000,000 and to expand the scope of allowable uses. <i>(Finance Committee – 09/08/2015)</i></p>	<p>Mr. Rosen</p>
<p>4. RESOLUTION authorizing the New York City Health and Hospitals Corporation, through its President, to delegate to each hospital's Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through each hospital's Quality Assurance process to the Board of Directors <i>(Med & Professional Affairs / IT Committee – 09/10/2015)</i></p>	<p>Dr. Calamia</p>
<p>5. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to enter into a sole source agreement with SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed \$4,769,555 (which includes a contingency reserve of \$229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms. <i>(Med & Professional Affairs / IT Committee – 09/10/2015)</i> EEO: Approved / VENDEX: Pending</p>	<p>Dr. Calamia</p>
<p>6. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to procure and outfit eighty-nine (89) ambulances in Fiscal Year 2016 on behalf of the Fire Department of the City of New York (“FDNY”), through City-wide Requirements Contracts for a total amount not-to-exceed \$34.8 million. <i>(Capital Committee – 09/17/2015)</i></p>	<p>Ms. Youssouf</p> <p>(over)</p>

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<p><u>Generations Plus/No. Manhattan Health Network</u></p> <p>7. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to proceed with the construction and procurement necessary for renovation of an existing 23,000 square foot space on the 13th floor in the Martin Luther King (MLK) Pavilion, to create an inpatient geriatric friendly unit at Harlem Hospital Center for an amount not-to-exceed \$3,261,000. <i>(Capital Committee – 09/17/2015)</i></p>	<p>Ms. Youssouf</p>
<p><u>South Manhattan & Queens Health Networks</u></p> <p>8. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with the New York City Police Department for its use and occupancy of approximately seventy-five square feet of space to operate radio communications equipment at Elmhurst Hospital Center with the occupancy fee waived. <i>(Capital Committee – 09/17/2015)</i></p>	<p>Ms. Youssouf</p>
<p>9. RESOLUTION amending the June 2014 Resolutions of the Board of Directors of the New York City Health and Hospitals Corporation by which the President of the Corporation was authorized to execute five successive one-year revocable license agreements with the New York City Human Resources Administration (“HRA”) for the use and occupancy of space for primary care programs located at 413 East 120th Street, Borough of Manhattan and 114-02 Guy Brewer Boulevard, Borough of Queens administered by Metropolitan Hospital Center and Queens Hospital Center to (a) increase the base occupancy fee to be paid by \$1.00 per square foot for a total annual occupancy cost of \$96,873 or \$35.38 per square foot for the East 120th Street clinic and for a total annual occupancy cost of \$270,593 or \$27.25 per square foot for the Guy Brewer Boulevard clinic where in both cases the total annual occupancy fees are inclusive of surcharges for electricity, air conditioning and after-hour uses; and (b) extend the authorization for the President to execute renewals for an additional year to allow for renewals through 2020. <i>(Capital Committee – 09/17/2015)</i></p>	<p>Ms. Youssouf</p>
<p>10. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to approve a Capital Project for an amount not to exceed \$3,885,000 for planning, pre-construction, design, construction management and project management services necessary for the installation of two (2) new electric air cooled chillers for Operating Rooms at Bellevue Hospital Center. <i>(Capital Committee – 09/17/2015)</i></p>	<p>Ms. Youssouf</p>
<p><u>Committee Reports</u></p> <ul style="list-style-type: none"> ➤ Capital ➤ Community Relations ➤ Finance ➤ Medical & Professional Affairs / Information Technology ➤ Strategic Planning 	<p>Ms. Youssouf Mrs. Bolus Mr. Rosen Dr. Calamia Mrs. Bolus</p>
<p><u>Subsidiary Board Report</u></p> <ul style="list-style-type: none"> ➤ HHC Accountable Care Organization (ACO) ➤ HHC Assistance Corporation/OneCity Health Services – CSO 	<p>Dr. Raju Dr. Raju</p>
<p>>>Old Business<< >>New Business<<</p>	
<p>Adjournment</p>	<p>Mr. Campbell</p>

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 30th day of July 2015 at 4:00 P.M. pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Mr. Gordon J. Campbell
Dr. Ramanathan Raju
Dr. Mary T. Bassett
Mrs. Josephine Bolus
Dr. Jo Ivey Boufford
Dr. Vincent Calamia
Mr. Robert Nolan
Mr. Mark Page
Mr. Bernard Rosen

Jennifer Yeaw was in attendance representing Commissioner Steven Banks and Udai Tambar was in attendance representing Dr. Lilliam Barrios-Paoli, each in a voting capacity. Mr. Campbell chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

Mr. Campbell received the Board's approval to convene an Executive Session to discuss matters of personnel and quality assurance.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Mr. Campbell reported that, 1) the Board of Directors, as the governing body of Queens Hospital

Center, received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report presented; 2) as governing body of Kings County Hospital Center, the Board reviewed and approved its semi-annual written report; 3) as governing body of Susan Smith McKinney Nursing Home and Rehabilitation Center, the Board reviewed and approved its semi-annual written report; and, 4) as governing body of Segundo Ruiz Belvis Diagnostic and Treatment Center, the Board reviewed and approved its annual performance improvement plan and 2014 evaluation.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on June 18, 2015 were presented to the Board. Then on motion made by Mr. Campbell and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on June 18, 2015, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

Mr. Campbell announced that Barbara Lowe, the Manhattan City Council designee, will be joining the Board in September. He also introduced Mr. Udai Tambar, who is Chief of Staff to Deputy Mayor Lilliam Barrios-Paoli and who is representing her on the Board.

Mr. Campbell updated the Board on approved and pending Vendex.

Finally, on behalf of the Board, Mr. Campbell thanked Mrs. Josephine Bolus for attending the dedication ceremony for the Ida G. Israel Clinic in Coney Island, as well as the Marjorie Matthews Award ceremony at Coler Rehabilitation and Nursing Care Center.

PRESIDENT'S REPORT

Dr. Raju's remarks were in the Board package and made available on HHC's internet site. A copy is attached hereto and incorporated by reference.

INFORMATION ITEM

Mr. Sal Guido, Acting Corporate Chief Information Officer, provided the Board with an update on the Corporation's Epic implementation.

ACTION ITEMS

RESOLUTIONS

2. Authorizing the President of the New York City Health and Hospitals Corporation to approve and appoint **Citigroup, JP Morgan and Morgan Stanley & Co.** to provide **investment banking services** and serve as **senior managing underwriters**, and to approve and appoint **BNY Mellon Capital Markets, Blaylock Beal Van, LLC, Drexel Hamilton, LLC, Fidelity Capital Markets, FTN Capital Markets, First Southwest, Janney Montgomery Scott, Jefferies, LLC, Loop Capital Markets, LLC, Mischler Financial Group, Ramirez & Company, RBC Capital Markets, Rockfleet Financial Services, Roosevelt & Cross, Inc., Stern Brothers, TD Securities and Wells Fargo Securities** to serve as **co-managing underwriters** for the Corporation's debt issuances from August 2015 through July 2020 to support its capital finance program.

Such authorization in respect to the entities mentioned above shall extend to the successors of any such entities which assume the business of such entities through merger, reorganization, consolidation or acquisition.

Further authorizing the President to negotiate and execute a contract with one of the three senior underwriters in the event of a Board authorized issuance.

Mr. Rosen moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

3. Authorizing the President of the New York City Health and Hospitals Corporation to enter into multiple contracts to **purchase health information related professional services** for the **Epic Electronic Medical Record program** and Epic related Revenue Cycle modules, as needed with 20 vendors through requirements contracts for a two year term with three one-year options to renew at the Corporation's exclusive option for an amount not to exceed \$119,292,988 million for the initial two-year period.

Dr. Calamia moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

4. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable five year **license agreement** with **Visiting Nurse Service of New York Hospice Care** for its continued use and occupancy of approximately 12,420 square feet of space on the 7th Floor of the Hospital Building at **Bellevue Hospital Center** to operate a hospice program at an annual occupancy fee of \$53.58 per square foot or \$665,436 for year one of the agreement, \$55.12 per square foot or \$684,534 for year two, \$56.70 per square foot or \$704,180 for year three, \$58.59 per square foot or \$727,630 for year four and \$59.90 per square foot or \$744,000 for year five, for a total five year occupancy fee of \$3,525,780.

Mr. Page moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

5. Authorizing the President of the New York City Health and Hospitals Corporation to issue a five year revocable **license agreement** with **Sirius XM Radio, Inc.** for its use and occupancy of 90-square feet to house roof-top communications equipment at the **Henry J. Carter Specialty Hospital and Nursing Facility** at an occupancy fee of approximately \$23,130 or \$257.00 per square foot for year one; \$23,823 or \$264.71 per square foot for year two; \$24,823.62 or \$272.65 per square foot for year three; \$25,274.78 or \$280.83 per square foot for year four; and, \$26,033.02 or \$289.26 per square foot for year five, for a total five year occupancy fee of \$122,800.31. Annual increased rates are based on 3% escalations per year.

Mr. Page moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

RESOLUTION

6. Authorizing the President of the New York City Health and Hospitals Corporation to **approve a Capital Project** for an amount not-to-exceed \$8,500,000 for the planning, pre-construction, design, construction, procurement, construction management and project management services necessary for the installation of **Permanent Emergency Power Feeders project** at **Woodhull Medical and Mental Health Center**.

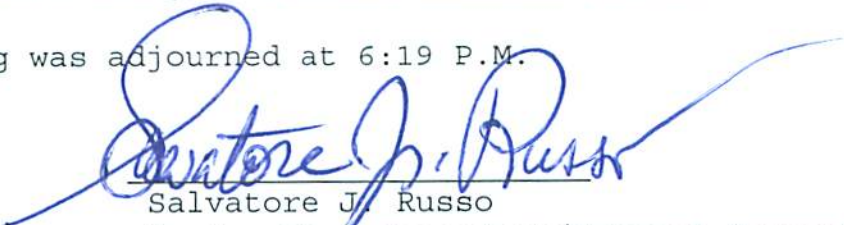
Mr. Page moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

SUBSIDIARY AND BOARD COMMITTEE REPORTS

Attached hereto is a compilation of reports of the HHC Board Committees and Subsidiary Boards that have been convened since the last meeting of the Board of Directors. The reports were received by Dr. Raju at the Board meeting.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:19 P.M.


Salvatore J. Russo
Senior Vice President/General Counsel
and Secretary to the Board of Directors

COMMITTEE REPORTS

Audit Committee – June 11, 2015

As reported by Ms. Emily Youssouf

Ms. Youssouf began the meeting by pointing out that there were no action items, but a number of information items. The first one being the KPMG 2015 audit plan. She asked for them to introduce themselves. They did as follows: Maria Tiso, Engagement Partner; Jim Martell, Client Service Partner and Joe Bukzin, Lead Senior Manager on the account.

Ms. Tiso began by stating that I am going to start on page two of the plan. As it relates to KPMG engagement team, probably all of the individuals on this slide are continuity. They are staff professionals that have serviced the Corporation in the past and will be returning to the engagement this year. As part of our team, we use subject matter professionals as it relates to various areas that require management's estimates and judgments. So we have subject matter professionals help us in the area of tax, IT, reimbursement and OPEB. We also have a second party review that reviews the various sets of financial statements that we will be issuing and also healthcare and technicality resources as it relates to technical topics that we encounter during the audit.

Page three are the deliverables that we will issuing which are outlined in the contract we signed with the Corporation. They are consistent to what we issued in the prior year except for the HHC ACO. That deliverable was not issued last year because it was in start-up – this will be the first year we will be issuing that financial statement. Page four is the objective of an audit. It is to express an opinion on the financial statements, making sure that the financial statements are materially stated. We do look at internal controls in order to render an opinion. The next couple of slides, pages five, six, and seven go through the responsibilities of management, KPMG and the Audit Committee. I am not going to go through all of them. Just briefly, management's responsibility is to make sure the financial statements are accurate, all the footnote disclosures are in accordance with GAAP, maintaining effective controls and making sure that all the financial records are appropriate. If there are any material adjustments, that they are recorded on a timely basis and giving the auditors access to all of the information as we conduct our audit. Your responsibility is one of oversight and monitoring – you rely both on your internal auditors, your external auditors, your management team as it relates to the fair presentation of the financial statements. Page eight talks about independence. As your auditors, we have to maintain independence as it relates to the Corporation and affirming that we are independent as it relates to the Corporation. We have various systems in place to make sure we monitor that throughout the year. At this point Mr. Bukzin will walk through the time line as it relates to the 2015 audit.

Mr. Bukzin saluted everyone and said that starting on page nine we have the start of our audit time line. In the April through June period, this is where we are having our meetings with management, having discussions internally as well as determining the overall audit approach. Working though the review from an IT perspective and obviously today we are here to present the audit plan. In the June through July time period, this is where we are spending most of our time visiting the site locations, doing some of our detailed testing and touching upon some of the key controls. We will also work closely with Mr. John's team during the audit to address any non-routine actions, which are described on a couple of pages later on.

Ms. Youssouf asked to give an example of the walk through. Mr. Bukzin responded that one of them is of the DSRIP program. That will be something that we will be working closely with the organization to review the account. Ms. Tiso added that it is very gray at this point of the accounting treatment of DSRIP and how the entire payment process works. Obviously the payment process is different for every health care system. Some are getting payment directly to the PPS, and others the PPS has to send payments to their downstream providers. We are actually going to consult with our national office and will also be consulting with other accounting firms to make sure that we are consistent in giving advice and consultation to our clients as to how the DSRIP dollars should be recorded. In speaking with Mr. John that payment is supposed to be arriving today for HHC, we will be working with his team regarding the accounting treatment of it.

Ms. Youssouf asked how much today? To which Mr. John answered that we expect \$330 million, the net is about \$110 million because we paid \$167 million yesterday and we are going to be paying another \$50 million in another two weeks.

Ms. Tiso stated that another matter is the upper payment limit funding. Every year we spend a lot of time with the management team making sure we have enough corroborative evidence to make sure it is an appropriate item on the financial statement to record. Sometimes the appropriate documents are not available at the time we are signing off. The other items are FEMA awards, the potential sale of the dialysis services, EPIC implementation and then Gotham FQHC, we will look at that to make sure that it is recorded appropriately.

Ms. Youssouf asked that you say EPIC implementation, are you looking at how we spent the funds allocated to EPIC installation and so forth?

Ms. Tiso responded that we look at the general IT controls to make sure that there is access controls, passwords, making sure it was configured appropriately.

Mr. Bukzin added that my understanding is that the implementation is going to occur in the 1st Quarter of 2016. We started to have some conversations up front this year but we would expect perhaps next year that there may be more involvement once the system is up and running and live. We will have to include that as part of the work.

Ms. Zurack commented that I think there is a little confusion – you do routine IT audits because our financial information is driven by what is in our IT system. You need to make sure that that information is correct as distinguished from doing a real program audit of the EPIC implementation, which is not your scope.

Ms. Tiso stated exactly – it is more around IT controls, we do not look at the operation aspects of that.

Mr. Campbell asked that problematically EPIC would not be part of the KPMG's engagement other than the Board, not to minimize the Board's role, is there any other auditor or any other review?

Mr. Martin responded yes, I have asked the Mayor's Office of Information and Technology to do a financial audit on EPIC implementation.

Ms. Zurack said that as part of that process we are developing a standard format report on the EPIC budget and spending that it is going to be programmed out of the mainframe so that we will have consistent reporting for all of the internal board committees as well as for the City. That is why I wanted to make the distinction because the KPMG piece is sort of a routine thing. They have to check our IT system because our data comes from them.

Mr. Telano added that Dr. Raju has asked internal audit to look at the budget and expenses related to the EPIC project. We have been on that project for about two months now.

Mr. Bukzin stated that we will looking at the accounting for those particular costs depending on what type of expenses were incurred. Some of those costs may be capitalized rather than expensed.

Ms. Youssouf asked if that is something you will look at. To which Ms. Tiso answered yes, that from a financial reporting perspective we will look at it.

Mr. Bukzin said that we jumped ahead and covered many of the items on page 13. Jumping back to a couple of previous pages - the audit time line. I can generally comment that the timing is consistent with what we have done in the past in terms of our reporting style and when we would meet with the committee to communicate results, present the management letter and go over the financial statements. Page 12 highlights where we spend a significant portion of our time during the audit process. These are significant audit areas in terms of where there is significant management judgment involved or estimations or specialists involved such as actuaries and third-party reimbursement issues. Page 14 highlights some of the other members or other organizations that assist us as part of the audit process. We are still working through confirming the minority business enterprise and their scope of work in terms of assisting us with some of the cost report work. We did have a kick off meeting with the internal audit team to discuss their role and the women's business enterprise consistent with the prior year they will assist us with the third-party reimbursement issues.

Ms. Youssouf asked how much time of internal audits you will be asking for. To which Mr. Telano responded that we assign one individual for ten weeks to assist them.

Ms. Tiso added that that is consistent to what we have utilized in the past and what is in the contract also.

Mr. Bukzin continued with page 15 which describes some of our general considerations related to risk of fraud in a financial statement audit. If during the course of performing some of these procedures something comes to our attention, we would be required to communicate and describe that and discuss it and assess how it will affect the audit. This is consistent with our audit approach in the prior years. Page 16 highlights the key members of management of the organization where we would discuss the risk of fraud and ask those hard pressing questions and see if there is anything out there that we would need to be made aware of as we go through the audit process. Page 17 and 18 describes our responsibility as well as management's responsibility with regards to liquidity and the risk of going concern. If you were a stand-alone hospital system there would be a different angle from going concern risk. But because you are a component unit of the City that helps from an audit documentation perspective to alleviate the risk of when you are reviewing the financials you would see losses and that net deficit position. We look at a number of things besides just the certain financial statement metrics – we consider the overall picture.

Ms. Tiso said that on page 18 is some of the information we request so that we document appropriately the going concern factor would be 2016 budgets and cash flow projections. We will speak to management and get their representations about what management's future plans are as it relates to the organization.

Ms. Youssouf asked that does that mean? Do you have the ability to look at any meeting from the City or any minutes? Ms. Tiso answered no, we do not look at the City's minutes but we look at the Corporation's minutes.

Mr. Martell added that the issue is, this is documentation from KPMG's perspective. Management has a business plan, a strategy and so forth. As Mr. Bukzin said, if you take a step back, forgetting about the organization is somehow related to the City, the continuing losses, of \$400 to \$500 million a year, obviously is always on the minds of management and are always looking for ways to reduce it. That is what we also look for as part of our overall conclusion. Unfortunately, the industry is not very conducive for an organization like HHC to turn the ship immediately. But that is something that is really secondary, everything here is a documentation to make sure that you will get a clean or unmodified opinion. Then you get to the next step, the operational side which management works on.

Mrs. Bolus asked if the information goes to the EEO Committee. To which Ms. Tiso responded that KPMG sends a certification to your committee as it relates to the minority business, the women business enterprise. I think that is part of the contract, certain information is requested from KPMG. I think it is on a quarterly basis because I get copied on it.

Mr. Martin commented that he would look into that.

Ms. Zurack stated that the way you guys left it you will have an MBE working on the cost reports and a WBE working on third party liabilities and you will meet your subcontractor requirements. I think you said you may not have identified the individual. When you presented this you were less than definite.

Ms. Tiso said that everybody has been identified and scheduled at this point.

Mr. Bukzin continued with the last slide – the new accounting announcements. We will work closely with management to assess the impact that these will or may have on the organization. So we are still going through that process right now.

Ms. Youssouf asked if there was anything in the report that required an explanation to the Committee. We talked about GASB 69, do you want to talk about GASB 70 or GASB 71? Mr. Bukzin answered that GASB Statement 70 talks about the non-exchange of financial guarantees. If one governmental organization guarantees an obligation of another entity that may require the guarantor to record a liability. So there is an assessment of probability and likelihood that you would actually have to step in their shoes and actually have to pay on behalf of the other organization. That is just an example of GASB 70.

Ms. Youssouf asked if that could be a slight issue. Ms. Tiso said that we are going to work through management to see how it affects the Corporation.

Mr. Bukzin stated that the last one in terms of fair value consistent with GASB perspective the fair value is now defined as what a market participant would pay for a particular asset or satisfy a particular liability. It is just redefining how fair value is from a market participant perspective.

Ms. Youssouf asked if that means our assets have to be reassessed. Mr. Bukzin answered not necessarily, I think a lot of it has to do with disclosure requirements. Your investments requirements for example are going to be recorded at fair market value, fixed assets stay the same.

Ms. Youssouf said that I was asking about fixed assets. Ms. Tiso responded that from our perspective it is more for disclosure changes more than anything changing on the balance sheet. This is early adoptions, it does not really apply for this year's audit and that concludes our presentation.

Ms. Youssouf thanked them and turned the meeting over to Mr. Telano for the audit update.

Mr. Telano saluted everyone and stated that on page three of the briefing is the audits currently being conducted by the New York City Comptroller's Office. The first audit we will discuss is of the affiliation agreement between PAGNY and Lincoln Medical Center. The start date of this audit was July 19, 2013, we received the final draft report on June 1, 2015. The audit took almost two years to complete, the responses to the report are due on Monday, June 15th. Although the report states that PAGNY generally complied with its HHC affiliation agreement to provide services at Lincoln Hospital, there were numerous issues noted resulting in ten recommendations in total. The most significant finding was that \$1.9 million was paid inappropriately to subcontractors because there was either insufficient documentation to support the payments or the services were not provided according to the terms of the subcontractor agreements. The recommendation to that finding is, once again I am quoting, "PAGNY should recoup those payments in which they are unable to verify those services rendered". There are other findings in the report that I will summarize. PAGNY was paying subcontractors without a service agreement, the maintenance of the faculty practice plan bank account was not adequately controlled or monitored, the audit of PAGNY's financial statements by an independent CPA firm were not completed timely or in accordance to their agreement with HHC, the recalculation of affiliate payments were not completed timely for fiscal years 2012 and 2013, and sessional payments were not consistent with the collective bargaining agreement with the physicians union. Overall, there were ten recommendations. PAGNY was responsible for responding to six of them while HHC was responsible for four of them.

Ms. Youssouf asked which ones HHC responsible was for. Mr. Telano responded that there were three recommendations regarding the Faculty Practice Plan (FPP) and the other was to make sure that PAGNY does their job related to the subcontractor agreements.

Mr. Campbell asked what is our response or plan vis-à-vis. Mr. Telano answered that we just received the response yesterday and right now we are going over them and they will be blue-sheeted tomorrow. Mr. Martin will receive them, along with Mr. Russo, it then ends up in Dr. Raju's office.

Ms. Youssouf asked what department is responsible for the responses. Mr. Telano said that three of the four responses for HHC is by Office of Professional Services and Affiliations and the other one is being given by Lincoln Hospital, the affiliation liaison there.

Mr. Campbell asked if the committee gets the responses. To which Mr. Telano answered that they will receive the entire report. Those responses will be in the final report issued by the Comptroller's office and they attach the final responses from us. But they will be disseminated to executive management before they are sent out.

Ms. Youssouf asked if the entire report will be sent to the committee. Mr. Telano said yes.

Ms. Youssouf asked if there was anyone here from PAGNY. Mr. Telano responded that I do not think so. I think there has been improvement. We did the audit of the corporate PAGNY operations and had minimal findings, mostly recordkeeping related. In the two or three years that we have been doing the PAGNY audits, we have seen vast improvement in their operations.

Mr. Martin added that they still are not where they need to be, and I responded to you when we did the medical professional fair presentation but they are making continued improvement.

Ms. Youssouf stated that obviously internal audit is going to be continuously reviewing them to be sure they are getting to where other affiliations are with this.

Mr. Telano added that we are currently conducting the affiliation audits and in September's meeting we expect to be discussing those final reports. Mr. Telano continued on to page four which is the other audit being conducted which is closed now. It is not being conducted by the Comptroller's office. They decided not to continue doing the review of patients revenue and accounts receivable as we refused to provide all the protected health information and resolve the conflict they decided not go further. On the next page starts the audits that have been conducted by internal audits since the last meeting. First is the audit of patient transportation at Metropolitan. He asked the representatives to approach the table.

Ms. Youssouf asked them to introduce themselves, they did as follows: Keith Tallbe, Office of Legal Affairs and Supply Chain; Jeanette Torres, Assistant Director; Michelle Figueroa, Senior Associate Director; Susan Callymore, Associate Director; Edie Coleman, Controller.

Mr. Telano continued by stating that central office supply chain services contracts with ambulances who are responsible for bed-bound patients and ambulettes who handle patients who cannot walk or need medical assistance. During the course of the audit there were 34 transportation contracts and we limited our audit to Metropolitan for four of the contracts. I will go over the audit findings and you can respond to it. The first one was about the background checks of the transportation drivers from Hope Ambulette had criminal history that we believe deem them unsuitable to work in a health care environment. The current procedure right now is HHC receives an affidavit from the vendor stating that the background checks were done. We visited the vendors ourselves and we looked at the background checks and determined that some of those individuals had history of robberies and assault and sale of controlled substances and trespassing.

Mr. Tallbe stated that I reached out to Hope Ambulette regarding the three drivers. The one driver who had not had a background check performed has had a background check performed and there is no criminal history for that driver. The driver that had several crimes listed is no longer working on HHC accounts and the third driver had a very old crime dating back to 1981, which was a first degree attempted assault. That driver has been approved to work according to New York State's 8 Point Guideline of when considering whether a criminal background should disqualify a person from employment.

Mr. Martin stated that I believe the issue is what are going to do moving forward in the future. Is that your responsibility to check and assure that the background checks are done prior to employing these people?

Mr. Tallbe said that this goes to the next finding – that is why I did not address it here. Mr. Martin said that I stand corrected, sorry.

Mr. Telano continued with the next finding which is the licenses and the certificates of liability insurance are not kept current, and as a result, there was a three month lapse that Metropolitan was using General Ambulette in which there was no contract signed. The other finding has to do with HHC paying for patients that were non-Medicaid patients. We reviewed 99 of these transactions. It was found that the first 38 of the trips were approved and paid for a higher rate than agreed to per the vendor agreement. Six of the invoices were paid for patients who were covered by Medicaid and HHC should not have paid the fee. There were nine instances in which there was no documentation within the medical records that the patient needed transportation and there was one instance in which there no record that the patient was at Metropolitan Hospital as of the date of service. Also, there were missing forms that they did not provide.

Ms. Youssouf stated that as Mr. Martin just commented, what is the remediation and who is going to make sure that it is in place. Mr. Tallbe answered that the remediation regarding General Ambulette is that specific provider no longer has a contract with HHC. As to the process going forward is that the agreement the vendor signed currently requires that they do a minimum background check in all New York State counties, as well as a criminal background check for any state the driver has lived in within the past three years. Any driver who is hired, they are required to provide us with a certificate stating that driver was hired despite their criminal background and why. That process has not been sufficiently monitored by supply chain currently and we are going through each vendor's certificate and their roster of drivers to make sure it will be and our deadline on that is mid-July.

Ms. Youssouf asked if we rely on the ambulette service to do the background check. To which Mr. Tallbe said that is correct.

Mr. Campbell asked if the background check is done every year. Mr. Tallbe stated the background check is performed by the vendor. So in terms of their periodicity of reviewing their own drivers' background, I believe that is annual. We have not firmed up what we will be requiring as a base minimum for the vendor's policies and procedures. But part of our process going forward is to review each company's policy and procedure for their background check and making sure it meets a base minimum that disqualified all drivers. That bare minimum disqualification standard is going to be based on New York State Justice Center. New York State Justice Center is a New York State agency for employment with certain other state agencies. Those state agencies use drivers in similar capacity that we use our drivers, one-on-one unrestricted, unsupervised contact with patients that might have diminished capacity. We will be using that minimum to disqualify any drivers.

Ms. Youssouf commented and asked that the only thing I'm worried about is we are not looking at the drivers. We are trusting vendors. Unless we do a thorough background check on the vendor and what their record is, how can we take any comfort in what a vendor says?

Mr. Tallbe responded that on audit's recommendation, we plan on doing an annual representative sample of audits of the vendors to assure compliance.

Ms. Youssouf asked about how it works as far as their liability goes. Let's say they have somebody who actually does something awful to a patient, where does the liability status stand, with HHC or with the vendor?

Ms. Keller asked if there is an event and the patient sues will the patient sue us or the ambulette. Ms. Youssouf then asked who is liable.

Ms. Keller responded that chances are both. I do not know if we have an indemnification.

Ms. Youssouf asked if we have any indemnification. Mr. Tallbe answered that we do. I know that all of these contracts have our standard terms and conditions which would require them to indemnify us for all acts of their drivers. Ms. Youssouf asked legal to check and let the committee know the type of indemnification we have in instances like this.

Ms. Keller stated that I'm sure we have a good indemnification provision. The only concern we would have is that an aggressive lawyer will find some role that HHC had in the wrong and that will not be covered in the indemnification. If it is simply a matter of total involvement of just the ambulette company and that is our only connection we should be very well covered.

Mrs. Bolus asked who in central office supply has the responsibility to validate the vendor's taxi and limousine license. To which Mr. Tallbe responded that the contract manager who was managing the contract.

Mrs. Bolus then commented that six times he did not do what he was supposed to do. Mr. Tallbe answered that that is correct, but upon further review, the Taxi and Limousine Commission (TLC) license is not required for this type of service because it is a point-to-point service. Where a call is made ahead of time, a TLC license is not required.

Mrs. Bolus asked if it was something that we required. Mr. Tallbe responded no, it is not a separate requirement of HHC. Mrs. Bolus then asked why not and Mr. Tallbe said that because in the older forms of the contract it either was a requirement by TLC and that requirement has now changed.

Mrs. Bolus asked if it was required in 2010. Mr. Tallbe answered correct.

Mrs. Bolus then stated that someone did not do their job in 2010 because it was required. Mr. Tallbe commented that it was not done on a periodic refresh basis. It was done upon initiation of the contract.

Ms. Youssouf expressed her concern because staff responses seemed very vague -- especially because of the questions about liability insurance. The report indicated that there was not any validation of the certificate of liability insurance of the vendor. Ms. Youssouf instructed the staff give to internal audit, and Mr. Telano give to us, some kind of firm specific plan that you have in place to make sure these kinds of things do not happen.

Mr. Tallbe stated that he misunderstood the question -- if the question was about the liability insurance, the plan going forward is that our third-party vendor, Willis Insurance, will be receiving a copy of each vendor's contract along with the insurance requirements stated in the contract. They will then file for the certificate to make sure it is compliant with our insurance policy and follow the expiration of all those policies.

Ms. Youssouf then commented that for each question we had multiple ones to get to an answer. So that does not give me a lot of comfort.

Mrs. Bolus stated and asked that this says going forward, it does not say anything about what was done before. Mr. Tallbe responded that he has only been in the supply chain for a year so he could not answer the previous history.

Mrs. Bolus asked if no one else in your organization has been there longer than one year. Mr. Tallbe responded that Ms. Torres has.

Mr. Martin then added that the supply chain was just created two years ago.

Ms. Keller then stated that Mr. Tallbe is making an effort to address the issue of mediation and how we can be certain these things will not occur in the future.

Ms. Youssouf pointed out that prior to this some of these issues that occurred were not done by central office, noting that some of issues go back to 2010 and 2011 at the hospital level; is that correct? Mr. Martin responded yes, --supply chain was created two years ago, prior to that, it had to be at the hospital level.

Ms. Zurack commented that everything that is been said to her knowledge had been accurate but it is one of these nuance situations where there was a central office materials management department that did do central contracts. So, even though it was not as robust as the current function, it did exist; and maybe part of the reason we made it more robust was for a lot of the things you're finding.

Ms. Keller stated that the insurance program is one of these new more robust efforts that is being made in central office. It is really a great effort that we will not have these terrible lapses anymore being exposed.

Ms. Youssouf stated that I think we need something that this great effort that's been developed so we have an idea of how it's going to be prevented. Because our biggest fear in this committee is that in fact something will happen and we will then be facing a giant lawsuit. I'm sure you understand the concern, and obviously none of you were responsible for all of this that happened but you are responsible now.

Mr. Martin said that I am ultimately responsible -- we will make sure it happens.

Ms. Youssouf thanked them and Mrs. Bolus asked when do they get back to us? To which Mr. Telano answered that we will do a follow-up audit and if the findings are negative we will have them come back. If they are positive or we see they have taken action to correct all the deficiencies, we will just send out a report saying everything is fine and they would not have to come back.

Mr. Telano continued and stated that moving on to page seven of the briefing – this was an audit of research protocols at Queen Health Care Network and asked the appropriate representatives to approach the table.

Ms. Youssef asked them to introduce themselves for the record – they did as follows: Toni Lewis, Research Administrator; Dr. Glenn Martin, Associate Dean at Mt. Sinai; Kiho Parks, Associate Executive Director; Imah Jones, Senior Director; Ross Wilson, Senior Vice President/Corporate Chief Medical Officer.

Mr. Telano stated that when we conducted this audit there were 101 protocols for the Queens Health Care Network. We selected 20 for review, our findings are a reflection of those 20.

The first finding is that the participation of human subjects in the research studies were not documented in their medical records. The second one was that three of those 20 that we reviewed, the research projects, they are forwarding 90 percent of the expenses reimbursed to HHC by the research project sponsor, they were forwarding 90 percent back to Mount Sinai and no documentation at the time of the audit could be provided substantiating the reason for this practice and the purpose of these payments to Mount Sinai. The third issue we noted, this is in line with Dr. Raju's mission to stress the positive aspects of HHC. One of the goals of internal audit is not only to look at internal control and efficiency of operations but also to ensure that the mission of the Corporation is being adhered to. We believe that this was an opportunity because there were only good findings in the research area and this was an opportunity to stress those things and publicize the results of these projects. So we recommended that that be done more regularly. The fourth finding is that we noted that the CO research administrative staff at the central office, was not documenting their invoicing and payments on an efficient basis. There were also contract agreements that could not be found or partially could not be found during the audit. The fifth finding is that the Queens Health Care Network research coordinator, who is an HHC employee, reports to the Mount Sinai Associate Affiliation. We were concerned about this because this research coordinator is a member of the Facility Research Review Committee, and at this committee they decide the feasibility of the projects. We felt that the independence of this individual was concerning as she would be voting in favor of Mount Sinai maybe more than HHC. I'm not saying it is happening but it is a possibility. The sixth finding is that the Queens Health Care Network does not utilize the automated system used by other facilities to monitor their research projects. The last finding regarding this audit is that the central office research administration does not monitor regularly the grants during the life of the grants. They provide an initial approval. However, they do not control and monitor it on a regular basis after the initial year. Please feel free to respond.

Mrs. Bolus asked that the people who are part of the research project, while it was not put in their records, did they all sign? Everybody clearly understood what they were part of? What research were they part of? Dr. Martin responded absolutely. Mrs. Bolus then asked why a copy was not put in their folder. To which Dr. Martin answered that there is an electronic system at Queens Hospital. The particular PI misunderstood the capabilities of the QuadroMed system that was built for him and did not enter the information in the system. We have since modified the system to make it clearer where that information should go. At last look, all of it was going in. It was not a question of consent. Nor is it a question of them filling out the appropriate research forms or doing the research testing or anything else. It was paper records that were not integrate into the electronic system fully. We have corrected that issue. It was isolated to endocrinology cancer, which is actually the largest research enterprise that we have that does not have that problem. It was one-of event and we have taken care of it. We appreciate that audit picked it up so we could correct it.

As for the publicity issue, again in my IRB hat, I am always a little bit leery about publicizing research in terms of marketing because the federal regulations require that any direct contact or recruitment is under the control of IRBs. Therefore it is a little bit dicey about what you mean when you talk about that. We have no problem whatsoever about discussing the contributions at Queens Hospital and Elmhurst Hospital has made to the research enterprises. There are a couple of things cited in the report where actually one of the things that Dr. Kemeny has at Queens, is a grant specifically from the Feds looking for minority recruitment and retention within research projects. Which she has actually been doing. What we are actually able to provide, which a lot of other research institutions are not, is a diverse population.

One of the advantages of living in Queens and working there, and the advantage of years' worth of efforts, and I believe Mr. Martin knows this from his days at Queens, of trying to educate both the personnel and the community. Certainly tooting our

own horn is something we probably do not do as well as we could. We will try to improve that. One of the issues also has been, quite honestly, as you probably know, the 30 or 40 year old board resolution having to do with research has been rewritten and signed off by Dr. Raju and approved by the board only I think a month ago which does address some of these. I am pleased to say that Dr. Kemeny and myself and others were very much involved in that committee over the years trying to make the research enterprise throughout all of HHC more robust going forward. It is something that we are aware of, we are trying to address. There is also concerns about projects that are open with no one being enrolled. I want to briefly point out that especially in cancer, if you are looking for people who unfortunately are so sick and they have a certain stage, a certain ethnicity and a certain failure rate, you are going to open up the project almost hoping you do not have too many people in it. Unfortunately at Queens we do tend to get late stage surgical cancer.

There are some projects that are going to be open with no one. Which is almost a good thing because no one was sick enough to have gotten into the project. We are also going to have projects that are closed to enrollment for years because we have two, three, four, five years follow-up that is going to occur afterwards. You still have to keep those open in your books. Then you have a situation where you are going to end up having data analysis and scrubbing. That can take two years where you are still keeping something open. It looks like there is no activity for a lot of projects when in fact there is ongoing activity at a low level. Or we are looking for somebody who can come in. At the point of annual review by IRBs, and in our shop it's mainly Sinai and BRANY, the IRB has an obligation to look over the conduct of the research for the prior year.

One of the things we do look at is enrollment, if you are not going to enroll enough people to be able to get to the end that you said you had given us a power analysis that you could come to a conclusion, then we will indeed push back because if you are doing research that cannot come to a conclusion then there is benefit to anyone.

Ms. Youssouf stated that I appreciate everything you are saying. I think the point was that if something really good happens as you recognize the report said, it would be a good idea to kind of work with perhaps even central office to get the information to at least other HHC people, and obviously you all recognize that and that is something that can be done. How about the expenses being forwarded to Mount Sinai as opposed to being reimbursed to HHC?

Mr. Park responded that during the audit period we looked at how many research checks we received and how many checks are processed through Mount Sinai. To put this in perspective, we received 31 checks and we processed these other four checks that we are talking about.

Ms. Youssouf asked if you received 31 checks, what you did with the rest of the checks. To which Mr. Park answered that the rest of the checks stay with the network as a revenue and other checks are given to Mr. Sinai for the PI's direct expenses. Those are the 90 percent, after I keep our network overhead, direct expenses for PIs such as patient incentives when they enroll patients, part-time research coordinators are paid out of those.

Mrs. Bolus asked about the amount you are talking about. Mr. Park answered \$24,000 that was paid to Mount Sinai. Mrs. Bolus then asked how much did you receive? Mr. Park said \$66,000.00. Ms. Youssouf said that is not 90 percent. Mr. Telano added that our sample, which we did 20 out the 101, and of those 20 we came across three of those grants in which \$27,000 was received from the sponsors of HHC and in turn HHC cut a check to Mount Sinai for \$24,000. The other checks that might be totaling up to \$60,000 may not have been in our sample.

Mrs. Bolus asked if we received any portion of the rest of it. Mr. Telano responded that I cannot account for the other. It may not be in our sample. For those three grants there were four checks totaling \$27,000 of which \$24,000 of it was returned.

Mrs. Bolus asked if we have a mechanism where we know where every dollar goes.

Mr. Park said that the research checks come to us in two ways, some grants are sponsored by the central office. I get it from central office administration and they inform central office finance grant saying we received a check and they post it to our research account. If you look at the 6821 call center they list all the recent checks we received. If our network gets it then I forward it to central office finance to put it into research. The record of what we receive is there, and what was audited was the

OTPS system, they looked at four checks that were written. Those four checks total amount the sponsor gave us was \$26,000 and the checks that we processed to Mount Sinai was \$24,000. That's the 90 percent of the amount that we received in the process.

Ms. Youssouf asked that your response was that a new form would be completed identifying all relevant information; is that correct? To which Mr. Park responded that I was not disputing the fact that we wrote over 90 percent of the amount we received to Mount Sinai because those are the direct costs for the PIs. But what the audit team, who spent with us for a long time, correctly identified was we did not have a formal process of when we process those checks. We formalized the transfer of money and Mount Sinai affiliation is going to inform us of how they are going to spend those monies and we formalized the process. They created the separate research account, which they did not have before, and they will bill us every three months exactly how much the money was spent. So we will have a complete accounting.

Ms. Youssouf asked if they have a complete record for each grant, how much you keep, and all those forms.

Mr. Jones added that previously, as Dr. Martin pointed out, we did not have any formalized policy of procedure on this issue. For example, they have a process, each facility have their own process as Queens Hospital just described. Now we have a formalized process in place. Mrs. Bolus then asked since when?

Mr. Jones answered since November when the board approved. Again, created from before the policy and procedure was approved. Now we have all this process in place and it describes all these mechanisms happening now established and central office is in charge of monitoring, working with them and making sure all policies and procedures are followed. They report on a monthly basis so all of us know we are on the same page. This information was not available when the audit was conducted, but now we have the information.

Mrs. Bolus asked why did you not have this procedure in place before now -- since November. Mr. Jones responded that the last policy and procedure, as Dr. Martin mentioned, was in 1991.

Mr. Martin added that we have been working on this policy and procedures for many years. Then Mrs. Bolus asked why it took three years? Mr. Martin said that all the stakeholders had to agree -- this involves the IG, Internal Audit.

Dr. Wilson stated that the research agenda for us over the last four years has been a complicated one. The first thing, the people deserve to be researched, studied more than they have been. So we have to get ourselves in a position so we can provide research. Secondly, the processes we had in place were inadequate and we had significant problems. So we went very quietly until we rebuilt the infrastructure. That ended to two things, one is this document, it is 176 pages, which the board approved in November, and it was finally reviewed by other parties, including the IG, and was signed and released on April 29, 2015. This sets in place policies and procedures around all of the issues raised and sets a framework for them to be addressed. As Dr. Martin said, he and many other key leaders across the Corporation actively participated in the development of this work program.

The second thing that is important is that this research approval process was inadequate. It was a software-based system that the Queens Network did not even participate in. They were on paper entirely and we had replaced that over the last 12 months with a new approval and tracking system. So that we can track each single application and the status of each grant through the process all the time. That process is called STAR, the rollout of that has only been completed over the last two months or so. Now we have a new a set of rules and regulations. We have a platform for tracking, and I think we have a much clearer role delineation around everybody's function, central office's role, the facility's role and the facility research coordinator's role. The next phase, is hopefully getting us to a place where we were -- I guess another evidence that I was not happy with where we were is that I asked Mr. Telano way back in 2011, 2012 to come in and review a lot of our processes because of my concerns about the inadequacies that we had and Mr. Telano kicked off this process for us.

The next step is to reconstruct a new corporate research counsel. One of the charges of that counsel will be the promotion and promulgation of the outcomes of the work pertaining to one of the other recommendations. Because there are ways to do that but at the moment mostly they are in professional journals in a narrow way that do not necessarily get the information to all the stakeholders and often do not necessarily reflect on HHC. I think we have made huge steps and progress. We are not quite there

yet but we are pretty close. I think over the next 12 months I would welcome Mr. Telano coming back and reviewing again to make sure that firstly we have the policies and procedures right and secondly that we are adhering to them.

Ms. Youssouf asked if the oversight and monitoring of the research protocols and payments is covered in the policy and procedure. Mr. Jones responded yes, this is well addressed. I am going around to facilities to amplify it and make sure we understand what is in there. I provided the training and the workshop working with other finance folks to make sure they understand and will carry out the process.

Ms. Youssouf then said that I do not understand why an HHC employee reports to Mount Sinai.

Dr. Martin said that quite honestly, a question of convenience and better functioning within -- basically the way we are set up Ms. Lewis is in fact the person we are referring to. She at this point reports to Mr. Harris, who is the affiliation administrator for Elmhurst. One, because they work next to each other. Two, Ms. Lewis would otherwise be reporting to myself or Mr. Larry Reich would be the way you would normally do it because we are the heads of the research committees. It made more sense to let an administrator do it because frankly they are going to be around and easier to take care of, from at least my perspective. We are talking about vacations and other associated things. It just ended up being a question of convenience and the like. That is basically how it got started, the actually working relationship are with two chairs of the Library Research Committees as well of course with the office downtown and with finance and everything else, you know, she ends up dealing with half a billion stakeholders a day.

Ms. Youssouf asked if she should reporting within HHC. Dr. Wilson responded that if the person is representing HHC's interests they should be reporting within HHC. Ms. Youssouf then asked that that means a change. Dr. Wilson said yes.

Dr. Martin commented that I believe this report had been discussed internally at the Queens Health Network at pay levels above me and it was felt it was better for the operation to do it this way. If there is a need to switch we will switch it back again.

Mr. Park added that there were extensive discussions within our network and we conversed with downtown as well.

Ms. Youssouf said that from an Audit Committee standpoint we cannot be paying somebody not to report to HHC.

Dr. Wilson added that it will happen, but can I just add in the affiliation environment in which we operate this is not a clear cut issue in that we have a number of people who are technically employed by the School of Medicine at Mount Sinai who operate at Queens Health Network in the interests of HHC through a contract on every day and routine matters.

Ms. Youssouf stated that this is not a contract. This is an HHC employee. Dr. Wilson that we will make it happen, but the audit issue points out the complexity we have. We will find out and report back to you.

Dr. Martin stated that I used to be service line director for the Department of Psychiatry for the Queens Hospital Center and HHC employees reported to me all the time as I was service line director and I would report up to the medical director or to Mr. Martin or the Executive Director. It is not all that unusual especially out in our neck of the woods where the affiliation and the Corporation get along well enough that we can do that. I understand what you are saying. If it needs to be changed we will change it.

Mr. Martin said that it is the optics. To which Dr. Martin added that it is not anything beyond that.

Mr. Telano continued by stating that on page nine of the briefing, this is an audit of vital records, which is basically birth and death registrations and this was conducted at Jacobi Hospital. He asked the representatives to come to the table and introduce themselves. They introduced themselves as follows: Barbara Wikoren, Associate Executive Director; Janice Halloran, Network Senior Associate Director; Neville Trowers, Associate Director.

Mr. Telano said that death and birth registrations are input into the software system provided by the Department of Health, Electronic Vital Events Registration System (EVERS). In our review we found numerous input errors as there was no review process by the appropriate departments. We also found that the individuals who are allowed access to EVERS was not current as terminated employees and inactive employees still had access. We also noted that the biometric devices, which are provided by

the Department of Health, to certify the input into EVERS was not controlled. Originally the Department of Health provided 17 devices to Jacobi free of charge. During our audit we could only locate four. When additional devices were requested, the Department of Health had changed their policy and now they charge us for them. So, three of the devices needed to be purchased. We also found two devices where we could not determine whether the Department of Health gave them to us. According to their records they did not, and we could not find any invoices as to whether they were purchased. We are not exactly sure how they were obtained. There was also a lack of segregation of duties as registrars fully controlled the process of birth registrations. Lastly, the certification of termination of pregnancies was not being done timely. We found spontaneous terminations were being done between 6 and 33 days and induced terminations were done between 6 and 21 days.

Ms. Halloran said that my segment of this are the terminated pregnancies induced. Seven of which were found to be beyond the five day window. Six of those were at the six or seven day window. The one that is recorded as 21 days was truly done in the five day window but there was one clerical error when the person who entered it put in the wrong date. So the date would say 21 days. It was actually done within the five. The majority of those that were late were because they were entered within the five day window but they were not signed off within the five day window. The majority was attributed to one provider and that is being remedied, they are more cognizant of the need to sign off. We have also enhanced our log. We have actually enhanced that and now it is gone over to an associate director of women's health OPD, who reviews that weekly with her staff to ensure that it is complete. It is signed off, it is in a logbook, it is electronic but then there is a signed copy that goes into a logbook weekly just to ensure that we have everything done within that five day window. Primarily our issue was the certification by the provider.

The Spontaneous Termination of Pregnancies (STOPs), most of those are done in the Labor and Delivery department (L&D). Occasionally they are done in the Termination Unit, but most are done at L&D. The ones that were noted in the report were from women's health were the I2Ps.

Ms. Wikoren stated that having acquired the department in late 2013 some of these plans that were in place were obviously antiquated and I was not familiar with them. When the audit team came and reviewed them this was business as usual.

Mrs. Bolus asked if she was talking about EVERS. Ms. Wikoren answered no, talking about the policies and procedures for birth and deaths via the admitting department. The EVERS policies and procedures are far looser which I learned by meeting with the EVERS personnel. It requires us to be that much stricter because they are not. Having gone through the audit, we realized that the whole process needed to be revamped. We created all new standard work, there are admission officers who now function as admission officers, and they certify every birth and every death before it is submitted. All the documents are reviewed by me personally before they go into the system. There is a purchasing standard work and a relinquishment standard work for the biometric devices. As we purchase them we log them into a database. As we retire them we log them in to a database and they are followed through the relinquishment process. There is also a hierarchy change in the admitting department as the original individual no longer works in that particular area. We monitor the flow of every birth and every death as they proceed in real time. Every document has been revised to include the physician of record where they must sign and indicate they are certifying either the birth or death on the paperwork, not just in the EVERS system. There is a co-signature by the admissions officer and myself.

Mrs. Bolus asked if the person who signs the death certificate is the same person who puts it in the computer and signs. Ms. Wikoren responded that it depends on who is working on the shift. The person can create and certify but they cannot submit it through the EVERS system without the admissions officer reviewing it and then solidifying the process.

Mrs. Bolus then asked what hours are they on duty. Ms. Wikoren said that we have folks 24-7.

Mrs. Bolus stated that there should be no problem with them finding someone when they put the information in.

Ms. Wikoren stated that some of it happened while I was there but there was a different admitting director in charge of admitting at the time. I was the senior associate director for the department. I did not micromanage the department, the department is now being micromanaged.

Mrs. Bolus asked if someone does not log into this system over 365 days, why would they log into it now.

Ms. Wikoren responded that there is usually a rotation schedule, so that physicians may not be on that rotation where a death would occur. They could be on a research rotation, on an EMS rotation or out doing a presentation schedule. Unfortunately we have to keep them in the system because there is a possibility that in two months they may return to a rotation that would require them to certify a death and you them to be active. What we do is we have a very tight connection now with our Medical Staff Affairs Office where in fact daily I receive a list of folks who are on FMLA, who are resigning or being on a leave. If you are on a leave, I am taking you out of the system. If you are resigning, I am taking you out of the system. If you are terminated, I am taking you out of the system. If you come back, I will recertify you.

Mrs. Bolus asked about other devices that was supplied by the Department of Health (DOH). Ms. Wikoren said that all of the devices at that time were supplied by the DOH. The DOH is not in the business of giving us biometric devices any longer, they would like us to purchase our own. There is a handful of vendors that the city has a contract with in which we can purchase them. There is a purchase order attached to anything new that has been purchased.

Mrs. Bolus asked how was 13 out of the 17 lost. Ms. Wikoren answered that I do not know where they were. They were scattered throughout the facility. They may have been discarded by the previous administrator.

Ms. Youssouf stated that I think the main thing now is that you come in, fix this stuff. I am very happy to hear. She thanked them for coming in.

Mr. Telano continued and stated that the last audit if of medical surgical inventory controls at Woodhull and asked for the representatives to approach the table and introduce themselves. They introduced themselves as follows: Henry Kuzin, Senior Associate Director; Jaime Gonzalez, Director; Ivan Figueroa, Assistant Director.

Mr. Telano stated that when we conduct this type of audit the first day we do a surprise count and we counted 104 items. We only found 12 discrepancies of which eight could be accounted for. Overall we felt that there were only four discrepancies. As you can see, we do not comment on that at all because I believe the inventory is controlled effectively. The only comments we have is about security issues, the doors were left open. A piece of cardboard was over the lock so people could enter the side doors. Individuals had access to the warehouse that should not have. The cameras were not working on the loading dock. One of the other issues had to do with access to passwords to certain systems, the employees were sharing the passwords. The other findings had to do with the commingling of the department's inventory with other departments. There was no indication that the materials management department was routinely performing periodic inventory accounts.

Mr. Figueroa commented that we were performing the cycle counts. What we were not doing was filing the documentation for those cycle counts. We did not realize that that was a requirement. As of the time of this audit we are maintaining the documentation for those cycle counts. As far as the exit doors, all the exit doors are maintained closed at this time. The supervisors have been advised, as well as staff, all doors must be closed at all times unless staff are entering or exiting the department. We did create a log to monitor the staff that are accessing the storeroom and identify which supplies are taken. We have a storage room that houses supplies for different departments, and we are now monitoring who accesses it. We have a supervisor who walks with these individuals to assure they are getting the supplies and exiting the department once they have gotten those supplies. The user names for the various programs, the sharing of user names for those various programs has been disallowed. Proper access has been required through each of the staff to access these programs.

Ms. Youssouf asked if the cameras were fixed. Mr. Gonzalez responded that there were six cameras that were replaced with high definition digital cameras. Three inside the loading dock, two outside of the loading dock and one in the main corridor that leads to the loading dock and also it gets a bird's eye view of the exit doors from the loading dock. All cameras are functioning right now and recording live.

Ms. Youssouf asked what took so long to fix them. To which Mr. Gonzalez answered that we do a monthly check of our system and we identified that those cameras were down. When I identified them, we reached out to material management, did an assessment with them and informed them the cameras were down. We gave them a quote of how much it was going to cost.

They put it through the process, generated a purchase order. The vendor came in with his technicians and replaced all the cameras.

Ms. Youssouf asked when the cameras were installed. Mr. Gonzalez answered that I believe about May 5th or May 4th. Ms. Youssouf then asked that it took from October 26th to May 4th to get new cameras. Mr. Gonzalez responded that that is correct.

Mrs. Bolus asked was it a vital area? Mr. Gonzalez responded that it is a vital area. Mrs. Bolus then asked did you go up a little bit higher and say we really need this.

Mr. Gonzalez said that I reported it to material management and what we did in the interim we had security patrols that patrol the building. We paid specific attention to that area, during the day tour there is a lot of personnel that works there. During off tours, weekends and the midnight tour we had constant patrol that goes for that area and since then we have not had one issue.

Mr. Martin asked can you explain why it took six months to obtain cameras. To which Mr. Gonzalez responded that once we identified it we replaced it as soon as we could.

Ms. Youssouf stated that if you were having problems there is a central office you could go to and say I cannot get this fixed or go to the Executive Director. At the worst, on top of that, no video cameras and doors that were open. It seems like people were sleeping or something. People could go in and out and do whatever they wanted and the storerooms were open. This does not sound like very tight security management.

Mr. Figueroa added that that is correct, we have addressed the issues. As far as the cameras not working, the material management department was not aware of this until the audit took place. When we did our monthly inspection, based on our system sometimes our system will go down. Those cameras sometimes were working and sometimes they were not.

Mr. Martin commented that one good thing is that you have a lot of very noble staff because you have all these security lapses and your inventory was intact for the most part.

Mr. Figueroa said that we did not see anything in the inventory to say there is a problem, what is going on.

Ms. Youssouf commented that you are missing the point obviously. The point is that all of this stuff should be checked on a routine basis. You should know that these doors are open. You should fix them immediately, there is no reason, and if the cameras are broken you should get them fixed. This is a hospital, drugs in it. It is has vulnerable people in it. We are supposed to be protecting our patients, and working doors that lock and video cameras seem to be like the least we can do. I hope you have protocols in place and you know Mr. Telano is going to be back there when you least expect it. I hope you have protocols in place that somebody is going to be held responsible over checking on this stuff on a regular basis. I cannot imagine that nobody noticed no doors were locked. It is mind boggling.

Mrs. Bolus asked if somebody is supposed to be watching these cameras. Mr. Gonzalez responded that the cameras are recording live as we speak. Mrs. Bolus then asked if you have bank of cameras. Mr. Gonzalez answered that we have a main monitor in the command center which monitors high patient care areas that is the loading dock areas.

Mrs. Bolus asked who was monitoring them. Mr. Gonzalez said that sometimes they were working and sometimes they were not working. When they were working we were able to see, because it is an analog system, sometimes they would go down and sometimes they would go up. We could not put a Band aid on it any more so that is why we decided to go with a new camera system.

Mr. Martin said let me ask Rick Walker, I ask you to be responsible for assuring me and this committee that not only this issue but all security issues within Woodhull. You need to do an assessment that they are taken care of and address it very quickly.

Mr. Walker said we read the findings and we always work closely with Mr. Telano's office. We actually encourage Chris to come out. Then Mr. Martin said what I am saying to you is that this one issue gives me pause to think about other issues that may be

going on within your institution that need to be addressed. I am asking you to do an assessment to assure us that everything is being taken care of.

Mr. Walker stated that the point I was going to make, I was just highlighting Mr. Telano's work, yes, at the senior levels we have discussed this, as we do with all audits, and we were concerned with some of the findings, particularly with respect to the cameras. We have a very old system as identified. It is this old analog system that needs to be upgraded. We are looking at assessing what it would cost Woodhull to revamp the entire surveillance system. However, when we looked at the findings in terms of the actual losses sustained they were not significant. The point is that what was significant for us was that there was constant lapses. For example, when someone chucks a door open that is serious to us. Unfortunately it does not just happen in materials management. It is a common occurrence throughout the hospital that is something we deal with on a routine basis. In this particular case point, we are sitting down with Lisa Scott-McKenzie, who has operational responsibility for this area. They have come up with corrective actions and plans. Then they will report back up and then we will come back with a plan that best meets the operational needs of the institution as it relates to surveillance and practices in critical areas.

Ms. Youssouf and Mr. Martin thanked them.

Mr. Telano stated that that concludes his presentation.

Mr. McNulty introduced himself as Wayne McNulty, Senior Assistant Vice President and Chief Corporate Compliance Officer and saluted everyone and stated that he wanted to provide the Audit Committee with an update of the Corporation's own analysis with HHC's compliance with the HIPAA security rule analysis requirements. He reminded the Audit Committee (the "Committee") that back in February 2015 he reported that HHC has a requirement to satisfy the security rule with respect to doing an assessment of all the potential risks and vulnerabilities to the confidentiality and integrity and availability of electronic protected health information that is accessed, stored or transmitted by HHC's systems and applications.

He further reminded the Committee that our review of HHC's adherence to these HIPAA security rule requirements found that the inventory of HHC's information systems and applications that access, store or transmit EPHI was a work in progress and therefore was not comprehensive at that particular juncture back in February. He added that although HHC's Enterprise Information Technology Services ("EITS") has taken numerous steps and significant measures to enhance and maintain the confidentiality of the security, integrity of HHC information systems, further steps were needed to meet the eight point prongs of the risk analysis that were promulgated by the Office of Civil Rights.

Mr. McNulty stated that in April Mr. Sal Guido, the Acting CIO and Senior Assistant Vice President, informed the Committee that a solicitation for a vendor had taken place. Mr. McNulty announce that a vendor has been selected. In sum and substance, he advised that the vendor would report to him on audit issues with respect to performing audits in IT and information governance. He advised that the vendor would be performing a: (i) risk analysis on all of our high risk applications; (ii) HIPAA audit protocol; and (iii) a number of other information governance audits. He stated, in summary that IT was working on a statement of work with the selected vendor and that the Committee would be provided with a follow up report on the same in September. As to the scope of work, he added, we are hopeful that the vendor will already be started so we will have some findings to report back to Committee.

Mr. McNulty moved on to the external audits and discussed the status of an ongoing review by the Department of Health and Human Services Office of Civil Rights ("OCR"). In summary, he reminded the Committee that, in April 2014, OCR commenced a review of Metropolitan Hospital's Center's ("Metropolitan") meaningful use and access to individuals with limited English proficiency ("LEP"), which included a review of the privacy and security of PHI (protected health information) of individuals with LEP. He advised the Committee that HHC provided a response to OCR's review and OCR thereafter requested numerous follow-up responses and HHC followed back up with OCR in July 2014 with regard to HHC's risk analysis. He further advised the Committee that HHC was recently informed by OCR that they were going to schedule a walk-through of Metropolitan. In sum and substance, he advised the Committee that he believed the walkthrough was scheduled to take place in a week, and that OCR's focus would be the LEP program at Metropolitan. He informed the Committee that directly after the Committee meeting he was scheduled to participate in a telephone conference with OCR with HHC's Office of the General Counsel and Office of Information Technology Services to discuss HHC's risk analysis status. In summary, he informed the Committee that: (i) OCR was scheduled to

have their data security expert on the phone; (ii) he expected OCR to have a number of suggestions with regard to HHC's information governance program; and (iii) he would report the content of said telephone conference with OCR back to the Committee in September.

Mr. McNulty then moved forward to discuss privacy incidents and related reports. He stated that since the last time the Committee convened there were three breaches that he would like to discuss. He explained that two were discussed in a previous executive session, and one was a new breach. Starting with the new breach, Mr. McNulty advised the Committee that a week ago HHC began to notify almost 4,000 patients who received services at Metropolitan about the disclosure of some of their personal and protected health information when a Metropolitan employee sent an email file that contained protected health information through his personal email account. He advised that all affected patients were offered one year of free credit monitoring services. He further advised that the Department of Health and Human Services ("HHS") was notified. He added that notice was provided to the media as required under the HIPAA regulations. He informed the Committee that the employee (who responsible for the breach) was terminated from employment at Metropolitan Hospital and HHC.

Mr. McNulty then discussed one of the breaches that was previously reported in Executive session. He stated that in late April HHC notified 90,000 patients about the disclosure of their protected health information when a former employee accessed their information six days after being separated or after being separated from services from a Network and the Corporation. He informed the Committee, in summary, that HHC provided credit monitoring to all 90,000 patients at a cost of \$220,000 to the Corporation, which is being charged back to that particular Network (the Network where the former employee was previously employed). He stated that notification was provided to the media and HHS. He commented that, since this was an ongoing investigation, he could not provide additional comments with regard to any further findings.

Mr. McNulty then discussed the second breach that was previously reported in Executive Session. He advised the committee that back in April HHC notified 3,300 patients at Bellevue Hospital Center ("Bellevue") when an employee there sent PHI to a relative to help her with an Excel spreadsheet. He told the Committee that employee has since been disciplined. He advised the Committee that HHC provided: (i) credit monitoring to all affected patients; (ii) notification to the media; and (iii) notification to HHS. In sum and substance, he advised the Committee that all these incidents described in the subject report were detected and discovered through HHC's information governance system, which monitors all email communications that leave the Corporation. He explained that HHC now has a system in place that these emails are blocked and screened before they can even go out. He further explained that if any emails are sent to a personal email account or to a vendor that is not known to the Corporation, it automatically gets stop in its tracks and we have to review it and the sender has to provide justification why the information is being sent out.

Mrs. Bolus asked if that is in all hospitals. To which Mr. McNulty replied that all of HHC - - every single facility. He stated that at the next Committee meeting he would provide an update on the numbers and the significant measures that have been made. In summary, he informed the Committee that he met with all the senior vice presidents yesterday and informed them of all the activities that have taken place and they have ensured Mr. Martin and myself that they will take measures within the facilities to make sure the employees are transmitting (information) safely and in accordance with HHC rules.

Mr. McNulty moved along to the monitoring of excluded providers. He informed the Committee that on Tuesday (June 9, 2015) the OCC received one report of an excluded provider at the Northern Manhattan/Generations Plus Network. He stated that the matter was under investigation. He stated that he would provide an update to the Committee on the same at the next Committee meeting.

Mr. McNulty discussed the Revision of Corporate Compliance Policies and Procedures. He reminded the Committee that various policy procedures were being revised, particularly the Corporation's code of conduct. Dr. Boufford recommended that I reach out to Pam Breyer, who is the CEO and president of Maimonides Medical Center. I did reach out to her for her insight. They have a very good code of conduct in place there and I will be following up with them.

Mr. McNulty then discussed the Compliance training update. He stated that at the last Committee he informed the Committee that the health care professional module had a 20 percent completion rate. He stated that the completion rate was now up to 47 percent. He advised that the physicians' module was at 27 percent in April - - and it was now at 39 percent. In summary, he

stated that at the senior vice president (“SVP”) meeting yesterday he informed the SVPs that he would be providing them with the names of all physicians and health care professionals that have not completed their training to date and that they would, in return, ensure that the training is completed in a very expeditious manner.

Mr. McNulty then continued by discussing the corporate wide risk assessment process. In sum and substance, he stated that, as he previously discussed, on a biannual basis the Corporation performs, through the Office of Corporate Compliance (“OCC”), a Corporate-wide risk assessment on all the risks and vulnerabilities that could affect operations of the Corporation, particularly in the area of fraud, waste and abuse, but in all operations, privacy, record management and HHC’s adherence to the conditions of participation for Medicaid and Medicare. He stated that the OCC prepared a list of predefined risks that would be shared with senior leadership throughout the Corporation and all the various compliance committees so they can consider the same. He explained that, with regard to the Office of the Inspector General, they would be looking at their: (i) two work plans; (ii) fraud alerts; (iii) compliance program guidance for the various providers; (iii) and their special advisory bulletins. He added that they would also look at the Medicaid Inspector General’s Work plan, the Medicaid and Medicare conditions of participation, and the Department of Health regulations, as well as the New York State compliance program regulations and guidance from the New York State Office of the Comptroller on the practice of internal controls.

He explained, in summary, that the OCC was somewhat delayed (with the risk assessment process) because for the first time this year HHS (Office of Inspector General (“OIG”)) issued an interim work plan. He further explained that HHS normally issues a work plan in October and November and won’t issue one again for a 12 month period. He stated that this year in May they issued an interim work plan, which was 80 pages long, so that the OCC has to go through that document and look at the particular risks which HHS has highlighted to make sure that is part of the risk assessment process. He stated that the OCC was hopeful that within the next week a document could be issued to the different compliance committees and the risk assessment process could start. He elaborated that once the process was over with, the OCC would go through all of the risks. He stated that the last time the OCC performed this process, 199 risks were identified corporate wide, which were prioritized and scored. He added that, in the end he believed that 18 work plan items were looked at. He stated that, this year, once the process was finished, he expected the (number of) risks to be higher (than the previous year) because the number of people participating in the exercise would be expanded. He explained that, once the risks are prioritized, he would come before the Audit Committee so that the Audit Committee can exercise the risk tolerance and risk appetite, which is under their purview. In the interim, he stated, from now to September he will communicate with the Committee and explain that process and how it will take place.

Moving along to section 8 – the vendor and contractor management. In May the members of my office, along with a number of members of senior leadership, met to discuss contractor and vendor management and governance throughout the Corporation, and included the head of procurement, Paul Albertson, Senior Assistant Vice President, Barbara Keller, Deputy Counsel, myself, and Sal Guido, Senior Assistant Vice President and acting Chief Information Officer and we discussed how information governance will be taking place throughout the Corporation as far as vendor due diligence and looking at vendors before they are procured. We also discussed the requirements under Medicaid and Medicare for contractors. We discussed the Department of Health regulations, which are similar to Medicare regulations, which basically says that once you hire a contractor the hospital is basically responsible for everything that the contractor does. We were making sure that we have internal controls present to perform random audits as necessary. We are also going to look at compliance with STARK and anti-kickback statutes. We are going to make sure that with respect to any license agreements for space that they adhere to the fair market value for rental of space to comply with the STARK provisions and anti-kickback provisions. We are going to look at any affiliation contract. The smaller affiliation contracts -- the big affiliation contracts are all reviewed very carefully by outside counsel. We are going to look at the smaller affiliation contracts and make sure there are no provisions in there that put us at risk of violating STARK and anti-kickback statutes. We will also look at the business associate agreements to make sure that all of the vendors that have access to protected health care information actually have business associate agreements in place. The Office of Procurement has created a database to make sure that the business associate agreements can be readily identified. The work group will convene again within the next month or so to discuss the Deficit Reduction Act to make sure that all of our vendors are in compliance with the same.

Mr. McNulty updated the Audit Committee on the Accountable Care Organization compliance program. On June 12, 2012 the board of directors, by way of resolution, approved the formation of the HHC ACO, Inc., which is a wholly-owned subsidiary public benefit corporation in order to establish an accountable care organization. The CEO of the organization is Dr. Ross Wilson, who is also the Senior Vice President of Quality and Corporate Chief Medical Officer of the Corporation. The medical director is Dr.

Nicholas Stine and the Director of Operations of the ACO is Megan Cunningham. As of now the participants of the ACO is Coney Island Medical Practice Plan, Downtown Bronx Medical Associates, Harlem Medical Associates, Mount Sinai, Metropolitan Medical Practice Plan, NYU, HHC and PAGNY.

The restrictions of patient inducement that the entities will provide that are part of the accountable organization. Not give or offer any gifts or any other remuneration to patients for their participation in Accountable Care Organization and patient avoidance, that the entities and providers that are part of the ACO are prohibited from avoiding at-risk patients, including those patients who have a high risk score for high cost due to hospital utilization are duly eligible or have a disability or mental health or substance abuse disorder.

There are five key elements to the compliance program that we have to meet. Element one is the appointment of a designated compliance official. I have served as the chief compliance officer of the Accountable Care Organization (ACO). Element two is a development and implementation of mechanisms for identifying and addressing compliance problems, we have a reporting system. If there are any issues with the Accountable Care Organization they can report that to the Office of Corporate Compliance. We also meet with the ACO with respect to the risk assessment process. I will be working closely with the director of operations, Megan Cunningham, to make sure they are involved in the corporate-wide risk assessment process. Element three is a method for the ACO and participants and other entities to anonymously report activities and compliance complaints to my office. They can do that by our toll free hotline or email or regular mail or do it in person. Element four is compliance training. All ACO participants that are members of our medical staff they have access to our compliance training. They are mandated to do the compliance training, and there's a particular section in there that is dedicated strictly to the Accountable Care Organization requirements. Further, there is a requirement to report probable violations of law to a law enforcement agency and we have processes in place to do that.

Mr. McNulty discussed the Delivery System Reform Incentive Payments (DSRIP) compliance program. He informed the Committee that in April 2014 the State finalized an agreement with the federal government to allow the State to reinvest over \$8 billion of the \$17.1 billion in savings generated through Medicaid redesign team reforms. He stated that, of this approximately \$6.5 billion was allocated for the Delivery System Reform Incentive Payments, which is the main vehicle that the State will utilize to implement the savings generated through the Medicare redesign reforms. He stated that, DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicare program with the primary goal of reducing avoidable hospital use by 25 percent over five years. He explained that the compliance program for DSRIP mirrors the eight elements of the compliance program for all other risks. He informed the Committee that the subject elements were outlined on pages 25 and 26 of the report. He explained that these elements are similar to the same elements as the Accountable Care Organization. Mr. McNulty provided in summary that, the only difference between the providers that will be part of the provider network and HHC -- as the PPS lead in the provider network -- is that HHC will have to be involved somewhat with the training and education. He stated, in sum and substance, that HHC will have to make sure that participating providers have access to OCC's compliance systems to make complaints with respect to any misuse of DSRIP funds.

He advised the Committee that the Office of the Medicaid Inspector General (OMIG) basically said if you are a PPS lead you are required to "follow the money," Mr. McNulty explained that we have a responsibility to make sure the DSRIP funds are appropriately allocated and in compliance with any DSRIP programs requirements promulgated by the State.

Ms. Youssouf asked about the work load.

Mr. McNulty responded that it will up the work load but added that as part of the DSRIP budget, we will have two compliance officers that will be dedicated to work on DSRIP activities. One will be temporary and if we need to continue have to that person on we will. We will have a permanent person that will be focused on this. The one key point is the training to make sure that people get trained and we can take a certification from them but OMIG requires us to do audits periodically.

Ms. Youssouf asked is the training going to be the same training as HHC training and ACO training. To which Mr. McNulty responded no. He elaborated further by stating that it will be similar in some parts but we will have to with respect to DSRIP outline the requirements of DSRIP. He stated that some of the providers are already certified under the Medicaid program as an effective compliance program. With regard to those providers, he stated that they already have their staff trained. He provided,

in summary, that the training in question is more with regard to the smaller providers and that we will have to provide them information and make sure that they disseminate that information to their staff. They will not necessarily have access to our training systems. We will have to provide them with an overview of the topics that they should train their staff on and then audit periodically to make sure it is done.

Mr. Martin asked Mr. McNulty, in summary, if Mr. McNulty was talking about all of the partners that we have within DSRIP. Mr. McNulty answered yes.

Mr. Martin asked if their staff need to be trained. Mr. McNulty said absolutely, they need to receive materials from us.

Ms. Zurack asked if it can be by Computer-based training (CBT) or some kind of electronic form. Mr. McNulty replied that HHC can provide the training at once completely, but then that is a tremendous cost to do that. The alternative is you can provide them the information that they need to train their corporate workers on and then certify that all their workers have been trained.

Ms. Youssouf commented that that is training 200 trainers to train their people. Still a big job, very costly and time consuming.

Mr. McNulty stated that the other key element is that they will have access to our reporting hotline to report any DSRIP-related compliance issues and that we will have respond to that.

Mrs. Bolus asked no way out of it? Mr. McNulty replied, in summary, that there was no way out of it because, as the PPS lead, the State's position is we are giving HHC X amount of money and in return HHC must carry out these responsibilities.

Mr. McNulty continued on with Gotham Health FQHC and compliance oversight. We met with the Gotham chair and members of their board of directors back in April and we provided them with a compliance update with regard to the HIPAA security risk assessment requirements which I discussed earlier and also any privacy incidents that occurred at the diagnostic treatment centers ("D & TCs"). We also discussed whether or not there were any excluded providers at the D & TCs and we talked about the risk assessment process and how we will involve the D & TCs. We plan to meet with the Gotham board and Dr. McCray. We meet bimonthly to provide them an update on compliance issues.

Mr. McNulty move forward as requested that the Committee turn to page 29 of the Report and the corresponding attachment, which was a joint guidance document issued by the Office of the Inspector General; the Association of Internal Auditors; the American Health Lawyers Association; and the Health Care Compliance Association. He informed he Board that the document was titled the *Practical Guidance for Health Care Governing Boards and Compliance Oversight*. He explained that the document covered the following: (i) expectations for board oversight and compliance functions; (ii) roles and relationships of the various departments throughout the enterprise that are responsible for compliance and quality; (iii) the reporting mechanism to the board; (iv) potential auditing and risk areas; and (v) accountability and compliance. In summary, he informed the Audit Committee that he would go over the document in greater detail in September.

Mr. McNulty concluded his report.

Capital Committee – July 9, 2015

As reported by Ms. Emily Youssouf

Senior Assistant Vice President's Report

Roslyn Weinstein, Senior Assistant Vice President, Operations, advised that the meeting agenda included three action items; a license agreement with Sirius XM Radio for authorization to continue to operate an antennae on the roof of the Henry J. Carter Specialty Hospital and Facility; a license agreement with the Visiting Nurse Service of New York for authorization to continue to occupy space at Bellevue Hospital Center; and, a request for project approval to install new permanent energy feeders at Woodhull Medical and Mental Health Center.

Ms. Weinstein provided an overview of Fiscal Year 15, highlighting positive changes in the Capital Committee process, and general accomplishments from July 2014 through June 2015. Ms. Weinstein explained that the inception of the Capital Collaborative Committee had made the capital planning process more transparent by allowing Networks to prioritize their own capital needs, and by including representatives from the Finance Department and Procurement in the entire process. She noted that a new methodology was in effect for purchase of medical equipment, which involved direct review by Procurement, which should also facilitate the process.

Ms. Weinstein advised that a decision by the Office of Legal Affairs to use Fair Market Value (FMV) rates in lieu of Institutional Cost Recovery (ICR) rates when leasing and licensing space within HHC facilities had increased revenue by an estimated \$40,000.

In summation, Ms. Weinstein reported that spending over the fiscal year included \$101,409,570 in construction and \$5,593,000 in payments for equipment purchases. She said that she believed that 99% of the projects completed were on budget and on time, and for the few that were not, the Department of Facilities Development was aware of causes, involved in solutions, and reported to the Committee ahead of time so as to minimize the number of surprises. She noted that the Corporation had also received \$5.7 million in energy funding, which would help the Corporation meet the Mayoral mandate of reducing emissions by 80% over the next 50 years. She said that she was personally proud of the work that the Capital Committee had done, with support of the Board of Directors and the facilities, but believed in continuous improvement, and therefore looked to keep the momentum going in the coming year.

Mrs. Bolus said thank you.

That concluded Ms. Weinstein's report.

Action Items:

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to execute a five year revocable license agreement with Sirius XM Radio Inc. (the "Licensee") for its use and occupancy of 90 square feet to house rooftop communications equipment at the Henry J. Carter Specialty Hospital and Nursing Facility (the "Facility") at an occupancy fee of approximately \$23,130 or \$257.00 per square foot for year one; \$23,823 or \$264.71 per square foot for year two; \$24,823.62 or \$272.65 per square foot for year three; \$25,274.78 or \$280.83 per square foot for year four; and, \$26,033.02 or \$289.26 per square foot for year five, for a total five year occupancy fee of \$122,800.31. Annual increased rates are based on 3% escalations per year.

Michael Buchholz, Senior Associate Executive Director, Henry J. Carter Specialty Hospital and Nursing Facility, read the resolution into the record on behalf of Robert Hughes, Executive Director, Henry J. Carter Specialty Hospital and Nursing Facility.

Mrs. Bolus asked if the facility formerly known as Goldwater had moved their on-site radio station to the new Henry J. Carter facility. Mr. Buchholz stated that the resolution being presented was about antennae equipment for Sirius XM radio, and not related, but yes, the radio station had been moved.

Mark Page asked for a description of Sirius XM Radio and whether the occupancy fee was based on Fair Market Value rates. Mr. Buchholz explained that Sirius XM Radio was a satellite radio company that streamed music, news and other radio broadcasts. He said that the agreement had been inherited by HHC, as it was originally located on the North General building and that contract continued under HHC, but at a lower occupancy fee than that being presented. He advised that after the Real Estate segment of Legal Affairs had performed their reviews and HHC was officially drafting a new agreement, the fee had been increased by 43% and was now at fair market value.

There being no further questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable five year license agreement with Visiting Nurse Service of New York Hospice Care (the "Licensee") for its continued use and occupancy of approximately 12,420 square feet of space on the 7th Floor of the Hospital Building at Bellevue Hospital Center (the "Facility") to operate a hospice program at an annual occupancy fee of \$53.58 per square foot or \$665,436 for year one of the agreement, \$55.12 per square foot or \$684,534 for year two, \$56.70 per square foot or \$704,180 for year three, \$58.59 per square foot or \$727,630 for year four and \$59.90 per square foot or \$744,000 for year five, for a total five year occupancy fee of \$3,525,780.

Steven Alexander, Executive Director, Bellevue Hospital Center, read the resolution into the record. Mr. Alexander was joined by John Delfs and Rosemary Baughn, Visiting Nurse Service of New York (VNSNY).

Mr. Alexander explained that the original agreement between Bellevue and VNSNY had been initiated in 2009 after the closing of Saint Vincent's Hospital. At that time VNS had to find a new partner to work with and they found that partner in Bellevue. Upon their arrival at the facility they renovated the space they occupied, and proceeded to operate a distinct Article 28 facility, providing inpatient hospice care. Mr. Alexander noted that a number of ancillary agreements covered medical needs ranging from blood work to lab test, and those were billed to VNSNY at fee for service rates. He said that agreements were also in place to pay for television, food service, among other things. Mr. Alexander said that the Corporation historically had a good working relationship with VNSNY over the initial five (5) year term.

Gordon Campbell, Acting Chair, Board of Directors, asked that Jeremy Berman, Deputy General Counsel, provide an overview of negotiations. Mr. Berman explained that HHC's real estate consultant had provided an FMV assessment that resulted in an occupancy fee above that which was finally settled on. The FMV rate was proposed to VNS and lengthy negotiations followed. Mr. Berman noted that VNS had argued that they could only afford to pay half of the current rate that they were paying, and HHC responded that would not fall in line with fraud and abuse rules, and would therefore would be unacceptable to the Capital Committee and the Board of Directors. Ultimately a compromise was made that the rate would stay at the current rate, the prior Institutional Cost Recovery (ICR) rate, and the basis on which HHC bills Medicaid, for the initial year of the new five year term.

Mr. Berman explained that some licenses that dated back five (5) years, when ICR rates were being used, did experience a market shock, when the conversion to FMV was made.

Mr. Berman added that VNS had regular increases over the previous five (5) year term, and those increases were substantial and difficult to pay. He explained that the compromise was made to remain at the current rate for the first year of the term and provide for further increases over the remainder of the agreement, but there would be a one year holiday from any increase. He noted that VNS had expressed concern about managing the rates going forward and that either party had the right to terminate if financial obligations could not be managed. The benefit to Bellevue was deemed worthy of moving forward, with a safety net in place that termination rights can be exercised if needed.

Mr. Page asked what an Article 28 facility was. Mr. Berman explained that Article 28 was part of a public health law licensing vehicle by which hospitals and other corporate practices of medicine were authorized to operate.

Mr. Page asked if VNS was a not for profit organization. Mr. Gordon said yes.

Mr. Page advised that while he was not bothered by the compromise regarding occupancy fee for the agreement in discussion, and agreed that it was a relevant service to the public, and indeed in line with HHC's basic service goals, he remained steadfast that requiring compensation for use of space by other organizations, even when services are related to HHC goals, makes sense. He urged that decisions not be based strictly on the organizations value to HHC, as HHC was a financially stressed organization and therefore should be shown the cost of the services they provide and the cost of what a licensee (such as VNSNY) does. He expressed concern that HHC policy on such matters was confused. He reiterated that he was in favor of the service being discussed, having it co-located within the facility, and the compromise for a fee increase holiday, particularly given its relation to HHC service.

On an unrelated note, Mr. Gordon thanked Mr. Alexander for hosting a recent visit to Bellevue.

There being no further questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve a Capital Project for an amount not-to-exceed \$8,500,000 for the planning, pre-construction, design, construction, procurement, construction management and project management services necessary for the Installation of Permanent Emergency Power Feeders project (the "Project") at Woodhull Medical and Mental Health Center (the "Facility").

Lisa Scott-McKenzie, Network Deputy Executive Director, Central/North Brooklyn Health Network, read the resolution into the record on behalf of George Proctor. Mrs. Scott-McKenzie was joined by Ricardo Corrales, Senior Associate Director, Woodhull Medical and Mental Health Center.

Mrs. Scott-McKenzie explained that Woodhull Medical and Mental Health Center was lucky enough to have access to tertiary emergency generators, and those generators were connected by feeder cables which had deteriorated and were in need of replacement. She advised that authorization for this project would help prevent unsafe conditions and allow the facility to better prepare for future projects and possible emergency needs.

Mr. Gordon asked how the project would be funded. Louis Iglhaut, Assistant Vice President, Office of Facilities Development, said that the project had been fully funded through the New York City Office of Management and Budget (OMB), and that funding included monies for contingency and asbestos abatement work. Mr. Iglhaut explained that existing cables were laid out on the ground, outside of the facility's boiler plant, and were therefore exposed to the outside elements and suffering. He advised that the project had only been waiting on funding from OMB, and now that the funding was in place, and a Certificate to Proceed (CP) had been issued, it would allow for moving of the conduits below ground surface, away from the elements. Mrs. Scott-McKenzie added that the cables in place ran through the facility's mechanical room, which created further vulnerability in case of emergency, and this project would also allow for that issue to be remedied.

Mr. Gordon said that it sounded like a must do project. Mrs. Scott-McKenzie said yes.

Mr. Page asked for an explanation of Mrs. Scott-McKenzie's statement about access to tertiary energy. Mrs. Scott-McKenzie said that back-up generators were a facilities first option for secondary energy, in case of emergency, and these emergency power feeders were the line of defense after that.

So they are a back-up to the back-up, asked Mr. Page. Is that common? Mrs. Scott-McKenzie said no that is not common but a number of years ago, funding from the Federal Emergency Management Agency (FEMA) had provided for the initial cabling. She noted that Woodhull Medical and Mental Health Center was a receiving facility in event of emergency and this would allow for the facility to remain on line and shelter in place if needed.

Mr. Page asked if this secondary back up would be more flood proof. Mrs. Scott McKenzie said it would be after completion of the proposed project.

Mrs. Bolus asked if this would affect patient care. Mrs. Scott-McKenzie said no, it should not.

There being no further questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

Information Items:

Project Status Reports

There were no reports provided.

Ms. Weinstein advised that a ribbon cutting had been scheduled for July 15, 2015 at the Ida Israel Clinic, and members of the Board of Directors were invited to attend.

Mrs. Bolus asked that Emily Youssef, Chair of the Capital Committee, who was not in attendance, be provided with the information shared in the Senior Assistant Vice Presidents report. Ms. Weinstein said she would do that.

Mrs. Bolus asked that a summary of accomplishments by all Committees over the course of the year be shared with the full Board of Directors. Mr. Martin agreed that would be a good idea.

Finance Committee – July 14, 2015

As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Zurack stated that her report would include HHC's year-end cash status, the City's Adopted Budget and HHC's work plan for FY 16 relative to the financial plan and cash flow. Taking the Committee through HHC's year-end cash position, HHC ended FY 15 with a cash balance of \$547 million or 34 days of cash on hand (COH). This was achieved as previously reported to the Committee through a delay in HHC making its FY 14 City payments until July 2015; and the FY 15 and FY 16 payments have been scheduled on a quarterly basis throughout the current FY 16. The year-end cash balance is due largely to the continued delay of HHC payments to the City.

Ms. Youssef asked if after those payments are made how much it will reduce the year-end cash balance.

Ms. Zurack stated that it would be reduced to \$240 million or 14 – 15 days of COH; however, HHC is awaiting the receipt of certain UPL payments in August 2015 that would increase that cash balance and COH to higher levels. However, HHC will have a very difficult cash year this FY 16 and in order to remain afloat essentially HHC must achieve its below the line actions totaling \$309 million as part of its gap closing plan and continue to press the State and Federal governments to be more timely in the issuance of the UPL payments to HHC. Additionally, HHC will need to explore seasonal borrowing from the City of NY in order to maintain an appropriate level of cash. HHC has been meeting with the State on identifying some additional revenue sources of at least five. Additionally, Corporate Finance is preparing a presentation to the City advising them of HHC's financial status and to get their guidance on how HHC should proceed. HHC is also in discussions with the City regarding seasonal borrowing. It is important to note that the majority of HHC's revenue that has been pending has been rolled over cash from prior years and programs that were in place last FY 15 such as the Interim Access Assurance Fund (IAAF) a one-time grant from the State that was not sustaining and not continuing. Therefore, other funding options to support that loss must be identified. HHC has been in discussion with CMS and their team and there are a significant number of items that HHC has been requesting and is in constant discussions with the City regarding its status.

Dr. Raju added that the City is very much aware of HHC's cash flow issues and HHC will continue to work with OMB and Deputy Mayors on addressing those issues that are critical to HHC financial stability.

Ms. Zurack stated that the City's Adopted Budget for FY 16 included some very significant changes for HHC most notably being the Correctional Health program which adds additional funding for both budget and expense that total \$137 million for FY 16 growing to \$156 million in FY 17 – FY 19. The City has included in the Adopted Budget additional funding for collective bargaining (CB) for Doctors Council, plumbers, etc. On the capital side an additional \$12 million has been included for the primary care expansion. The Borough Presidents have added \$3.4 million for three major projects and \$11 million from the City Council for a variety of projects throughout HHC.

Ms. Youssef asked how the seasonal borrowing would work. Ms. Zurack in response stated that HHC would borrow from the City in the form of a note.

Mr. Page added that from a technical standpoint, HHC can legally issue notes and those under NYS law are under some constraints, recently a legal investment for NYC.

Ms. Zurack stated that the City would purchase an HHC note.

Mrs. Bolus asked what would be the interest rate. Ms. Zurack stated that HHC is in process of exploring what that rate would be and will be negotiated. In the past when HHC did seasonal borrowing it was not at a low interest rate it was at market rate.

Mr. Rosen asked what HHC would pledge. Mr. Page interjected that it would be general credit to which Ms. Zurack agreed.

Mr. Page added that in the past when this mechanism was used it was at market rate for notes of this kind.

Ms. Bolus asked when the last time this type of borrowing was done by HHC. Ms. Zurack stated that it was in 1994.

Ms. Youssouf asked how the process would work for this type of borrowing and whether it would entail HHC getting a rating and would the issuance be in a formal way.

Ms. Zurack stated that it would be a formal issuance but no rating is required. Mr. Page added that it would depend upon what the buyer will require.

Ms. Zurack stated that there are some transactions required but it is not the same as a typical borrowing.

Mrs. Bolus asked if it would affect HHC rating. Ms. Youssouf stated that it could be impacted by the amount of debt HHC has. Ms. Zurack agreed.

Mr. Page added that the issue of HHC's rating and if the City agrees and there is a smooth mechanism to provide a steady cash flow that would help HHC. However, the underlying cash problem regardless of these notes is of greater concern.

Ms. Zurack added that HHC has a structural budget problem that must be addressed and HHC has been meeting with CMS, the State and Federal governments in an effort to resolve the various issues impacting this problem. The cash flow is another layer of that but they intercept. If the appropriate level of revenue such UPL payments were to flow as it should to HHC there would not be a cash flow problem.

Mrs. Bolus asked if the outsourcing that HHC has done would have an impact on the flow. Ms. Zurack stated that had HHC not done those outsourcing initiatives and not achieved the savings the structural problem would be greater.

Mr. Rosen commented that it would be a seasonal borrowing and HHC would be expected to repay the loan within the year.

Ms. Youssouf added that it is not the best approach for HHC considering the current status of HHC's revenues.

The reporting was concluded.

Key Indicators/Cash Receipts & Disbursements Reports

Ms. Olson stated that the utilization report reflected data through May 2015 and that utilization continued to show a downward trend that has been ongoing throughout the year. Billed ambulatory care visits were down by 2.8%; D&TCs visits were down by 3.7%; discharges were down by 1.6%, excluding Coney Island discharges were down by 2.3% which is an improvement over the prior year whereby the downward trend was at 6.5%.

Ms. Youssouf asked if there were any significant changes in utilization given that across the system utilization was down.

Ms. Olson stated that NCB was due to the labor and delivery unit that reopened. Inpatient admissions were down due to the decline in readmissions and lower one-day stays. Some of the trends are positive and some are not relative to the impact on utilization.

Mr. Page asked how much of an impact it was. Ms. Olson stated that it was 50% and readmissions and one day stays are down at a greater rate than in prior years.

Ms. Youssouf added that the trend is going in the direction that HHC has expected. Ms. Olson agreed but added that it has had an adverse impact on utilization.

Ms. Zurack added that it is something that HHC has been working on in order to comply with the new regulations but it has not necessarily been in the best interest of HHC.

Ms. Olson continuing with the reporting stated that nursing home days are up by 2.1% compared to last year with Gouverneur showing the most improvement compared to Hank J. Carter which has remained flat.

Ms. Youssouf asked what the issues with Renaissance are. Ms. Olson stated that a few months ago, Mr. Samms, Network CFO addressed this issue with the Committee as it relates to the decline. The competition in the area has had a significant impact on the facility's workload; however, the facility has a plan to address this issue.

Ms. Zurack noted that Renaissance had to move to less desirable location and new competition in the community have impacted their utilization; however, the facility has been addressing the issue and has developed a plan to restore its market share.

Ms. Olson stated that the LOS compared to the corporate-wide average overall, two facilities were above the average. Coney Island remains significantly above at 6.10 of a day. The CMI was up by 1.8% due to the decline in one-day stays.

Mr. Covino continuing with the reporting stated that FTEs were up b7 436; however, for the month the increase was 162 due to the transitioning of per diems who were working full time as per diems to full time employees. In total 700 FTEs will be added to the full time headcount. Receipts were \$47 million worse and expenses were \$158 million worse than budget. Receipts and disbursement against last year's actuals through May 2015, receipts were \$379 million higher than last year due to the DSH/UPL payments of \$394 million. MetroPlus risk pools were up by \$16 million; Medicare and Medicare managed care were up by \$39 million and hospital medical home was up by \$23 million, offset by an \$88 million reduction in the SubSLIPA pools which was paid earlier in FY 14 as an advancement that reduce the payment by one for FY 15. Expenses were up by \$39 million and PS expenses were up by \$210 million of which \$170 million was due to CB increases; allowances were up by \$22 million; overtime was up by \$7 million compared to last year. Fringe benefits were up by \$36 million due to CB. OTPS expenses were up by \$102 million due to pharmaceutical cost relative to the change in the 340B policy changes and an increase in the cost of generic drugs. Purchased services were up by \$22 million and other than professional services were up by \$20 million and medical surgical expenses were up by \$17 million.

Mr. Page asked where on the report is the City's commitment to fund CB increases reflected.

Mr. Covino stated that it comes in as a receipt thru City services under the tax levy category. The fund are received and shown as an expense.

Ms. Zurack stated that it is in the tax levy category but there were other things that decreased that funding.

Mr. Page stated that by reporting it in that way was misleading and perhaps should be shown and reported differently, given that some of what is also booked in that category is HHC's obligation that is not related to the CB. Therefore it should be reported and booked differently. Also a lot of time was spent on the reporting of the conversion of the per diems to full time employees; however, in actuality the numbers do not represent the actual headcount.

Ms. Zurack agreed and Mr. Covino added that next year's metric which will be based on global FTEs will be more reflective of the actual headcount compared to the current metric that is not all inclusive.

Mr. Rosen added that based on his discussion with Mr. Covino the FTE change was basically a change in the payroll status. Mr. Page noted that was understood but the reporting was not reflective of what was shown on the report relative to the comparison.

Ms. Youssouf asked what was included in purchased services. Mr. Covino stated that it includes expenses for the Cerner project; IT initiatives; Meaningful Use initiative through QuadraMed and \$16 million in cost related to the lab initiative.

Ms. Youssouf asked if contracts such Surgical Solutions would be included in that category. Mr. Covino stated that it wasn't clear whether it would be book under that category but would check and report back to the Committee.

Ms. Zurack added that it would be in the overall OTPS expenses; however, that level of detail would not be included on the report given that the report is based on the aggregated changes in the OTPS and would include all contracts as part of the OTPS expenses.

Ms. Youssouf stated that part of the rationale for all of the outsourcing initiatives was to generate savings and where those savings are being shown is not reflected on the report which is what the Committee would expect to see.

Ms. Zurack stated that at that level of the reporting the data is aggregated so it difficult to get to that level of detail that is embedded in the total expenses which are what HHC is spending for OTPS and those very fine changes would be difficult to pinpoint at that level of reporting.

Ms. Youssouf stated that the purpose of doing those types of program is for the overall changes and savings and if it is being done for that purpose, those savings are not being reflected in the reporting and it should be.

Ms. Zurack added that those savings are dwarfed by other growth in expenses which is unfortunate. Therefore, there is no net reduction in cost. It is not like HHC is doing those small program that generate some savings. These initiatives do not reduce the spending but rather the spending is over one year over the next.

Ms. Youssouf stated that HHC has been able to generate some savings that trimmed or cut expenses and that is what the Board needs to know.

Mrs. Bolus added that it should be in the simplest form.

Mr. Page stated that while the numbers dwarf the results of those initiatives the question of initiatives to outsourcing of structural achieved savings in services warrants a separate report that would show what has been achieved in the last year to generate savings.

Ms. Zurack stated that reporting in that level of detail would not be recommended given that it would be looking backwards at something that is not included in HHC's financial plan which is what the Committee should be holding HHC accountable for. Those reductions total \$309 million which is not those initiatives but other things such as the global FTEs and various revenue items. By focusing on those initiatives that are currently reflected in the plan, the Board would be holding management to the strategic objectives which HHC has to achieve. If not achieved, HHC will be in a serious financial problem.

Mrs. Bolus added that it important for HHC to look forward; however, the Board needs to feel comfortable about the decisions it has made relative to those contract and the expectations that were identified as the reason for the outsourcing. At the end of the FY it is important for the Board to know whether those initiatives were successful which for the Board is a very critical issue.

Ms. Zurack stated that there are concerns about HHC's cash flow going forward and the request by the Committee are material things and it would be advisable for the Board to think of the future in a different way.

Mr. Rosen stated that it is a difficult analysis to do based on speculation of what might have occurred if HHC did not move forward with those initiatives. It is easier to measure input than output.

Ms. Zurack stated that there is a major program of actions that must be achieved otherwise it will be worse and the Board should try to focus on that. Perhaps in the future some type of analysis can be done in response to the Committee's request. Mr. Martin does an analysis of those types of initiatives which can be done at a future date for the Committee.

Mr. Martin stated that he would provide the Board with an annual report on those initiatives in conjunction with finance.

Ms. Youssef stated that the Board will continue to be supportive of HHC; however, more detail is needed.

Mr. Covino continuing with the reporting stated that the comparison of the actual spending against the budget, receipts were down by \$85.5 million due to Medicaid fee-for-service (FFS) compared to the budget workload, paid Medicaid was down by 2,100 paid discharges; chronic days down by 23,000; psych days down by 4,500. Outpatient receipts were up by \$48 million due to an increase in the risk pool transfers from MetroPlus. All other receipts were down by \$9.7 million due to a shortfall in the budgeting of the pools. PS and fringe benefits were on budget; OTPS spending was up by \$105 million; affiliation expenses were over budget by \$4.5 million due to a shortfall in fringe benefits at Jacobi hospital. The reporting was concluded.

Action Item

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve and appoint Citigroup, JP Morgan and Morgan Stanley & Co. to provide investment banking services and serve as senior managing underwriters, and to approve and appoint BNY Mellon Capital Markets, Blaylock Beal Van LLC, Drexel Hamilton LLC, Fidelity Capital Markets, FTN Capital Markets, First Southwest, Janney Montgomery Scott, Jefferies LLC, Loop Capital Markets LLC, Mischler Financial Group, Ramirez & Company, RBC Capital Markets, Rockfleet Financial Services, Roosevelt & Cross Inc., Stern Brothers, TD Securities and Wells Fargo Securities to serve as co-managing underwriters for the Corporation's debt issuances from August 2015 through July 2020 to support its capital finance program. Such authorization in respect to the entities mentioned above shall extend to the successors of any such entities which assume the business of such entities through merger, reorganization, consolidation or acquisition.

Further authorizing the President to negotiate and execute a contract with one of the three senior underwriters in the event of a Board authorized issuance.

Ms. Dehart stated that the resolution was for the approval of a number of firms to be authorized to serve as underwriters for the Corporation. It does not immediately result in a contract. The role of the underwriter is triggered upon approval by the Board of an authorization for HHC to issue debt. Imbedded in that issuance is the Board's approval of the development of a contract with the senior underwriter to serve in an advisory capacity in the development and execution of a deal; manages the sales and generally sells the largest share of the funds; and works directly with the co-manager firms who participate in the marketing and sales. As part of the selection process an RFP was issued in March 2015 for these services with proposals due in April 2015. There were nine firms that submitted proposals for senior underwriter and eleven submissions to serve as co-managing underwriters. The selection and review Committee consisted of representation from corporate finance, Office of Facility Development (OFD), Bellevue finance, OMB and the City's Comptroller's office. Six firms were interviewed in June 2015 and three were selected to serve as senior underwriters which include, Morgan Stanley, Citigroup and JP Morgan Chase. All of the remaining firms were deemed qualified to serve as co-managers for a total of seventeen. There were representatives from the three senior underwriter firms in attendance. From Citigroup, Katherine Fedele and Marjorie Henning, JP Morgan Chase, Edith Alfenas and from Morgan Stanley, Joan Marion and Barbara Scudder Pritchard.

Mr. Rosen stated that it is an annual contract. Ms. Dehart stated that it is a five-year contract.

Mr. Page added that it is not an annual contract but a contract each time HHC borrows.

Ms. Zurack stated that the procurement was for five years but as Mr. Page indicated a contract is needed each time HHC does borrowing.

Mr. Page added that it is important that HHC has a debt structure that has proven to be very resilient up to now. In structuring the underwriters group for future debt issuance there is a need to have some fixed standard in terms of the capitalization of the firms that from time to time HHC uses in its bond issuance. There should be a commitment to have a group of underwriters who have the resiliency to genuinely support HHC in its marketing efforts and the placement of its debt going forward. To which Ms. Zurack and Ms. Dehart agreed.

Ms. Bolus stated that given that it is a large group how often would HHC need to consult with the whole group. Ms. Dehart stated that HHC would consult primarily with the senior underwriter who would manage the deal and for each deal one is selected to manage that deal.

The resolution was approved for the full Board's consideration.

Information Item:

Lisa Sbrana Essential Plan – The Basic Health Program (BHP) In NY

Ms. Zurack informed the Committee that Marjorie Cadogan, Executive Deputy Commissioner, Citywide Health Insurance Access, Human Resources Administration was also in attendance and she has been working closely with HHC on increasing its market share and MetroPlus enrollment. Ms. Sbrana has worked with HHC for a number of years and having her come to present to the Committee the BHP is extremely important to HHC's strategic efforts in assisting MetroPlus in its enrollment efforts.

Ms. Sbrana of the NYS of Health, the health insurance marketplace for NY stated that there is some excitement about moving forward in the new initiative this fall. NY is one of two states that took up the ACA option for the BHP that is for people between the federal poverty level (FPL) and 200% of the FPL. Those individuals currently get some cost sharing relief and premium assistance but not to the extent of getting into the new program. The premiums average depending on the tax credit could be \$50.00 per month and on the basic health program that would be approximately \$200.00 per month. The deductible is also being eliminated so that individuals will have first dollar coverage when they come in. The BHP is required to provide all of the essential benefits that are currently in the plan and most of the plans that are providing qualified health plans today in the marketplace are also taking up the BHP. As such there should not be any shuffling in terms of continuity of care. The way the program is funded is through federal dollars that individuals will get for the premium tax credit or their cost sharing reductions the State will get 95% of that and the state funds used are from the savings from the Medicaid program. The population that will be in the State BHP will include individuals under the age of 65; a state resident; eligible for Medicaid or Child Health Plus (CHP); there will not be any children in the NY on the BHP due to the coverage under the CHP that goes up to 400% of the FPL and BHP only goes up to 200%. The program is primarily for adults and the other groups are under the federal rules of 138 – 200%, 0-138% of the FPL who are not eligible for Medicaid under the federal rules. In NY the rules are more expansive but there are immigrants who will be in the basic health program.

Ms. Youssouf asked who the immigrants are. Ms. Sbrana stated that they are not undocumented. They are immigrants under the federal rules for those who have not had their status for five years those individuals are not eligible for federal Medicaid but are eligible for Medicaid in NYS and those individuals who are residing under color of law or Permanently Residing Under Color of Law (PRUCOL).

Mrs. Bolus asked if those individuals who are included in HHC Options would fit into that plan.

Ms. Zurack stated that some of the Options individuals will be eligible for that program and HHC will assist them in signing up to become eligible which is part of the reason for Ms. Sbrana presentation on the program to the Committee, as one of the things in HHC plan is to convert more people into health plans.

Ms. Sbrana stated that there are two major categories of Medicaid recipients who receive coverage and who will not go into the BHP due to the function of their medical needs and what is included in that program. Individuals who need long term care or under the ACA having minimal essential coverage, Medicaid wraps around that coverage which is usually employer base coverage that cannot be done through the BHP. Individuals who come into those categories will go back into Medicaid. There will be a

wrap of Medicaid services around the BHP. The BHP is required to provide all of the essential benefits that people in the Qualified Health Plan (QHP) receive and that does not include some important Medicaid benefits such as non-emergency transportation, non-prescription drugs, adult dental, orthotic devices, orthotic footwear and vision care. The health plans will be asked to provide a premium for the Aliessa population in the Essential Plan that reflects the wrapped benefits. Under the federal rules, NYS was required to choose how it would go forward and choose a hybrid of Medicaid and commercial coverage rules. Individuals who are eligible for the BHP will not be locked into the open enrollment period and can enroll at any time during the years. The coverage is similar to Medicaid managed care and CHP. It is on the first or the following month depending on when an individual enrolls if before or after the 15th of the month. There is an opportunity under the federal rules to provide continuous coverage. As of now, if an individual enters the Medicaid program and the income increases the eligibility would not change. NYS health offers twelve month continuous coverage and this is being discussed with CMS for the BHP program as well. Renewals are every twelve months; verifications are the same, appeals for eligibility are through the market place but if there are coverage appeals those would follow the rules of the program that the individual is covered under.

Ms. Youssouf asked for clarification of the continuous coverage regardless of an increase in income.

Ms. Sbrana explained that it was not in the current terms of the program but rather what is being proposed under the BHP given that some individuals cycle in and out of employment. There are no premiums for those individuals who are below the FPL, 150% to 200% of the FPL for 200% of the FPL would be \$20.00. The premium level for 150-200% is \$20.00 and a 30-day grace period for none payment which follows the CHP rules.

Mr. Rosen asked if the program is subsidized by the federal government to cover the difference in what individuals will pay.

Ms. Sbrana stated that NYS under the federal rules allows for the acceptance of the federal funds that are placed in a designated trust fund. The BHP will be offering plans that include dental and vision and will have an increase premium. Individuals above 138% that will be provided through Medicaid but for all other there will be an option for them to get the dental and vision benefits for a small or reduced fee. As part of the cost sharing there are no deductibles for any of the income groups which is different from what individuals are receiving today as part of the 150-200% of the FPL. All of the co-pays are lower than what this group would pay currently.

Mr. Rosen asked for clarification of how the funding from the federal government as part of the subsidy would flow to the insurers.

Ms. Sbrana stated that the funds would flow to the plans and the plan would pay the providers. These are all commercial insurers. The rates are being set by DOH under the State law rather than the Department of Financial Services (DOFS). That group is working on the rates and is expected to have those completed by the end of July 2015 with negotiations to follow thereafter.

Ms. Youssouf asked how much the program would help HHC in achieving its plan's reduction of \$309 million.

Ms. Zurack stated that this is part of the MetroPlus strategic plan to get to the 1 million covered lives. This first bid was to get the Aliessa population into the BHP which is less important for HHC but more important for NYS. Essentially when the Aliessa population which was state only gets into this program the federal government will pick up a large share of that which is a big windfall for the NYS. However, next year when 138% - 200% of FPL comes into effect it will represent a significant portion of the MetroPlus strategic plan uptick. HHC will report back to the Committee on how much of that will benefit HHC as part of the BHP. HHC wants to be supportive of MetroPlus and its patients.

Ms. Youssouf asked if the self-pay population would be impact by that group.

Ms. Zurack stated that it would. Some of the people as part of the Options are eligible for the BHP and HHC will work with them on getting enrolled for the coverage and MetroPlus will get the premiums and pay HHC the fees as expected benefits of the BHP. In the out years of the plan, HHC assumes \$104 million after the entire ACA is implemented through increase Medicaid eligibility and commercial eligibility.

Ms. Sbrana stated that the opening enrollment starts November 1, 2015; however, the Aliessa group has been transitioned in placed into the plan.

Ms. Zurack asked if the State has considered offering the BHP to the undocumented immigrants.

Ms. Sbrana stated that under the BHP it is not allowed to offer the program to that population. However, there are some discussions regarding that particular group but it is unclear as to how or what the outcome will be.

Mrs. Bolus asked if individuals could prepay for the year. Ms. Sbrana stated that it was unclear if that is permitted but will confirm and report back.

Dr. Raju thanked Ms. Sbrana for taking the time to come and present to the Committee adding that as a take away from what was presented unless the rates are set HHC will not be able to determine the network. There is opportunity for HHC to benefit from the BHP but there is also a potential threat for HHC as well. HHC's options program is only for HHC as a source of treatment. Now as a MetroPlus member there are more choices for individuals and some will opt to go to another hospital system. Therefore there is a potential for HHC to lose more utilization. As such, it goes back to the patient care experience which is more critical given those options available to individuals and patients.

Ms. Sbrana stated that the networks are between the plans and John Ullberg's group at DOH. Ms. Zurack asked if it was the network or the premiums for that group. Ms. Sbrana stated that the rate setting is with Ullberg's group and the network is with another group.

Ms. Zurack asked if she had any insight into what the requirements of the network are.

Ms. Sbrana stated that the requirements are the same as for the QHP. Dr. Raju added that if that is the case that is a problem for HHC. Ms. Sbrana stated that the program is trying to ensure that continuity of care is there for individuals. In terms of the networks that is looking at provider ratio to patients and how many hospitals are in the network, and access. There have been some narrowing of the network that have been approved based on the rates but it is unclear whether that would work. Basically it is looking at whether the individuals will have the same access which would be a major factor.

Ms. Zurack stated that based on discussions with the State the premium was a mix of something between a commercial and Medicaid that would be higher than Medicaid but lower.

Ms. Sbrana stated that her office has not been a part of those discussions and therefore could not confirm that rate structure. The presentation was concluded.

Governance Committee – June 15, 2015

As reported by Mr. Gordon Campbell

Mr. Rosen asked and received the Committee's approval to convene in Executive Session to discuss a personnel matter.

Mr. Rosen stated that this meeting was convened to discuss the appointment of Patricia (Patsy) Yang, Dr.P.H. to the position of Senior Vice President for the newly created HHC division of Correctional Health Services.

Dr. Raju informed the Committee that control of the City's correctional health services is to be transferred to the Corporation.

To support this area of responsibility, Dr. Raju determined that it would be best managed centrally via a division of correctional health services headed by a senior vice president reporting directly to the president. Therefore, he is recommending Dr. Yang to be considered for this position.

Dr. Yang is a veteran in city government and the Corporation having served in planning and analysis positions in administration and operations at both private and HHC facilities as well as her 26-year experience in executive positions at the Departments of

Health for Westchester County and for New York City; and currently as the Director for Policy in the Mayor's office as advisor to the Deputy Mayor for Health and Human Services.

The management of correctional health services requires a person of strength, determination and resilience to successfully administer in this capacity and he believes the Dr. Yang can fulfill this role admirably given her experience within city government which will further augment her abilities to operate successfully in this effort.

She is fully aware of the needs and attention that this service requires and is very passionate and committed to the responsibility of serving the comprehensive health care needs for this population.

The Committee wholeheartedly agreed with Dr. Raju's position and unanimously approved his recommendation for the full Board's consideration.

Medical & Professional Affairs / Information Technology Committee

-July 9, 2015 – As reported by Dr. Vincent Calamia

Chief Medical Officer Report

Machelle Allen, MD, Deputy Chief Medical Officer, reported on the following initiatives.

Office of Population Health

This summer, HHC will be participating in another season of the Fruit and Vegetable Prescription program in partnership with Wholesome Wave. The program supports overweight or obese children and their families with nutrition education and goal-setting on healthy eating. The program also provides families with a prescription for fruits and vegetables that can be redeemed for fresh produce at local farmers' markets.

Office of Behavioral Health

Transformation Project; Readiness for Managed Care:

A learning session was held on June 23, 2015 which presented the results of the four pilot sites and presented the next step pilots for all HHC facilities. The conference was well attended and included several CEO's and CFO's of the facilities demonstrating the commitment of facility leadership to this process. Evaluation of the conference was very positive and attendees demonstrated high levels of enthusiasm and energy about the projects. The pilots that are planned for all facilities are the following:

- Increase Behavioral Health Access: by expansion of the current Access project;
- High Utilizer Data project: focusing on high utilizers of psychiatric emergency room services;
- Inpatient to Outpatient Bridging: using peers for transition;
- Outpatient Engagement: using community outreach to engage patients;
- Behavioral Health, Primary Care Integration: transition of identified stable patients from Behavioral Health clinics to Primary Care services.

An implementation plan for each facility has been developed for the Access and High Utilizer projects. Specific playbooks and implementation plans are being developed for the other projects and are scheduled for startup in September 2015.

Family Justice Center – Domestic Violence program:

This is a potential program which establishes evaluation and short term treatment for victims of domestic violence which will be provided on site at the Family Justice Center program. A meeting has been scheduled with Dr. Catherine Monk who is the director of a similar program at Columbia University. We are in the process of developing a model for this program and a proposal will be finalized for review.

NYSOMH / OPWDD (Office of People with Developmental Disabilities) / HHC collaboration:

This is a collaboration to explore and develop a specialized treatment program at one of our acute care facilities for people with both mental illness and developmental disabilities. Discussions with OMH are occurring now. We are awaiting utilization data and financial information from OMH. A next step evaluation meeting is to be scheduled.

HHC Behavioral Health Incident Review Committee:

This is a new committee established to meet the new requirement of the Justice Center. The committee is corporate wide and multidisciplinary and has been set up to review incident data in order to provide guidance to the corporation on trends and management issues. This committee meets every 2 months, the third meeting is scheduled for August.

Office of Patient Centered Care

1. The CNO's spent an entire day reviewing Epic and are quite pleased with the product. There are issues and processes that are being addressed after their input, but it was a positive experience for the nurses and the Epic team. There are additional meetings scheduled with the nurse educators, infection preventionists and Home Care.
2. HHC was awarded a grant from the Hartford Fund, the funding for which started on July 1st of this year. This grant will allow the enhancement of the role and expertise of registered nurses in the ambulatory Geriatric practices, leveraging NICHE (Nurses Improving Care for Healthsystem Elders), our PCMH and ACO experience.
3. The 2015 Nursing Excellence event will be held on October 27, 2015. Please save this date as all of our nurses always appreciate the participation of our leadership.

Accountable Care Organization

- The ACO has convened internal management discussions and planning in preparation for reapplication to the Medicare Shared Savings Program for 2016. The ACO is also meeting with affiliates and HHC ACO Board of Directors in coming weeks to ensure satisfaction of CMS submission requirements by the August 7th deadline. The ACO is also exploring expansion of network partnerships to broaden primary care population and capacity in the next application cycle.
- Roughly 20% of the ACO's overall population is publically housed in New York City Housing Authority (NYCHA) developments. NYCHA residents have access to various resources and services - crisis intervention, care management, education and counseling, home delivered meals, etc. - that help keep residents healthy in the community. Starting in June, the ACO began 'flagging' patients who reside in public housing. The goal in providing this information is to strengthen connections between HHC facilities, NYCHA, and the community-based organizations (CBOs) that provide services for NYCHA residents - particularly the elderly and disabled. This follows from a pilot with Dr. Judy Flores and the ACO team at Woodhull, who identified ACO patients from three NYCHA developments nearby, then connected ambulatory care/social work leadership with representatives from NYCHA and the CBOs in those locations. The ACO will continue to work to develop streamlined process for referrals and communication.
- The ACO was recently featured in publications in Crain's New York and HHC Insider, highlighting the ACO's population management activities at HHC facilities and the ACO's policy perspective on changes to the Medicare ACO program structure.

Laboratory Service

HHC laboratories is participating in a 3 day Cerner event scheduled 14, 15 and 16th of July, 2015. The event includes review of the HHC Cerner build to date as well vendor training of HHC Super Users from Queens/Elmhurst, Jacobi and North Central Bronx laboratories. Laboratory Services continues to work closely with the EPIC team to insure a seamless communication between the laboratories and the clinical service providers.

MetroPlus Health Plan, Inc.

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of June 1, 2015 was 473,905. Breakdown of plan enrollment by line of business is as follows:

Medicaid	415,887
Child Health Plus	13,309
MetroPlus Gold	3,526
Partnership in Care (HIV/SNP)	4,738
Medicare	8,446
MLTC	893
QHP	26,403
SHOP	601
FIDA	102

There are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

NYS Department of Financial Services is continuing to review the 2016 Qualified Health Plan Rates we submitted in May. An answer is expected to be released in the first week of July.

New York Health Plan Alliance released a summary of the most common reasons for discrepancies between issuers (insurers), eMedNY (State enrollment database) and NYSoH (which contribute to member dissatisfaction and therefore potential disenrollment). MetroPlus is facing the same issues as the other participants, namely late renewals, the State's failure to process 834s, renewal date not available to plans, duplicate accounts, or the State's failure to submit effectuations.

The MetroPlus Quality Management department is working diligently to collect and submit the 2014 Medicare Star rating data. We predict our score to be the same as the past two years (3.5 stars).

In a previous report to this Committee I mentioned that our growth strategy includes expansion of our network into Staten Island. We have had discussions with the two hospitals in Staten Island – Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC). We expect to finalize rates with RUMC this week. SIUH is more challenging due to its being part of the overall North Shore LIJ network. We are primarily targeting PCPs and high volume specialties. In addition, after mailing over 1,000 letters to Staten Island providers, we have almost 150 in the credentialing/contracting pipeline. SIUH Physicians and RUMC physician group (Amboy Medical PC) will both be contracted at the same time as the hospital agreements. This will provide over 500 physicians for the network. We also have a relationship with Advantage Care physicians through the Preferred Health Partners group in Brooklyn. They offer two sites in Staten Island with approximately 120 providers who are willing to contract. Pharmacy, Dental and Behavioral Health/Substance Abuse providers are all being addressed through our delegated vendors. We already meet network requirements for Staten Island in these areas.

As of the date of this report, we are undergoing the Onsite BH/HARP Readiness Review. The components of the onsite review are Program Operations (clinical program structure, clinical interviews with Utilization Management and Case Management staff, members services structure and protocols), Information Systems (claims, data warehouse, clinical and telephonic systems), and Document Review (sample of executed provider contracts and corresponding credentialing files, as well as resumes of plan staff participating in interviews). I will provide information about the outcome at the next meeting.

Since I have mentioned the HARP Readiness Review, I will inform you that MetroPlus is also scheduled to undergo the Article 44 Audit at the end of September 2015.

In looking at state-wide data on the Fully-Integrated Dual Advantage (FIDA) program, total enrollment in NYS as of June 2, 2015 was 4,407. There were 47,702 opt-outs. The passive enrollment schedule will enroll 3,908 individuals in July (effectuated June 1, 2015), and 5,584 in August (effectuated July 1, 2015) across the State. In addition, I would like to bring to this committee's attention that the three-way contract requires plans to move the provider payment agreements from fee-for-service to alternative payment arrangements. We are required to submit proposals for DOH review and approval by August 15, 2015.

Action Item:

Sal Guido, Acting Corporate Chief Information Officer, Enterprise Information Technology Services presented to the committee on the following resolution:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to enter into multiple contracts to purchase health information related professional services for the Epic Electronic Medical Record program and Epic related Revenue Cycle modules as needed with 22 vendors (the "Contractors") through requirements contracts for a two year term with three one-year options to renew at the Corporation's exclusive option for an amount not to exceed \$119,292,988 million for the initial two year period.

The resolution was approved by the committee to be considered by the board.

Information Item:

Charles Barron, MD, Interim Medical Director of Behavioral Health, Medical and Professional Affairs presented to the committee the Behavioral Health Updates.

Behavioral Health Transformation - Current state

NY State is transitioning to Medicaid managed care with fully integrated behavioral/physical health and specialized Health and Recovery Plans (HARPs) for the seriously ill, between 2015-17 – ending fee-for-service (FFS) reimbursement for carved-out

services. Impending changes to BH Medicaid funding could significantly impact HHC. DSRIP has major implications for BH. Given its large BH service, high proportion of Medicaid patients, significant value at risk and strong mission for serving the neediest, our efforts here need strong support. The Largest BH service in NYC (e.g., >40% of total IP discharges). Medicaid FFS accounts for ~52% IP/~40% OP by volume with \$250M revenue at risk. HHC has taken significant strides recently to improve its BH service. It's improved outpatient wait times by 15% as part of ambulatory care access project. It has reduced length of stay (LOS) for inpatient psych by >20% since 2012.

The managed care transformation overall project phases & timeline:

Phase 1 Rapid baselining 9/15/14 to 11/1/14

Phase 2 Solution design Planning 11/1/14 to 1/1/15

Phase 3 Program launch Demonstrate in 4 sites (3 adult, 1 child/adolescent) 1/1/15 to 7/1/15

Phase 4 Standardized pilot roll-out 7/1/15

Phases 2 & 3: Solution Design & Program Launch

"Pillars" of Transformation

Increase use of peers: Strengthen care management; Make care co-occurring capable; Primary care integration; Complete OP and crisis continuum; and Develop community partnerships.

There are **4 Early Adopter Sites** - Adult population: Elmhurst; Kings County; Gouverneur Health and Child/Adolescent population: Bellevue.

Standardized Transformation Activities: Wave 1 - ACCESS: HIGH UTILIZER REPORTS – kick off July, 2015 and Wave 2 - IP-TO-OP BRIDGING; OUTPATIENT ENGAGEMENT and BH/PC INTEGRATION – Kick off /September, 2015

Pilots and Lessons Learned: Early Adopter Pilots – Kings, Elmhurst, Gouverneur (Adults) and Bellevue (Child)

Lessons Learned -The importance of facility steering committee, Inclusion of Finance, Managed Care, DSRIP, Importance of a site transformation coordinator, Importance of regular weekly team performance meetings, importance of regular monthly steering committee meetings, need for Behavioral Health coach for teams and the need to standardize future pilots across all facilities simultaneously.

Next Steps

To develop new, efficient ambulatory and crisis services including rehabilitation and recovery services as part of the 1915(i) waiver (HCBS – Home and Community Based Services); Accelerate efforts for prepare for Managed behavioral health and HARP; Coordinate above efforts with the DSRIP initiatives - especially integration of primary and BH. These require: changes to both clinical practice and operations strengthened relations with finance, centrally and at facility levels; a stronger culture of continuous quality improvement along with standardization of increased data collection and analysis

Strategic Planning Committee – July 14, 2015

As reported by Josephine Bolus, RN

Senior Vice President Remarks

Federal Update

Supreme Court Ruling on King vs. Burwell

Ms. Brown provided the Committee with an update concerning the King vs. Burwell case in which plaintiffs challenged the Obama Administration regarding the Affordable Care Act (ACA). The question that was put before the court is whether the language of the ACA limited health care subsidies to enrollees who reside in states who have established their own health exchanges, rather than the federal exchanges. Ms. Brown reported that, on June 25th, the Supreme Court of the United States ruled, by a vote of 6-3, that the Affordable Care Act can provide federal tax credits to individuals under both state and federally run health exchanges.

She stated that Chief Justice John Roberts wrote the decision. An adverse ruling would have jeopardized the future of “Obama Care” because only 16 states and Washington D.C. have established state run exchanges. Three states including Nevada, New Mexico and Oregon have state exchanges but use the federal website for enrollment. Ms. Brown explained that such a ruling would have prohibited approximately 8 million persons who reside in the 34 states that use federally run exchanges from receiving federal tax credits. Ms. Brown added that a key finding was that the wording of the ACA implied that tax credits would be available to those “enrolled through an exchange established by the state” was properly interpreted by the Internal Revenue Service (IRS) to include federal exchanges. Chief Justice Roberts argued that any significant differences between state and federal exchanges would have been clearly delineated by the statute; and that an adverse ruling would have led to a ‘death spiral’ in the insurance markets in those states, which was clearly not the intent of Congress. Ms. Brown commented that this was the last major legal challenge to the ACA; and even opponents of the ACA were struggling to preserve subsidies if the court had sided with the plaintiffs.

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

Ms. Brown reported that, at an April 2nd meeting, the Medicare Payment Advisory Commission or MEDPAC suggested that Congressional lawmakers should push for repealing the Two-Midnight Rule in its entirety. The passage of the SGR bill postponed Two-Midnight Rule until September 2015. In a proposed payment rule posted on July 1st, the Obama Administration (CMS) said it planned to allow physicians to exercise judgment to admit patients for short hospital stays on a case-by-case basis. CMS also said it would remove oversight of those decisions from its administrative contractors and instead ask quality improvement organizations to enforce the policy. Recovery audit contractors, meanwhile, would be directed to focus only on hospitals with unusually high rates of denied claims.

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

Mrs. Bolus asked how well this information was being explained to patients regarding whether or not they are admitted or in an Observation status. Ms. Brown deferred the question to Dr. Raju who reassured Mrs. Bolus that he would investigate and get back to her with a response. **NOTE:** Ms. Brown followed up on Ms. Bolus’ inquiry. All patients who are placed on Observation status for up to two midnights are provided a letter.

GAO Report on 340B Drug Discount Program

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

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

Ms. Brown reported that, without Congressional action, the James L. Zadroga 9/11 Health and Compensation Act for injured and ill 9/11 survivors and responders would expire in less than a year and a half. Support for a permanent extension of the Act reached a critical milestone last week with 102 Members of the House of Representatives, including 24 Republicans, now backing the effort. The Reauthorization Act (H.R. 1786) introduced in the House by New York Representatives Carolyn Maloney, Jerrold Nadler and Peter King, just three months ago, is rapidly gaining cosponsors as the 14th anniversary of the attacks approach. Reauthorization in the Senate is being led by New York Senator Kirsten Gillibrand along with Senator Chuck Schumer and has 23

Senate supporters, 4 of whom are Republicans – the same four who had initially signed on in April when reauthorization was introduced, Mark Kirk of Illinois, Susan Collins of Maine, Lisa Murkowski of Alaska and Tom Cotton of Arkansas, who pledged to garner more Republican support. The James L. Zarodga Act funds HHC’s World Trade Center Environmental Health Center, legislatively known as the Survivor Program. The Survivor Program provides health care services to individuals who lived, worked or attended school in the affected neighborhoods on and after 9/11, who became ill resulting from exposure to WTC dust. With about 8600 enrollees and growing every month, HHC’s program is fully funded by the Act until the end of 2016. HHC along with the City of New York supports the law’s permanent reauthorization.

City Update

New York City’s Budget

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

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

HHC Capital Funding Highlights

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

Ms. Brown reported that facility specific funding also varied each year. This year, Kings County Hospital Center (KCHC) did very well. KCHC received nearly \$5 million. Of that total, \$2.5 million will be used for a new Nurse Call Station. The remaining funds will be used to purchase ventilators and endoscopy, echocardiograph, and radiology equipment. Ms. Brown stated that Council Member Eugene and the Brooklyn Delegation are to be commended. The Pharmacy Department expansion received \$1.5 million in total with the funding added from the Borough President. Funding was also included for projects on Sea View’s campus including the new Meals on Wheels building (\$250,000) and the Grace Foundation building (\$170,000).

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

- Nearly \$5 million for Kings County Hospital
- \$1.7 million for Coney Island Hospital for Cardiac Cath
- \$1.25 million for Elmhurst Hospital for clinical monitoring systems
- \$951,000 for Woodhull’s Gamma Nuclear Medicine Camera
- \$650,000 for Roberto Clemente Center Renovations
- \$500,000 for Queens Hospital to expand the Pharmacy Department

- \$300,000 for the Judson Health Center Roof
- \$185,000 for equipment purchases at Bellevue Hospital
- \$90,000 for Harlem Hospital to purchase a Bariatric Table
- \$40,000 for Gouverneur Healthcare Services to purchase an Ophthalmology System

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

Information Item

Presentation: Key Updates from 2015 New York State Legislative Session

Wendy Saunders, Assistant Vice President, Office of Intergovernmental Relations

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

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

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

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

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

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

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

- Extend New York's statute of limitations from thirty months from the date of the alleged malpractice, to thirty months from whenever the alleged malpractice is discovered
- Amended to clearly apply to HHC and other public facilities

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

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

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

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

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

- **A.1323B (Rosenthal)/S.676B (Hannon) CARE Act:** Hospitals and nursing homes must provide discharge information to patient-designated informal caregivers. Both houses passed legislation that would put in place new requirements for contacting and coordinating the discharge of hospital and nursing home patients with any informal caregivers the patient designates. This is known as the Caregiver Advise Record and Enable – or CARE – Act and was the AARP’s top priority. It is anticipated that the Governor will approve this legislation.
- **A.7791A (Mayer)/S.5892 (Valesky) - Discharge Information for the Elderly:** Patients 60 or older must be provided with a list of senior services and programs. Another bill that passed both houses requires hospitals and nursing homes to provide all patients 60 or older with a list of services and programs offered by their local area agency on aging. Seniors would also be provided with contact information for the agency. The State Office for the Aging is responsible for developing the information to be provided.
- **A.7465, Gottfried /S.4874, Hannon) - Sepsis Data Collection:** Delays public release of hospital-reported information until validated and analyzed. Both houses also passed legislation that would provide up to a two-year delay on the public release of data related to incidents of Sepsis in hospitals, which the State Health Department began collecting last year. The delay provides the State Department of Health time to validate and analyze the data so they can provide accurate and meaningful information to the public.

All bills passed BOTH Houses

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

- **A.123B (Paulin)/S.4739 (Hannon) - Pharmacist Immunization Administration:** This bill would allow pharmacists to vaccinate for acute herpes zoster, meningococcal, tetanus, diphtheria and pertussis. Governor Cuomo also signed legislation that expanded the immunizations that pharmacists may give to adults. Under the new law, pharmacists can now provide vaccines for acute herpes zoster, meningococcal, tetanus, diphtheria and pertussis in addition to influenza and pneumococcal.
- **A.1034A (Gunther)/S.3621 (Funke) - Assault on Direct Care Workers:** This bill would make assault on direct care workers a class D felony. The Legislature passed a bill to add direct care workers to the list of professionals who are protected from assault by enhanced penalties. If the bill is signed by the Governor, assault on any direct care worker will be a class D felony, as it currently is for registered nurses.
- **A.2150 (Gottfried)/S.1153 (Hannon) - Surrogate Decisions for Hospice:** This bill would allow physicians to make decisions for incapacitated patients who don’t have a surrogate. Legislation passed both houses authorizing physicians to make decisions for a hospice-eligible patient who is incapacitated and does not have anyone who qualifies as a family healthcare decision-maker.

All bills passed BOTH Houses.

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

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

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

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

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

All bills passed BOTH Houses

Presentation: Ida G. Israel Community Health Center Update Presentation

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

Ms. Bolus introduced Mr. Daniel Collins, Senior Associate Director of Facilities, Coney Island Hospital, and invited him to provide an update on the Ida G. Israel Community Health Center. Mr. Collins began his presentation by stating that Coney Island Hospital has operated a community health center since the mid 1980's in the Coney Island community of Brooklyn. Mr. Collins shared images of the damage that the former Ida G. Israel Community Health Center had sustained as a result of Super Storm Sandy.

Mr. Collins presented Ida G. Israel Community Health Center's utilization of services data as the following:

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

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

Mr. Collins described the race and ethnic make-up of the patient population served by the Ida G. Israel community as the following:

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

He described the age make-up of the patient population served by the Ida G. Israel community as the following:

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

Mr. Collins reported that the Center's new location at 2925 West 19th Street was less than a mile from its former location at 2201 Neptune Avenue. Ms. Brown reminded the Committee that the Board had made a commitment to restore Ida G. Israel Community

Health Center in the neighborhood. She added that Mr. Arthur Wagner, Coney Island Hospital's Executive Director and his team did not only listen to the Board, but most importantly, they listened to the voices of the people in the community. Mr. Collins added that the Center's new location was accessible to transportation and that subway Lines included the F, N, Q and D. The bus lines include the B36 and B74.

Mr. Collins presented the Center's initial hours of operation as outlined below. He added that extended hours would be established post ramp-up.

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

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

* Extended hours will be established post ramp-up.

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

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

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

Mr. Collins informed the Committee that the community has been kept abreast of the progress of the new Ida G. Israel Community Health Center. Community advertisement included:

- Rendering of new facility stating "Coming Soon Summer 2015" posted at construction site and on the homepage of CIH Intranet

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

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

SUBSIDIARY BOARD REPORT

MetroPlus Health Plan, Inc. – July 7, 2015

As reported by Mr. Bernard Rosen

Chairman's Remarks

Chair Rosen welcomed everyone to the MetroPlus Board of Directors meeting of July 7th, 2015. Mr. Rosen stated that the meeting would start with the Executive Director's report presented by Dr. Saperstein followed by the Medical Director's report presented by Dr. Dunn. Mr. Rosen stated that there would be two resolutions for approval.

Executive Director's Report

Total plan enrollment as of June 1, 2015 was 473,905. Breakdown of plan enrollment by line of business is as follows:

Medicaid	415,887
Child Health Plus	13,309
MetroPlus Gold	3,526
Partnership in Care (HIV/SNP)	4,738
Medicare	8,446
MLTC	893
QHP	26,403
SHOP	601
FIDA	102

Attached are reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

We have recently submitted the 2016 Qualified Health Plan (QHP) premium rates to New York State Department of Financial Services (DFS). We continually review the amounts we charge to manage our members' healthcare needs. We have taken significant cost-saving measures which resulted in decreased premiums for the majority of our products and minimized the increase for two of our SHOP plans in 2016. In 2015 MetroPlus offered some of the most affordable rates across many of the health insurance options available on the NY State of Health Marketplace.

The rate changes vary based on product (SHOP and Individual) and across the various metal levels. The proposed decreases range from -2% to -9% for Individual plans and from -1% to -5% for SHOP plans. The two SHOP plans with proposed increases range from 0.2% to 1%. While we try to provide members with the most accurate information possible, final rates may differ based on the benefit plan design and other features members choose on renewal. Also, the final, approved rate may differ as DFS may change the proposed rate. For members who enrolled through the NY State of Health and qualified for financial assistance, called an Advanced Premium Tax Credit (APTC), their current premium is less than the amount shown in the letter they received from us notifying them of a rate change. Their 2016 premium will also be less than shown in the letter they received if they qualify for the

APTC again next year. NY State of Health will calculate their eligibility for financial assistance each year. Currently, approximately 84% of MetroPlus Marketplace members qualify for an APTC.

NYS Department of Financial Services is continuing to review the 2016 Qualified Health Plan Rates we submitted in May. An answer is expected to be released in the first week of July.

New York Health Plan Alliance released a summary of the most common reasons for discrepancies between issuers (insurers), eMedNY (State enrollment database) and NYSoH (which contribute to member dissatisfaction and therefore potential disenrollment). MetroPlus is facing the same issues as the other participants, namely late renewals, the State's failure to process 834s, renewal date not available to plans, duplicate accounts, or the State's failure to submit effectuations.

In addition, as a result of the ACA legislation and market pressures, we are realigning our Medicare offerings for 2016. We are consolidating two Medicare Dual-eligible SNPs (Select into Advantage). The members will see no change in the services they are provided. The plan will benefit from some operational efficiencies as well as see a reduction in overall cost (shifting some cost from the Plan to New York State Fee-for-Service). We are also closing our PIC (Partnership-in-Care) product. With rising premiums, PIC enrollment has fallen to approximately 50 enrollees. These enrollees are being encouraged to enroll in either our Advantage or Platinum products depending on their Medicaid status. The HIV+ members will see a decrease in their monthly premiums while getting the same services and physician network. We have also restructured our pharmacy network to reduce plan costs, something many competitors have already done.

The MetroPlus Quality Management department is working diligently to collect and submit the 2014 Medicare Star rating data. We predict our score to be the same as the past two years (3.5 stars).

In a previous report to this Committee I mentioned that our growth strategy includes expansion of our network into Staten Island. We have had discussions with the two hospitals in Staten Island – Staten Island University Hospital (SIUH) and Richmond University Medical Center (RUMC). We expect to finalize rates with RUMC this week. SIUH is more challenging due to its being part of the overall North Shore LIJ network. We are primarily targeting PCPs and high volume specialties. In addition, after mailing over 1,000 letters to Staten Island providers, we have almost 150 in the credentialing/contracting pipeline. SIUH Physicians and RUMC physician group (Amboy Medical PC) will both be contracted at the same time as the hospital agreements. This will provide over 500 physicians for the network. We also have a relationship with Advantage Care physicians through the Preferred Health Partners group in Brooklyn. They offer two sites in Staten Island with approximately 120 providers who are willing to contract. Pharmacy, Dental and Behavioral Health/Substance Abuse providers are all being addressed through our delegated vendors. We already meet network requirements for Staten Island in these areas.

As of the date of this report, we are undergoing the Onsite BH/HARP Readiness Review. The components of the onsite review are Program Operations (clinical program structure, clinical interviews with Utilization Management and Case Management staff, members services structure and protocols), Information Systems (claims, data warehouse, clinical and telephonic systems), and Document Review (sample of executed provider contracts and corresponding credentialing files, as well as resumes of plan staff participating in interviews). I will provide information about the outcome at the next meeting.

Since I have mentioned the HARP Readiness Review, I will inform you that MetroPlus is also scheduled to undergo the Article 44 Audit at the end of September 2015.

In looking at state-wide data on the Fully-Integrated Dual Advantage (FIDA) program, total enrollment in NYS as of June 2, 2015 was 4,407. There were 47,702 opt-outs. The passive enrollment schedule will enroll 3,908 individuals in July (effectuated June 1, 2015), and 5,584 in August (effectuated July 1, 2015) across the State. In addition, I would like to bring to this committee's attention that the three-way contract requires plans to move the provider payment agreements from fee-for-service to alternative payment arrangements. We are required to submit proposals for DOH review and approval by August 15, 2015.

Dr. Saperstein mentioned that MetroPlus submitted its 2016 Qualified Health Plan (QHP) premium rates to the New York State Department of Financial Services (DFS). MetroPlus has taken significant cost-savings measures which resulted in decreased premiums for the majority of the products and minimized the increase for two of the Small Business Health Options Program (SHOP) plans in 2016. The proposed decrease ranged from 2% to 9% for individual plans and from 1% to 5% for SHOP plans. Approximately 84% of MetroPlus Marketplace members qualify for an Advanced Premium Tax Credit (APTC). For members who are enrolled through the NY State of Health and have qualified for financial assistance, their current premium is less than the

amount shown in the letter they received from us notifying them of a rate change. MetroPlus has benefited from this in 2014. Mr. Dan Still asked if the APTC is the same as receiving a subsidy or if it is different? Dr. Saperstein responded by saying that APTC is like a subsidy. It is based on the member's income and it is a tax credit but it's a reduced rate. It is seen every month with the premium.

Dr. Saperstein informed the Board of Director's that MetroPlus is realigning the Medicare offerings for 2016. MetroPlus will consolidate two Medicare Dual-eligible SNPs (Select into Advantage). The members will see no change in the services that are being provided. The Plan will benefit from some operational efficiencies as well as see a reduction in overall cost (shifting some cost from the Plan to New York State fee-for-service). MetroPlus is also closing its Partnership-in-Care (PIC) product. With raising premiums, PIC's enrollment has fallen to approximately 50 enrollees. These members are being encouraged to enroll in either the Advantage or Platinum products depending on their Medicaid status. The HIV positive members will see a decrease in their monthly premiums while getting the same services and physician network. MetroPlus has also restructured its pharmacy network to reduce plan costs. This is something that many competitors have already done.

Looking at the state-wide date on the Fully-Integrated Dual Advantage (FIDA) program, the total enrollment in New York State as of June 2, 2015 was 4,407. There were 47,702 opt-outs. The passive enrollment schedule will enroll 3,908 individuals in July (effectuated June 1, 2015) and 5,584 in August (effectuated July 1, 2015) across the State.

Mr. Still wanted to know since the Qualified Health Plan (QHP) enrollment went down, was it due to the members not paying their premiums. Dr. Saperstein responded by saying that the new enrollees start at the beginning of the year, and as the year goes on, if members don't pay, they lose their coverage either one month or three months after that. If the members receive the premium tax credit, it is 90 days if they do not it is 30 days.

Mr. Still wanted to know regarding the rate change that MetroPlus will be making, is it due to the rate only or will it be based on other factors? Dr. Saperstein responded by saying that MetroPlus was no longer the lowest/cheapest plan. Other Plans like HealthFirst and Affinity had a big bump in their membership this year. Another problem that MetroPlus had was a significant number of complaints due to members not being able to get appointments. Moving forward, MetroPlus will make sure that members have better access to appointments.

Mr. Rosen mentioned that he recently attended a briefing on affiliations. At the briefing he asked if the Diagnostic & Treatment Centers (D&TC's) were open during the evenings. Currently, the D&TC's are open during the evening hours. He also wanted to know if MetroPlus should look to incorporate that information into MetroPlus' advertisements. Dr. Saperstein responded by saying if you look at most community doctors, they have one or two evenings a week for their own practices. It's not something special, it's something that is expected.

Medical Director's Report

FIDA and MLTC Update

As of the end of June 2015, FIDA will add 43 new members bringing our membership total to 102. We have cross trained our Medicare and MLTC marketing representatives to encourage enrollment in the FIDA program. Disenrollment in this program continues to be a statewide issue with roughly 90% of enrollees dis-enrolling. Lastly the state and CMS conducted an on-site CMTO (oversight) meeting at MetroPlus Health Plan. This informal review allowed them to observe our processes. Both groups expressed satisfaction with the Plan's progress in implementing FIDA.

In the period between April and June, the MLTC will have added 165 new members. Disenrollment for that same period in the MLTC was 166 members, with a resultant membership total of 892. The primary reason for disenrollment from MLTC is loss of Medicaid. For the month of June, only 2% of the MLTC patients moved to the FIDA line of business.

We have implemented a new onboarding process for new members to the MLTC to improve the patient experience and enhance the transition process for them. As part of our quality initiatives in MLTC, monthly outreach added additional member education around, and when interested completion of, Advanced Directives.

Behavioral Health Services Update

On June 22nd and 23rd MetroPlus Health Plan hosted 19 on site readiness review auditors who reviewed the Medicaid-SSI carve in of Behavioral Health and Substance Abuse Disorder Services and the HARP line of business preparedness (including HIV

Partnership in Care/HARP eligible). As a result MetroPlus is the first Health Plan in NYC to be awarded conditional approval for all of the above referenced products. Representatives of SDOH, DOH-MH, OMH, OASAS and the consultants for New York State, Mercer, delivered an exit interview that was very complimentary of MetroPlus Health Plan's efforts in this area. Areas needing continued improvement include training of Customer Services Representatives, as well as updated implementation plans and work plans. There was some attention to our vendor Beacon Health Options, model of Utilization and Case Management and the coordination of these services with MetroPlus. Since Beacon is working with several Plans in the area, the audit team will be reviewing Beacon as a separate entity on Friday, June 26th.

MetroPlus, in collaboration with Beacon Health Options continues with HARP preparedness activities under the watchful eyes of the SDOH, OMH, OASAS, and DOH-MH. The Behavioral Health team is actively participating in readiness review webinars and meetings at the OMH field office every other week. Additional meetings at DOH-MH are now the NYC Regional Planning Consortium, held monthly. HPA and PHP Coalition meetings are ongoing as are MCO/Health Home, Provider Training Work Group, Clinical Criteria, and Health Home enrollment task force meetings are continuing. As seen here, there are many stakeholders in the implementation of the Behavioral Health line of business.

Beacon Health Options is managing inpatient care for almost 300 members daily. Integrated Medical and Behavioral Health rounds are held for Medicaid and HIV PIC members to insure a comprehensive, quality focused approach to care. Continuous improvement of work streams between MetroPlus and Beacon are evolving as issues arise and have now expanded to include HARP and SSI carve in readiness activities.

Utilization Management Update

Our current utilization management system, CareSTEPP, is being replaced with an enhanced program; CareConnect. This new product will improve the tracking of necessary reporting requirements and enhance the ability to format required communications according to SDOH and CMS specifications. The FIDA/Medicare programs are scheduled to go live August 1, 2015. All other lines of business are scheduled to go live October 1, 2015.

Utilization Management is working with the consulting firm Kepner-Tregoe on a workflow efficiency program targeted to be completed in September 2015. This project has three components including, development of an efficient workflow and structure, provider and call center education, and a "one best way" initiative which will focus on reducing time to access key information, and improve productivity and morale. With clear roles, responsibilities and workflows, we are hoping to be able to enhance the effectiveness of this department.

Quality Management

Annual HEDIS results were submitted June 15th, 2015 to CMS and NYS. These scores are important to the Plan for both quality ratings and financial incentive payments. They are a component of our STAR rating which is currently 3.5 out of a possible 5 STARS.

MetroPlus has established a STAR steering committee to focus on the organizational processes that support patient satisfaction, preventive care, medication adherence and other measures that contribute to HEDIS, CAHPS, HOS and other data collected to assess Plan quality. Financial incentives are associated with scores above 4 STARS. With additional outreach to Medicare members by NPs and MDs, and new technology such as portable bone density measurement devices, we anticipate reaching many of the goals identified by these metrics and over time improving our STAR rating.

Optum's, Connect Portal is currently being implemented with an anticipated roll out of August 2015. This tool gives our Network Primary Care Providers user friendly, easily accessed data about their quality scores and patient data related to compliance such as mammography and colonoscopy follow up. The data will be updated monthly for the provider's use. We are anticipating improvements in our provider's ability to collaborate with their patients to improve their overall health and satisfaction with services.

Contracting and Credentialing

Contracting and credentialing of Staten Island providers continues in anticipation of the Plan's expansion into the Staten Island market. Discussions with the North Shore/LIJ Health System regarding inclusion of Staten Island University Hospital are ongoing as are our conversations with Richmond University Medical Center.

MetroPlus is in the final stages of negotiation with Wyckoff Hospital, and pending NYS contract approval, they should be in Network effective August 1, 2015. We are in discussions with Montefiore Hospital in an attempt to bring them in Network for the Exchange line of business. We have also initiated talks with the Mt. Sinai/Continuum System to bring them into our Network for the Medicare Advantage and Exchange products.

Currently being scheduled are on site audits of delegated entities. Over the next 3-4 months we will be auditing MedSolutions (Radiology UM), Caremark (Pharmacy), and Healthplex (dental). Outcomes of these audits are reported to the Delegation Oversight Committee, internal Quality Committee (QMC), and the Quality Committee of the Board (QAC).

Network Relations

Joint Oversight Committee meetings with our contracted acute care facilities are an ongoing initiative. Contractual concerns, reimbursement issues, credentialing issues, marketing opportunities, policy changes, goals and opportunities are all discussed. During 2015, Mt Sinai Medical Center, Jamaica Hospital, and Flushing Hospital were all added to the Joint Oversight process. The relationship between MetroPlus and our Network Provider community is critical and maintaining an open collaborative dialogue to enhance member outcomes portends success for both entities.

Provider training about the FIDA program is a key deliverable of the Plan to NYS/CMS. Network relations has been working on the FIDA steering committee to develop the training modules use for this purpose. The last of the five training modules has been completed and posted on the Lewin web-site. Provider Relations assist providers to access the Lewin Portal and have educated over five thousand providers.

Dr. Dunn mentioned as a continuing effort to educate and provide additional services to its members, MetroPlus began to identify the members that were current smokers and offered them Smoking Cessation information. Ads have been placed throughout numerous community papers including AM New York. Magnets have also been created and distributed for the members that smoke to remind them of the resources that are currently available to them. Positive feedback has been received since this was initiated.

Dr. Dunn stated that the Inspector General for the State began investigating plans for billing for family planning services, intrauterine devices and birth control pills. MetroPlus has not charged any member for copayments for any service related to family planning. Dr. Saperstein executed a letter that went out through Regulatory Affairs, and based on the analysis, it was discovered that 18 members paid copays. MetroPlus reimbursed those members while it was discovered that another 18 members who paid copays were yet to be reimbursed. Once all information was sorted, all members have been reimbursed. This policy falls under the Affordable Care Act, where there are no copayments or deductibles for family planning services.

Dr. Dunn mentioned that MetroPlus' current utilization management system, which is CareSTEPP, is being replaced with an enhanced program named CareConnect. The new product will improve the tracking of necessary reporting requirements and enhance the ability to format required communications according to New York State Department of Health (NYSDOH) and Centers for Medicare & Medicaid Services (CMS) specifications. The FIDA/Medicare programs are scheduled for go live on August 1, 2015. All other lines of business are scheduled to go live October 1, 2015.

Utilization Management is also working with the consulting firm, Kepner-Tregoe on a workflow efficiency program targeted to be completed in September 2015. This project has three components including, development of an efficient workflow and structure, provider and call center education, and a "one best way" initiative which will focus on reducing time to access key information, and improve productivity and morale. With clear roles, responsibilities and workflows, MetroPlus is hoping to be able to enhance the effectiveness of the Utilization Management Department.

Dr. Dunn mentioned that the annual Healthcare Effectiveness Data & Information Set (HEDIS) results were submitted on June 15, 2015 to CMS and SDOH. These scores are important to the Plan for both quality ratings and financial incentive payments. They are a component of MetroPlus' STAR rating which is currently 3.5 out of possible 5 STARS. MetroPlus has established a STAR steering committee to focus on the organizational processes that support patient satisfaction, preventive care, medication adherence and other measures that contribute to HEDIS, Consumer Assessment of Healthcare Providers & Systems (CAHPS), Health Outcomes Survey (HOS) and other data collected to assess Plan quality.

Action Items

The two resolutions were introduced by Dr. Van Dunn.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to increase the spending authority for and extend the contract with New York County Health Services Review Organization ("NYCHSRO"), dated April 1, 2010, and to allocate additional funds for the fulfillment of the contract, with the total amount not to exceed \$6,209,000 for the term to extend until November 30, 2015.

Dr. Christina Jenkins asked when the Quality Assurance Reporting Requirements (QARR)/ HEDIS season begins. Dr. Dunn responded by saying that it officially starts in January and the data is due in June. Dr. Jenkins also asked if uniform assessment was one that requires 40 hours of training before you can even administer service. Dr. Dunn responded by saying yes. Dr. Jenkins wanted the Board to know two things: 1) The New York State Department of Health (NYSDOH) from the Delivery System Reform Incentive Program (DSRIP) required for annual reporting a medical review, is not competitive with QARR/HEDIS, but a sample of patients in August is given and information needs to be reported through December. 2) The second piece is that for those performing providing systems that are perusing a project about palliative care and the Patient-Center Medical Home one of the requirements is that a uniform assessment is completed for everyone that is a Managed Long-Term Care member. A lot of people will be competing for that as well because no one has staff to train everyone. The market might heat up around Uniform Assessment System (UAS). Ms. Nolan mentioned that the proposals for the UAS request for proposal are due at the end of July. The vendor will be selected in August.

The adoption of this resolution was duly seconded and unanimously adopted by the MetroPlus Health Plan Board of Directors.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to negotiate and execute an amendment to the sole source contract with McKesson Health Solution LLC, dated December 15, 2001, and to allocate additional funds for the fulfillment of the contract, for a total amount not to exceed \$650,000 for the term ending December 14, 2016.

Dr. Dunn mentioned that McKesson provides MetroPlus with a product called InterQual. InterQual is needed to for utilization management because they have built in information and documentation to justify why one should or shouldn't be approved based on the clinical position. That information is needed when a decision is being made to justify why the request for the procedure was either approved or denied. The reason for the request to allocate additional funds is because they created 40 modules that did not exist before and MetroPlus' membership has increased since the execution of the contract. It's a combination of the increase in membership and chiropractic review (which was newly added). A Durable Medical Equipment (DME) component was also added because the Plan's DME requests have increased significantly. The Plan is required by the State to have a system to review request.

The adoption of this resolution was duly seconded and unanimously adopted by the MetroPlus Health Plan Board of Directors.

* * * * End of Reports * * * * *

RAMANATHAN RAJU, MD
HHC PRESIDENT AND CHIEF EXECUTIVE OFFICER
REPORT TO THE BOARD OF DIRECTORS
July 30, 2015

Good afternoon. As customary, I will highlight just a few items from the full version of my report to the board. The full version is available to all here and will be posted on our website.

HHC Launches Redesigned Newsletter for Public; Features Staff Diversity Video

In June we launched a redesigned monthly e-newsletter entitled “Patients First.” The newsletter tells stories of New Yorkers whose lives have been changed in a positive way through the care they received at our facilities. They are living proof of our new brand promise. They are living the healthiest life possible because of our care.

The newsletter is sent to approximately 100,000 readers and is meant to both increase awareness about our work and to drive people to our website for additional engagement.

We also use the newsletter to promote MetroPlus, our extended hours and positive patient experience. HHC’s diverse workforce and our focus on cultural competency was highlighted in July’s video. **Let's watch.**

Strengthening Our Brand Identity

To achieve our strategic vision for 2020, we must be able to provide a positive patient experience and create an emotional connection with our patients. We must be able to differentiate ourselves from our competition and help patients choose us among many NYC healthcare choices. That means we have to work differently and also look different.

Yet our brand today lacks uniformity, consistency and does not impart the value of one strong healthcare system. We have dozens of logos. And the materials we publish vary greatly in their quality as well as their look and feel. We need to change that.

We have begun to develop a new brand direction with the help of focus groups, leadership interviews and stakeholder input. The feedback has been very positive and I will be sharing more details with the Board in September.

The ultimate goal is to help bring our brand to life with a consistent and unifying expression of our look, tone and feel across all communications platforms and our entire portfolio of brands. We want to build on the strength of our mission to care for all New Yorkers, without exception, and communicate a new brand promise that reflects our transformation, excites our stakeholders, including our workforce, and supports our growth for the future.

We want to make it easier for everyone to identify with the NYC Health and Hospitals as one strong, inspired, integrated health system – no matter if you enter the trauma center at Bellevue, visit a primary care doctor at Gouverneur, deliver a baby at Elmhurst, get a visit from one of our home health nurses, live in one of our nursing homes, or even sign up for MetroPlus.

Our new brand strategy will help us deliver a clear message that we are one unique and essential health care system that offers exceptional quality, affordable services and culturally responsive health care in every community.

Legionnaires Disease

The New York City Department of Health and Mental Hygiene has confirmed a cluster of at least 30 cases of Legionnaires Disease in the South Bronx since July 10th. Some of the ill individuals presented to, and were treated at Lincoln Medical and Mental Health Center.

The Department of Health is investigating and, at present, has been unable to confirm the source of the infection. So far, two cooling towers, including one at Lincoln Hospital, have been discovered to contain Legionella bacteria.

There is no evidence of any link between this tower and the Legionnaires patients Lincoln has treated. No one at the hospital has gotten sick, and we know the patients under our care contracted the disease elsewhere. In fact, the Health Department found that the cases discovered to date are not clustered around any single location. Our environmental and infection control team has begun an aggressive decontamination regimen at the Lincoln cooling tower, which will remain in operation while under careful monitoring by the decontamination team to ensure the safety of all patients and staff. Testing is being undertaken as well at other Health and Hospitals facilities in the Bronx. An ongoing regular regime of testing is being implemented system-wide.

HHC Assumes Responsibility for New York City Correctional Health

In June, a formal announcement was made by the de Blasio administration that the provision of care to patients in the NYC jail system will become the responsibility of HHC. In conjunction with the return of management of correctional health services to HHC, the City will not renew contracts with Corizon, Inc. and Damian Family Care Centers, Inc. after their expirations in December 2015 and August 2016, respectively.

As the largest public health care delivery system in the nation, and widely recognized for its quality care and services, HHC's oversight of correctional health services will provide for greater continuity and coordination of care between hospital and jail-based health services, and access to HHC's geographically convenient ambulatory care centers will improve continuity of care after release.

The change in management will not result in staffing reductions or layoffs for DOHMH workers. Almost 300 DOHMH employees currently working on correctional health services will transfer to HHC on August 9th. These staff provide services ranging from information technology to discharge planning and other work essential to ensuring continuity of operations during the transition. Immediately after the transfer of responsibility, HHC will begin a full review of all current staff working with the current vendors.

HHC and a host of City agencies including DOC, OLR, OMB, DOHMH and others are working collaboratively to ensure that the transition of correctional health services does not disrupt the ongoing 24/7 operations and is effectively connected to the broader HHC care network and resources to better serve this vulnerable population.

50th Anniversary of Medicare and Medicaid

I'd like to acknowledge that today is the fiftieth anniversary of the enactment of Medicare and Medicaid.

Before these statutes came into being, the need for medical care or hospitalization threatened older, disabled or the poorest Americans with the risk of destitution.

Those days are thankfully gone. And in their place, for the last half century, has been a fairer, more equitable America.

Unfortunately, Medicaid has never ceased to be controversial. Pressure exists within and without government, calling for deep reductions to the program.

Our political leadership in 1965 recognized that expanding access to care helps safeguard the public health.

We are a healthier, and a better nation as a result of Medicaid. It's time we in the public health community rose more vigorously in its defense.

Federal Update

Meeting with CMS Acting Administrator Andy Slavitt

On July 16th, I met with the Acting Administrator of the Centers for Medicare and Medicaid Services, Andy Slavitt and his senior staff. LaRay Brown, Dan Wilson and Marlene Zurack joined me as we reviewed HHC's major issues. This included an overview of our role as an essential provider. We explained how HHC serves all New Yorkers including the City's most vulnerable populations and had cared for more than 469,000 uninsured patients last

year. We discussed the challenges of HHC's structural budget deficit and the need for timely prospective Upper Payment Limit (UPL) payments.

Mr. Slavitt asked about New York's DSRIP Waiver. We responded that HHC is the largest Performing Provider System with more than 200 partners; and that while the waiver seeks to dramatically alter New York's healthcare landscape for the better, DSRIP is both complex and costly to implement. Sustainability after the waiver period ends in 5 years will also be very challenging.

We also discussed how critically important the 340B Drug Discount program is to providers such as HHC. However, the 340B program is under continued threat. Mr. Slavitt acknowledged that access to expensive pharmaceutical regimens required by low income patients with conditions such as cancer, hepatitis C and mental illness were made possible by the 340B program.

Both sides thought the meeting was productive and we agreed to continue collaborating closely in the future.

Supreme Court Ruling on King vs. Burwell

In the last major legal challenge to the Affordable Care Act (ACA), the United States Supreme Court ruled last month in King vs. Burwell that the statutory language of the ACA provides federal tax credits to individuals under both state and federally run Health Exchanges. Chief Justice John Roberts wrote the decision in the 6-3 ruling. An adverse decision would have jeopardized the future of the ACA, as only 16 states and Washington D.C. have established state run exchanges. Such a ruling would have prohibited 8 million people in the 34 states using federally run exchanges from receiving federal tax credits.

CMS Expected to Modify Two-Midnight Rule for Short Stays

In a new proposed payment rule posted this month, CMS said it plans to allow physicians to exercise judgment to admit patients for short hospital stays on a case-by-case basis. The new proposed rule seeks to address an existing two-midnight rule for short stays that would limit reimbursement for stays that do not span two midnights. Implementation of the existing rule could cost HHC an estimated \$23 to \$38 million in Medicare revenue each year. Fortunately, the implementation of the existing rule was delayed by Congress until September 30, 2015.

In the proposed new rule, CMS would remove oversight of physicians' decisions from its administrative contractors and instead engage quality improvement organizations to enforce the policy. The administrative contractors, or Recovery Audit Contractors (RAC), would be directed to focus on hospitals with unusually high rates of denied claims.

The rule was conceived to address a spike in observation stays attributed to hospitals' fear that Medicare audit contractors would challenge their admissions. Many patients' stays in skilled nursing facilities were determined ineligible for Medicare coverage, notwithstanding having immediately spent days in a hospital because their hospital stays had been billed as observation visits. CMS has found that the number of observation visits lasting more than two days has declined 11% in fiscal 2014 compared with fiscal 2013.

Medicare Reform Bills Introduced In House

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

Also introduced was the Medicare Crosswalk Hospital Code Development Act of 2015 which would create a crosswalk that maps outpatient and inpatient codes in what appears to be an attempt to enable site-neutral payment reform. Site-neutral payments would have a negative impact on HHC. For example, the intent is to pay the same for a hospital outpatient clinic visit as for a physician office visit. At the next board meeting we should have more information on potential impact. These bills were introduced only yesterday.

City Budget Highlights

In the City Budget that was adopted last month, HHC received new expense and capital funding. This included: \$137 million was added for Correctional Health in FY 16. This grows to \$155 million in FY17 and \$156 million in FY19.

Additional funds were added for Collective Bargaining settlements. This includes \$7 million in FY16, \$11 million in FY17 & 18 and \$12 million in FY19.

City Council Discretionary funds of more than \$150,000 were added for Lincoln's Guns Down Life Up program and minor equipment and furniture at Gouverneur. The Council also added \$1.5 million to create programs focused on increasing access to healthcare services for immigrants. We will be talking to the Council about how we might be able to tap into these funds to assist in our efforts on Health Equity.

In total, the Administration and the City Council added \$23 million for Capital projects at HHC facilities. I want to thank the Administration and members of the City Council for their generosity this year. We are very appreciative of their support for HHC.

OneCity Health Update

The Master Services Agreement (MSA), the contractual document which defines the foundational roles and responsibilities for each entity participating in OneCity Health, has been approved by the OneCity Health Executive Committee. Partner-specific schedules will be developed with each Partner over the course of the next few months. OneCity Health also plans to submit its final State Implementation Plan (SIP) on July 31. The SIP is a blueprint oversight plan and represents a framework for DSRIP quarterly reporting.

OneCity Health has undertaken a meticulous analytical process to understand the operational capabilities of each Partner and identify needs and locations where gaps in the provision of service occur. Once we are fully confident in this understanding, OneCity Health will share an accurate listing of Partners on our website.

Bellevue Designated a National Ebola Training and Education Center

HHC Bellevue hospital continues to receive national recognition for its work with Ebola and other dangerous pathogens. Earlier this month Bellevue was named by the US Department of Health & Human Services as one of three medical research institutions to co-lead a new National Ebola Training and Education Center. The new Center will offer state health departments and health care facilities additional access to the clinical expertise and training capabilities offered by Bellevue and its two co-leaders, Emory University in Atlanta and Nebraska Medical Center in Omaha. Bellevue successfully treated New York City Ebola patient Dr. Craig Spencer during the height of last year's Ebola concerns, and has isolated and investigated more than 20 suspected cases. The hospital was later named by HHS as one of 55 designated Ebola treatment centers nationally, and in June 2015 was named one of just nine national referral treatment centers for patients with Ebola or other severe, highly infectious diseases.

Coney Island Hospital Re-Dedicates New Ida G. Israel Community Health Center

On July 15, Coney Island Hospital took a huge step toward restoring healthcare services that were lost in the neighborhood during Superstorm Sandy when it cut the ribbon on the new Ida G. Israel Community Health Center.

Built with \$7.5 million in resiliency funds from the Federal Emergency Management Agency (FEMA), the 13,000-square-foot facility is a new one-story building elevated to meet FEMA requirements for protection against a future storm surge. The new Center will provide the same services in adult primary care, pediatrics, dentistry, social services, family planning, behavioral health, chemical dependency and rehabilitation and Women, Infant and Child (WIC). The Center is scheduled to open in late-August, pending inspection by the State DOH, at 2925 West 19th Street, between Surf and Mermaid Avenues and across the street from MCU Park, less than half a mile away from the original location. Around 30 members of Ida Israel's extended family attended the ceremony, along with numerous elected officials and other dignitaries.

State-of-the-Art EMR Showcased in Queens Network

Earlier this month we debuted Epic, HHC's new electronic medical record (EMR) to all employees at Queens and Elmhurst Hospitals during the first EMR Showcase Days. During special events, staff saw Epic workflow demonstrations, explored specific areas of the EMR, and interacted with IT teams developing the system.

Under the leadership of our Information Technology Division, this important work, called **HHC GO**, will deliver the next generation of clinical information systems to HHC.

Our IT and clinical teams have worked tirelessly customizing an EMR already in use at the nation's most prestigious healthcare providers, for HHC's needs. The new HHC EMR will help ensure that our patients get what they need, when they need it. It will mean that we will spend less time looking for information, and more time delivering the quality care our patients deserve.

The new system is a prerequisite to accomplishing our 20/20 Vision strategic objectives: bringing excellence to patient experience, expanding access to care, and building our patient base.

HHC Staff Lead a Health Panel for Young Women

On Saturday, July 18, four HHC staff members led a health panel at the Soledad O'Brien and Brad Raymond Starfish Foundation's annual Pow-HER-ful Summit. This is a full-day event giving young women from underserved communities an opportunity to learn from experts in health, finance, science, technology, engineering, and mathematics.

The Fund for HHC partnered with the Foundation to incorporate an hour-long health panel into the event. The session, titled "Here's How: Take Charge of Your Health with HHC", drew 250 attendees. The panelists were Jennifer Havens, MD, Director and Chief of Service, Department of Child and Adolescent Psychiatry at Bellevue; Monique Collier-Nickles, MD, Chief of Adolescent Medicine and Director of Adolescent Health Services at Lincoln; Lillian Diaz, RN, Deputy Executive Director and Chief Nurse Executive, Patient Care Services at Metropolitan; and Elet Howe, Assistant Director, Adolescent Health Program at Central Office.

The panel marked the third collaboration between The Fund for HHC and the Starfish Foundation. In the next few months, deeper collaborations between The Fund and the Starfish Foundation around adolescent health will be announced.

Increase in Funding Support for Anti-Violence Efforts

The de Blasio Administration and the New York City Council recently announced the investment of approximately \$19 million to support and expand Cure Violence (CV) programs and other comprehensive, community-based strategies to prevent gun violence, such as HHC's Guns Down, Life Up programs. This investment is about a \$6 million increase from 2014.

Of the allocated grant monies, The Fund for HHC will serve as the fiscal conduit for approximately \$8 million for Fiscal Year 2016, to support Cure Violence organizations and other hospital-based work aligned with Guns Down, Life Up. The Fund for HHC will soon enter into contracts with provider organizations selected by the City Council and the de Blasio Administration for their respective locations within high-violence areas and for their capability to undertake and execute violence reduction work. The Fund for HHC will oversee these fully grant-funded contracts.

Farewell to Joanna Omi

It is with great sadness that we are saying goodbye to Joanna Omi, who will be leaving us after nearly 23 years of service.

Joanna has most recently been our Senior Vice President for Organizational Innovation and Effectiveness, leading the Breakthrough operational improvement system that has been so central to us for nearly eight years. Breakthrough has brought in about \$500 million in new revenue and cost savings and engaged almost 20,000 people across the corporation.

While at HHC, Joanna has brought compassion and an aura of calm urgency to the development of many firsts, including the first Federally Qualified Health Center on Staten Island. Her early work to improve access to 129 primary care clinics across HHC through the Ambulatory Care Restructuring Initiative reinforced her belief that the best ideas and solutions come from the people who are closest to the work – a prime principle of the Breakthrough system.

We wish her the very best, and we will miss her.

**Program of the Month:
Healthcare Tailored to Senior Needs
NICHE and NIPCOA**

Today I'm glad to call your attention to the ongoing focus on geriatric care occurring at facilities across our Corporation.

But allow me to make this note of full disclosure---It is with self-interest in mind that I highlight these efforts. I want to be absolutely forthcoming and transparent: One day -- not too soon -- but one day -- I plan on being just the kind of older New Yorker who benefits from HHC's commitment to geriatric care. When my afternoon nap, or my bingo playing, or my square dance lesson is interrupted for care, I'll know that the treatment I receive will be the very best.

The population of older residents of New York City is growing quickly, with more than 1.1 million aged 65 or over living in the five boroughs today. Many have a hard time managing their health, and struggle every day with specialized needs caused by multiple chronic conditions. And a great many are our patients.

Through the Nurses Improving Care for Health System Elders program (NICHE), members of our nursing staff have trained in the most advanced and up-to-date geriatric care practices. NICHE is a nationally recognized, training program designed to bring the most current knowledge and skill in geriatric care to bedside nurses and hospital staff.

At HHC, NICHE designation means improving the outcomes, and the experience, of older patients.

It means we recognize that patient and family-centric care is imperative to better outcomes and experiences.

NICHE means careful consideration of the big picture, like prioritizing closer in-patient care coordination for those suffering from multiple chronic diseases.

It also means devoting a great deal of attention to specifics, like---

--- ensuring that a patient's normal medication regimen is harmonized with whatever new or additional medications are prescribed during a hospital stay.

Or

---monitoring nighttime lighting to facilitate rest, while still illuminating a patient's path to the toilet.

HHC has partnered with the Hartford Institute, the geriatric arm of the New York University's College of Nursing, to implement the NICHE program at seven of our acute care facilities, including North Central Bronx Hospital, Harlem Hospital Center, Queens Hospital Center, Lincoln Medical and Mental Health Center, Jacobi Medical Center, Elmhurst Hospital Center and Coney Island Hospital all of which have achieved NICHE "Senior Friendly" designation. This great work has been accomplished with the enthusiastic engagement of our leadership team at Central Office and at the participating hospitals.

Over the past year HHC has broadened its partnership with the Hartford Institute to bring best geriatric care practices to the ambulatory setting as well. We've launched a program called Nursing Improving Primary Care of Older Adults (NIPCOA), which has been awarded \$200,000 by the New York Community Trust. Grant proceeds will

be used to expand geriatric training to our nurses at nine HHC primary care practices serving large older populations.

Expanding best practices geriatric care to the ambulatory setting is a perfectly aligned with our efforts systems-wide to emphasize wellness and the prevention of unnecessary hospitalizations.

I'm delighted to bring the NICHE program, and its NIPCOA counterpart to your attention today, and to recognize HHC Senior Assistant Vice President for Medical and Professional Affairs and Chief Nursing Officer Lauren Johnson who has spearheaded these efforts.

Individuals of the Month: HHC Staff Fights Ebola

We've talked a lot over the past year about the phenomenal work done Corporation-wide in early 2014 to prepare for an outbreak of the Ebola virus in New York City.

And the heroic efforts of the clinical team at Bellevue last October received a great deal of attention, all of it enormously deserved.

But today, I'm proud to take few minutes to highlight the work of HHC medical personnel who have offered care for the afflicted at Ebola's source, in West Africa.

Over the past 18 months Dr. Julie Hoffman an attending physician at Jacobi Medical Center and Sarah Back, a Nurse Practitioner at North Central Bronx Hospital each traveled to Sierra Leone as part of medical teams assembled by *Partners in Health*, an international aid organization that brings the benefits of modern medical science to those most in need. Their colleague, Dr. Carol Harris, also an attending physician at Jacobi Medical Center, travelled to neighboring Liberia as part of a medical team coordinated by the international relief and development organization, *Heart to Heart*.

These brave caregivers spent weeks helping to educate people about the virus, curb its spread and treat those who had become ill. Carol, Sara and Julie each have impressive and long standing records of global community care.

Each have spent their careers answering the call of international relief organizations when medical knowledge and skill and compassion were needed at the scene of a health crisis.

Each have selflessly devoted their own time and resources to travel to these places of need, whether they were occurring in Haiti, or West Africa or the far Pacific.

Dr. Hoffman, who joins us tonight, spent six weeks in Sierra Leone earlier this year treating up to 40 patients at a time, in the most trying of circumstances.

It's summer and maybe you've taken your family to the movies to enjoy *The Avengers* or *The Fantastic Four*, or *Ant Man*. But I'm hoping you'll go home tonight, or pick up the grandkids this weekend, and tell them about real heroes, like Carol Harris, and Sara Back

...and Julie Hoffman, who I am delighted has joined us today.

HHC In the News Highlights

Broadcast

Hospital homecoming for Australian born prematurely in NYC, WNBC, Bellevue: Donna Hennessey, Physicians' Assistant, Neonatal ICU

Celebrating Harlem House, FOX 5, Harlem

Dangers of Synthetic Marijuana, News 12 Bronx, Jacobi: Dr. Ben Raatjes, Psychiatrist; Dr. Maryann Popiel, Chair of Behavioral Health Psychiatry

Jimmy Fallon returns to 'Tonight Show,' reveals hand injury was so serious 'usually they just cut your finger off', WNBC, Dr. David Chiu, Dr. Scott Reis, Hand and Plastics Surgeons

Hot weather health tips, News12 Brooklyn, Woodhull: Dr. Robert Chin, Chief of Emergency Medicine

Kings County Farmers Market, News12 Brooklyn, Kings County: Natasha Burke, Chief of Staff; Dr. David Stevens, Chief of Ambulatory Care Services

Jacobi Hospital Burn enter has worldwide recognition, NY1 News, Jacobi: Dr. Bruce Greenstein, Burn Unit Director and Attending Doctor of Department of Surgery/Plastic Surgery; Dr. Michael Touger, Medical Director, Hyperbaric Chamber

City's Hospital system plans for takeover of Health Care for Rikers inmates, NY1 News

Print

Program to cut premature births through specialized care to start in Queens hospitals, Daily News, Elmhurst

Prenatal Program Comes to Queens, Tribune, Elmhurst: Karen Lockworth, Director of Women and Children Services

Coney Island Hospital dedicates new community health center, Brooklyn Daily Eagle, Coney Island

Coney Island Celebrates Return of Health Center destroyed by Sandy, Sheepshead Bites, Coney Island

Health center reopens in Coney Island, Brooklyn Daily, Coney Island: Arthur Wagner, Executive Director

Bellevue named co-leader of national Ebola training center, Capital New York, Bellevue: Dr. Ram Raju, President

New Farmers Market Opening at Kings County Hospital, DNAinfo, Kings County: Dr. Ram Raju, President

Gouverneur Health Launches New Farmers Market Run by Teens, DNAinfo, Gouverneur: Dr. Ram Raju, President

New Pitkin Verde Farmers Market Debuts in Cypress Hills, DNAinfo, East New York Diagnostic and Treatment Center

HHC Urges: Get tested and know your HIV status, Harlem World. HHC

Lincoln Medical Center receives accolades for stroke care, Amsterdam News, Lincoln: Milton Nunez, Executive Director

Hospital Rates a "Gold" Award, Daily News, Kings County: Ernest Baptiste, Executive Director

HHC Kings County Hospital Center receives national recognition for excellence in stroke care, Our Time Press

For the mentally ill, a daily refuge found at North Central Bronx Hospital, Norwood News, NCBH: Dr. Madeline O'Brien, Director, Partial Hospitalization Program

City names V.P. for correctional health services, Capital New York, Patricia Yang, Dr. P.H., Senior Vice President for NYC Correctional Health Services

Denise C. Soares: Makes history at Harlem Hospital, Caribbean Life, Denise C. Soares, Senior Vice President, Generations+/Northern Manhattan Health Network, Executive Director, Harlem Hospital

Jimmy Fallon's finger almost amputated after fall, Yahoo News, Bellevue: Dr. David Chiu, Dr. Scott Reis, Hand and Plastics Surgeons

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve and appoint Citigroup, JP Morgan and Morgan Stanley & Co. to provide investment banking services and serve as senior managing underwriters, and to approve and appoint BNY Mellon Capital Markets, Blaylock Beal Van LLC, Drexel Hamilton LLC, Fidelity Capital Markets, FTN Capital Markets, First Southwest, Janney Montgomery Scott, Jefferies LLC, Loop Capital Markets LLC, Mischler Financial Group, Ramirez & Company, RBC Capital Markets, Rockfleet Financial Services, Roosevelt & Cross Inc., Stern Brothers, TD Securities and Wells Fargo Securities to serve as co-managing underwriters for the Corporation's debt issuances from August 2015 through July 2020 to support its capital finance program. Such authorization in respect to the entities mentioned above shall extend to the successors of any such entities which assume the business of such entities through merger, reorganization, consolidation or acquisition.

Further authorizing the President to negotiate and execute a contract with one of the three senior underwriters in the event of a Board authorized issuance.

WHEREAS, the Corporation currently finances major capital projects, ongoing capital improvements and major movable equipment through funds received from the proceeds of tax-exempt bonds and leases issued by the Corporation or by other issuers on behalf of the Corporation; and

WHEREAS, the Selection Committee, consisting of representatives from the Corporation, the New York City Office of Management and Budget, and the New York City Office of the Comptroller, has reviewed and determined from proposals submitted in response to a Request for Proposals ("RFP") that the 20 responding firms are qualified to provide the investment banking services that are required for the restructuring, marketing, and underwriting of the Corporation's debt issuances; and

WHEREAS, the Corporation wishes to maintain a team of three firms to act as senior managing underwriter for maximum flexibility, in the event that one or more of the three senior managing firms indicated above is no longer a separate entity or no longer provides municipal underwriting services, the Corporation reserves the right to appoint one or more of the selected co-managing underwriter firms to act as senior manager based on the Selection Committee rankings, and

WHEREAS, the overall management of this contract will be under the direction of the Senior Vice President of Finance/Chief Financial Officer, and the Assistant Vice President of the Debt Finance/Corporate Reimbursement Services division.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to approve and appoint Citigroup, JP Morgan and Morgan Stanley & Co. to provide investment banking services and serve as senior managing underwriters, and to approve and appoint BNY Mellon Capital Markets, Blaylock Beal Van LLC, Drexel Hamilton LLC, Fidelity Capital Markets, FTN Capital Markets, First Southwest, Janney Montgomery Scott, Jefferies LLC, Loop Capital Markets LLC, Mischler Financial Group, Ramirez & Company, RBC Capital Markets, Rockfleet Financial Services, Roosevelt & Cross Inc., Stern Brothers, TD Securities and Wells Fargo Securities to serve as co-managing underwriters for the Corporation's debt issuances from August 2015 through July 2020 to support its capital finance program. Such authorization in respect to the entities mentioned above shall extend to the successors of any such entities which assume the business of such entities through merger, reorganization, consolidation or acquisition. Further authorizing the President to negotiate and execute a contract with one of the three senior underwriters in the event of a Board authorized issuance.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the Corporation”) to enter into multiple contracts to purchase health information related professional services for the Epic Electronic Medical Record program and Epic related Revenue Cycle modules as needed with 21 vendors (the “Contractors”) through requirements contracts for a two year term with three one-year options to renew at the Corporation’s exclusive option for an amount not to exceed \$119,292,988 million for the *initial* two year period.

WHEREAS, the capacity of the Corporation’s current employees is not sufficient to implement and deploy all required features for the Epic Electronic Medical Record; and

WHEREAS, the proposed contracts will allow the Corporation to secure the necessary expertise to complete required milestones and deliverable for the Epic EMR deployment; and

WHEREAS, the Corporation has selected EPIC, a single enterprise-wide EMR to meet the needs of HHC’s expansive size, improve patient care, control costs, and overcome gaps in care transitions; and

WHEREAS, the Corporation issued a Health Information Related Services Request for Proposals to which the Contractors responded; and

WHEREAS, the utilization of these contracts will provide the Corporation with health information related professional services on an as-needed basis for implementation, advisory, support and/or training services for a wide array of technology staffing needs for the EMR program; and

WHEREAS, the overall responsibility for managing and monitoring the agreements shall be under the Interim Corporate Chief Information Officer.

NOW, THEREFORE, be it;

RESOLVED THAT the President of the New York City Health and Hospitals Corporation (the “Corporation”) be and hereby is authorized to enter into multiple contracts to purchase health information related professional services for the Epic Electronic Medical Record program and Epic related Revenue Cycle modules as needed with 21 vendors (the “Contractors”) through requirements contracts for a two year term with three one-year options to renew at the Corporation’s exclusive option for an amount not to exceed \$119,292,988 million for the *initial* two year period.

Approved July 30, 2015

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable five year license agreement with Visiting Nurse Service of New York Hospice Care (the "Licensee") for its continued use and occupancy of approximately 12,420 square feet of space on the 7th Floor of the Hospital Building at Bellevue Hospital Center (the "Facility") to operate a hospice program at an annual occupancy fee of \$53.58 per square foot or \$665,436 for year one of the agreement, \$55.12 per square foot or \$684,534 for year two, \$56.70 per square foot or \$704,180 for year three, \$58.59 per square foot or \$727,630 for year four and \$59.90 per square foot or \$744,000 for year five, for a total five year occupancy fee of \$3,525,780.

WHEREAS, in May 2010 the Board of Directors of the Corporation authorized the President to execute a revocable license agreement with the Licensee; and

WHEREAS, in 2010 data indicated that New York City underutilized hospice care relative to the rest of the United States and the pending closure of the Licensee's hospice program at Saint Vincent Hospital created a need for the replacement of services lost; and

WHEREAS, the Licensee's hospice program at the Facility has been successful in providing care to patients and the Facility continues to have space available to accommodate its program requirements.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to execute a revocable five year license agreement with Visiting Nurse Service of New York Hospice Care (the "Licensee") for its continued use and occupancy of approximately 12,420 square feet of space on the 7th Floor of the Hospital Building at Bellevue Hospital Center (the "Facility") to operate a hospice program at an annual occupancy fee of \$53.58 per square foot or \$665,436 for year one of the agreement, \$55.12 per square foot or \$684,534 for year two, \$56.70 per square foot or \$704,180 for year three, \$58.59 per square foot or \$727,630 for year four and \$59.90 per square foot or \$744,000 for year five, for a total five year occupancy fee of \$3,525,780.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to execute a five year revocable license agreement with Sirius XM Radio Inc. (the "Licensee") for its use and occupancy of 90 square feet to house roof-top communications equipment at the Henry J. Carter Specialty Hospital and Nursing Facility (the "Facility") at an occupancy fee of approximately \$23,130 or \$257.00 per square foot for year one; \$23,823 or \$264.71 per square foot for year two; \$24,823.62 or \$272.65 per square foot for year three; \$25,274.78 or \$280.83 per square foot for year four; and, \$26,033.02 or \$289.26 per square foot for year five, for a total five year occupancy fee of \$122,800.31. Annual increased rates are based on 3% escalations per year.

WHEREAS, the Licensee is a U.S. corporation that provides satellite radio content to subscribers; and

WHEREAS, the Licensee operates antenna equipment on the roof of the Long Term Acute Care Hospital building on Facility's campus; and

WHEREAS, the Licensee's equipment was at this location when the building was owned operated by North General Hospital prior to the Corporation's long-term lease of the property; and

WHEREAS, the equipment complies with applicable FCC safety guidelines and therefore poses no health risks.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and is hereby authorized to execute a five year revocable license agreement with Sirius XM Radio Inc. (the "Licensee") for its use and occupancy of 90 square feet to house roof-top communications equipment at the Henry J. Carter Specialty Hospital and Nursing Facility (the "Facility") at an occupancy fee of approximately \$23,130 or \$257.00 per square foot for year one; \$23,823 or \$264.71 per square foot for year two; \$24,823.62 or \$272.65 per square foot for year three; \$25,274.78 or \$280.83 per square foot for year four; and, \$26,033.02 or \$289.26 per square foot for year five, for a total five year occupancy fee of \$122,800.31. Annual increased rates are based on 3% escalations per year.

Approved July 30, 2015

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve a Capital Project for an amount not-to-exceed \$8,500,000 for the planning, pre-construction, design, construction, procurement, construction management and project management services necessary for the Installation of Permanent Emergency Power Feeders project (the "Project") at Woodhull Medical and Mental Health Center (the "Facility").

WHEREAS, the existing temporary cables feeding the distribution switchboards from outside yard generators at the Facility were installed over eight years ago and were determined through tests to be unreliable for future use; and

WHEREAS, it was determined that replacing these cables with similar temporary cables is not feasible due to high replacement cost, and that the replacement cables would have to be removed to avoid any electrical code violations; and

WHEREAS, removing the temporary cables will leave the Facility without the use of the outside yards generators during emergencies; and

WHEREAS, the revision of Operating Procedure 100-5 requires that construction projects with budgets of \$3 million or more shall receive approval of the Board of Directors through Capital Committee; and

WHEREAS, the proposed total project budget, inclusive of all contingencies, is estimated to be \$8.5 million; and

WHEREAS, the overall management of the construction contract will be under the direction of the Facility's Executive Director and Assistant Vice President - Facilities Development.

NOW THEREFORE, be it

RESOLVED, the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve a Capital Project for an amount not-to-exceed \$8,500,000 for the planning, pre-construction, design, construction, procurement, construction management and project management services necessary for the Installation of Permanent Emergency Power Feeders project (the "Project") at Woodhull Medical and Mental Health Center (the "Facility").

The Joint Commission (TJC) Multi-Facility Survey of HHC, 2015

CAROLINE M. JACOBS. MPH, MS.ED.
CHIEF PATIENT SAFETY OFFICER AND
SENIOR VICE PRESIDENT
SAFETY AND HUMAN DEVELOPMENT

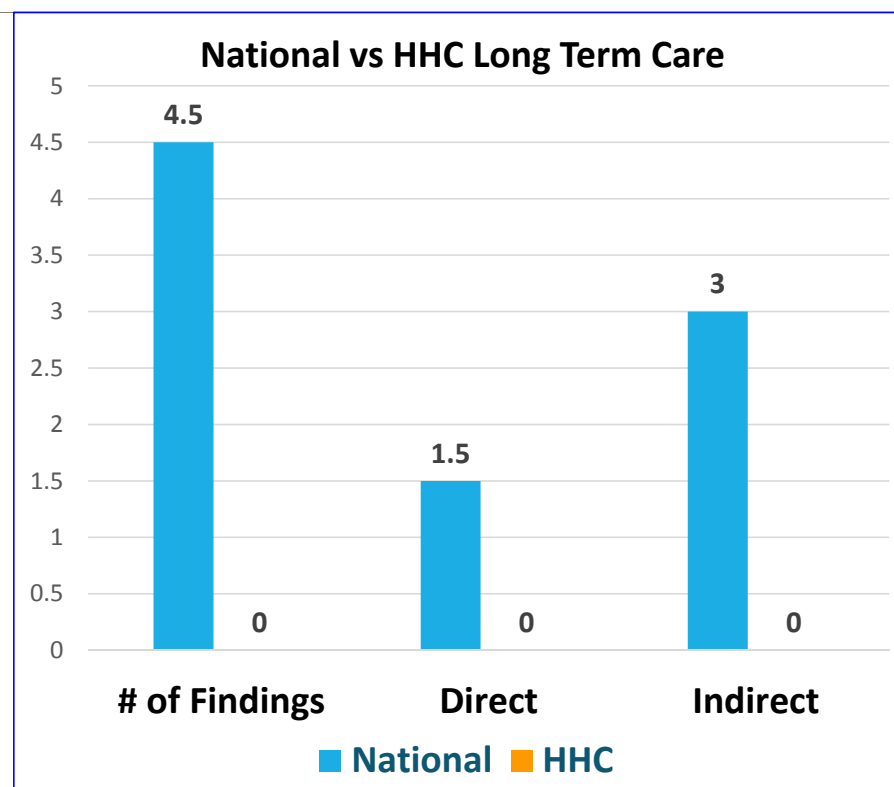
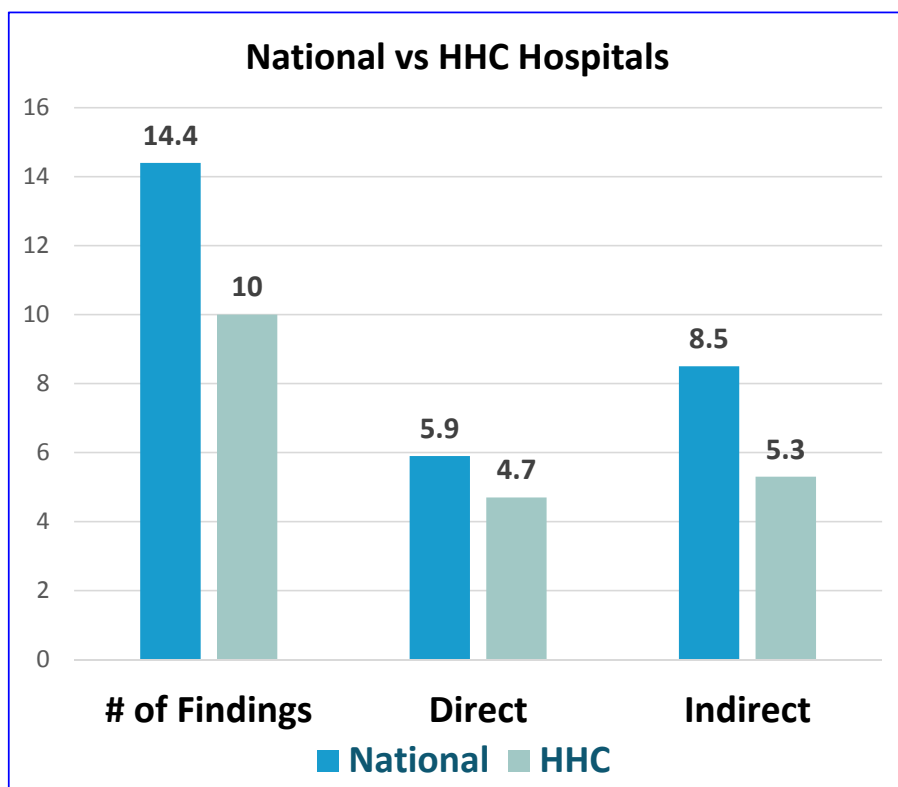
THURSDAY, SEPTEMBER 24, 2015

TJC Background and Overview

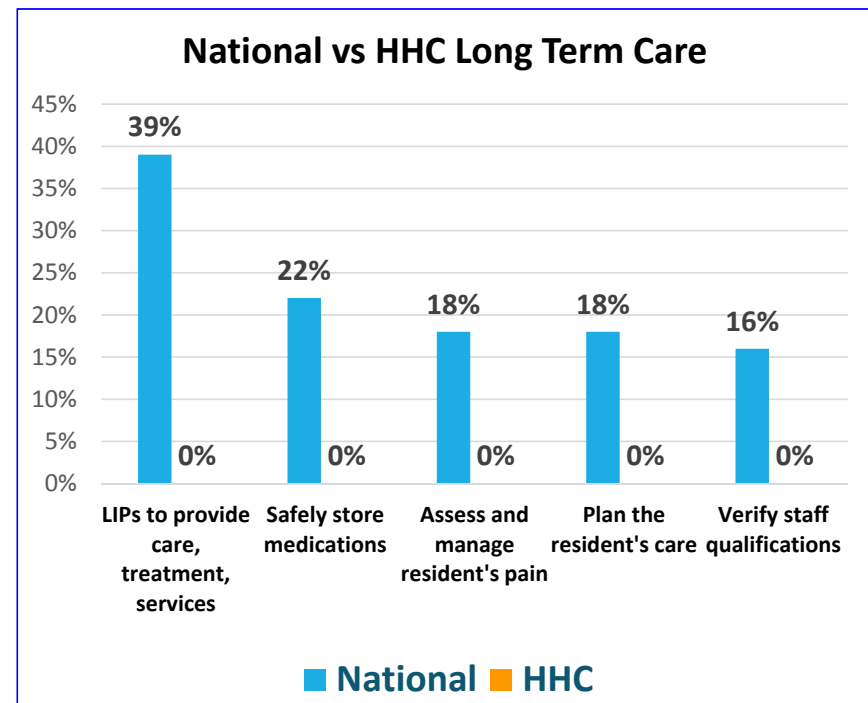
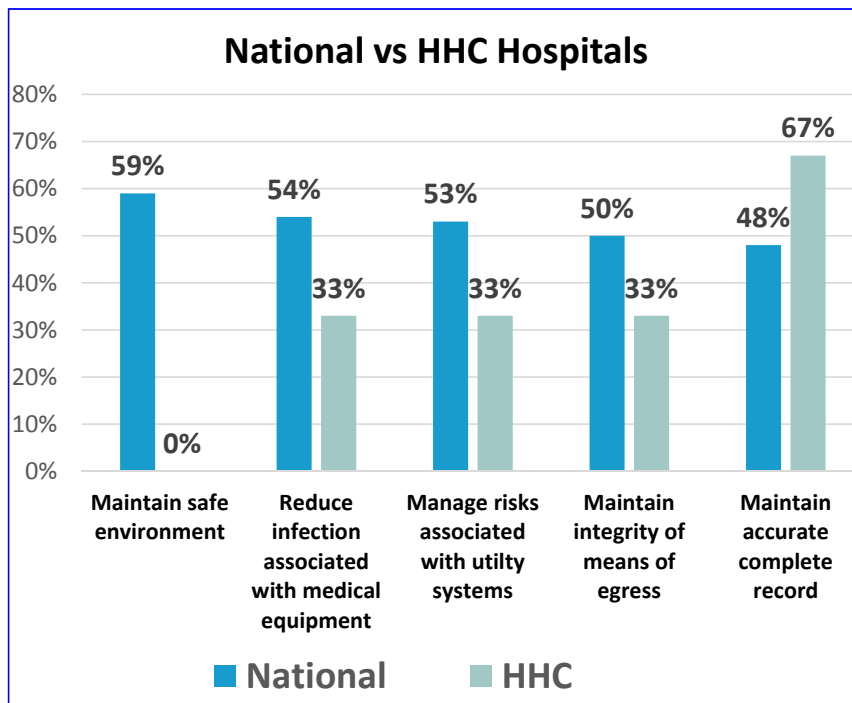
- An independent, not-for-profit national accrediting body
- Mission to continuously improve health care for the public (by evaluating health care organizations)
- Accreditation recognized as a symbol of quality reflecting an organization's commitment to meeting certain performance standards
- TJC accredits over 20,500 health care organizations in the US
 - Over 310 hospital standards (1,913 elements of performance)
 - Over 220 long term care standards (1,148 elements of performance)
- Surveys HHC as a multi-hospital system
- 2015 survey began on February 15th with the Corporate Orientation Program
- HHC facilities surveyed in 2015
 - Coney Island, Kings County and Lincoln Hospitals
 - 4 Opioid Treatment Programs (1 Methadone Maintenance and 3 Inpatient Medical Detoxification) Coney, Lincoln and Kings
 - SeaView Hospital Rehabilitation Center and Home

CY 2015 Comparative Data

Average Number of Findings, National vs. HHC



CY 2015 Top 5 Areas of Non-Compliance, National vs. HHC



Number of Direct Impact Findings – HHC Hospitals

Environment of Care (4)

Medication Management (1)

Infection Control (1)

Provision of Care (6)

Life Safety (2)

Number of Indirect Impact Findings – HHC Hospitals

Environment of Care (1)

Medication Management (3)

Emergency Management (1)

Medical Staff (2)

Infection Control (1)

Provision of Care (2)

Life Safety (4)

Record of Care (2)

Opportunities for Improvement – HHC Hospitals

Care, Treatment and Services (1)

National Patient Safety Goal 3 (1)

Infection Control (1)

Provision of Care (3)

Life Safety (8)

Record of Care (3)

Medication Management (2)

Patients Rights (1)

Four Opioid Treatment Programs (OTP)

METHADONE MAINTENANCE

Indirect (1)

- Record of Care

Opportunities for Improvement (2)

- Care, Treatment and Services
- Record of Care

MEDICAL DETOXIFICATION

Opportunities for Improvement (3)

- Care, Treatment and Services
- National Patient Safety Goal 15
- Record of Care

Examples of Survey Team Feedback

- Throughout the 2015 surveys, the survey team consistently praised the quality of care provided and the commitment of staff to an underserved and often vulnerable population
- Extremely impressed with HHC. Changed their perception of a public healthcare system
- Consistently recommended programs for submission to The Joint Commission's best practice database library
- Statement from a facility Exit Survey
 - “medical staff engagement and involvement are beyond what's seen elsewhere in the country; staff comfortable in what they're doing and evidently supported by leadership; commitment to serve and the manner in which you do it touches my heart; emotional to see what you're doing for the needy – thank you for what you're doing; will carry memories of this organization throughout the rest of my career; leaving this institution with renewed respect for the commitment and services you provide to this vulnerable and underserved population”.

Six Facilities Scheduled for Survey in 2016

- Elmhurst Hospital Center
- Harlem Hospital Center
- Jacobi Medical Center
- Metropolitan Hospital Center

- Gouverneur Healthcare Services (Nursing Facility)
- Dr. Susan Smith McKinney Nursing & Rehabilitation Center



THANK
YOU

RESOLUTION

Adopting the Corporation's Mission Statement and
Performance Measures as required by the Public
Authorities Reform Act

WHEREAS, the New York State Public Authorities Reform Act of 2009 requires local public authorities such as the Corporation to adopt each year a mission statement and performance measures to assist the Corporation in determining how well it is carrying out its mission; and

WHEREAS, the Corporation has posted on its website a mission statement that is a refined version of the purposes of the Corporation as expressed in the legislation which created HHC and in the HHC By-Laws; and

WHEREAS, the Corporation keeps extensive data on numerous performance measures for internal monitoring and external reporting; and

WHEREAS, the Corporation has selected performance measures addressing the core functions and values of the Corporation for reporting to the Office of the State Comptroller's Authorities Budget Office (ABO) as required by the Public Authorities Reform Act; and

WHEREAS, the ABO has required reporting of the Corporation's mission and performance measures, as well as responding to certain additional questions, on a form provided by that office and requires that the Board of Directors read and understand the mission statement and read and understand the responses provided to the ABO; and

WHEREAS, the attached "Mission Statement and Performance Measures" uses the same indicators as the last report approved by the Board of Directors except that some descriptions have been refined and the performance measures have been updated;

NOW, THEREFORE, be it

RESOLVED that the attached "Mission Statement and Performance Measures" as required by the Public Authorities Reform Act is hereby adopted.

Executive Summary

HHC is required to adopt and to report to the New York State Office of the State Comptroller's Authority Budget Office ("ABO") each year a mission statement and performance measures to assist the Corporation in determining how well it is carrying out its mission. The ABO requires completion of a specific form to achieve this reporting, as well as to respond to some additional questions. Attached is the complete report of our mission statement and the performance measures and the additional responses, all of which require the Board's adoption.

The attached "Mission Statement and Performance Measures" uses the same indicators as the last report approved by the Board of Directors except that some descriptions have been refined and the performance measures have been updated.

There have been minor variations on the HHC Mission Statement over the years. All are refined versions of the purposes of the Corporation as expressed in the legislation which created HHC and in the HHC By-Laws. The mission statement on the ABO form is the version currently included on our website.

The Corporation keeps extensive data on numerous performance measures for internal monitoring and external reporting. The measures included on the form were selected because they address the core functions and values of the Corporation. We were careful not to include any measures that were confidential quality assurance information not properly shared in this context.

The information on this form will be submitted annually so that we will have the opportunity to make whatever changes are deemed necessary for future filings.

Authority Mission Statement and Performance Measurements

Name of Public Authority:

New York City Health and Hospitals Corporation

Public Authority's Mission Statement:

To extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services of the highest quality in an atmosphere of humane care, dignity and respect;

To promote and protect, as both innovator and advocate, the health, welfare and safety of the people of the City of New York;

To join with other health workers and with communities in a partnership which will enable each of our institutions to promote and protect health in its fullest sense -- the total physical, mental and social well-being of the people.

Date Adopted: September 24, 2015

List of Performance Measurements:

	Indicator Name	Indicator Description	FY14
1	General Care Average Length of Stay (days)	Average length of stay for a general care inpatient hospitalization	5.1
2	Uninsured Served	Number of patients without health insurance served by HHC	410,791
3	Total Medicaid Managed Care Enrollment	Total number of individuals served by HHC enrolled in Medicaid managed care	560,631
4	MetroPlus Enrollment	Total number of individuals enrolled in MetroPlus Health Plan	473,442
5	Percent of eligible women receiving screening mammograms	Total number of women aged 40 to 70 who received a mammogram screening in the reporting period with a primary care or gynecology visit in the past two years	77.8%
6	Adult Psychiatry Average Length of Stay (days)	Average length of stay for adult psychiatry hospital stays	16.0
7	Total outpatient visits	Total outpatient visits	4,387,799
8	Total emergency room visits	Total emergency room visits	1,156,793
9	HIV connect to care	Percent of diagnosed HIV patients who are linked to care within 90 days of diagnosis	82.84%

Additional questions:

1. Have the board members acknowledged that they have read and understood the mission of the public authority?

Yes.

2. Who has the power to appoint the management of the public authority?

Pursuant to the legislation that created the New York City Health and Hospitals Corporation, the President is chosen by the members of the Board of Directors from persons other than themselves and serves at the pleasure of the Board. (Unconsolidated Law, section 7394)

3. If the Board appoints management, do you have a policy you follow when appointing the management of the public authority?

The Governance Committee to the Board of Directors, which is a special committee established by the Board, includes the functions of the former Personnel Committee and has, among its responsibilities, the duty to receive, evaluate and report to the Board of Directors with respect to the submissions of appointments of corporate officers.

4. Briefly describe the role of the Board and the role of management in the implementation of the mission.

In addition to standing and special committees which have defined subject matter responsibilities and which meet monthly or quarterly, the Board of Directors meets monthly to fulfill its responsibility as the governing body of HHC and its respective facilities as required by law and regulation by the various regulatory and oversight entities that oversee HHC. Corporate by-laws and established policies outline the Board's participation in the oversight of the functions designated to management in order to ensure that HHC can achieve its mission in a legally compliant and fiscally responsible manner.

5. Has the Board acknowledged that they have read and understood the responses to each of these questions?

Yes.

A RESOLUTION AMENDING A PREVIOUSLY
ADOPTED RESOLUTION IN ORDER TO INCREASE
THE AUTHORIZATION FOR ONE OR MORE
BORROWINGS IN AN AGGREGATE
NOT TO EXCEED AMOUNT FROM \$60,000,000 TO \$120,000,000
AND TO EXPAND THE SCOPE OF ALLOWABLE USES

WHEREAS, the President of New York City Health and Hospitals Corporation (the “Corporation”) has issued that certain Operating Procedure (40-58 Debt Finance and Treasury) (the “Operating Procedures”) relating to the delegation of certain powers for the incurrence of debt for various capital expenditures, including renovations, improvements, construction and equipment financing to the Corporation’s Chief Financial Officer by resolution to be adopted by the Board of Directors of the Corporation; and

WHEREAS, the Board of Directors of the Corporation, and the Finance Committee of such Board, pursuant to Section 4(f)(i) of such Operating Procedures, have determined that it is necessary and desirable to expand the authorization for the incurrence of debt for equipment financing, as previously authorized by the Board of Directors by Resolution adopted April 30, 2015, from an aggregate amount from time to time not exceeding \$60,000,000, to an aggregate amount from time to time not exceeding \$120,000,000, in the form of tax-exempt or taxable loans borrowed by the Corporation from time to time from one or more lenders (the “Lenders”), to provide funds to finance, refinance and reimburse the Corporation for the costs of various capital expenditures, including renovations, improvements, construction and equipment and various related capital projects and expenditures at the Corporation’s facilities, and to carry out the purposes permitted by law and set forth herein and consistent with the Operating Procedures;

NOW, THEREFORE, BE IT RESOLVED, AS FOLLOWS:

Section 101. Authority. This Resolution is adopted pursuant to the authority contained in the New York City Health and Hospitals Corporation Act and in the Operating Procedures.

Section 102. Principal Amount. The incurrence of debt is hereby authorized in the aggregate principal amount of not exceeding \$120,000,000, from time to time, for the purpose of financing various capital expenditures, including renovations, improvements, construction and equipment and various related capital projects and expenditures at the Corporation’s facilities. Such debt may take the form of borrowings, loan agreements, installment purchase agreements or lease agreements, all as contemplated by the Operating Procedures.

Section 103. Interest. Such debt shall bear interest as determined by the Chief Financial Officer of the Corporation as authorized in the Operating Procedures.

Section 104. Authorization of Related Documents. The Corporation is authorized to enter into one or more debt contracts, such as loan agreements, revolving credit agreements, notes, bonds, installment purchase agreements, rental arrangements or lease

agreements. The form, terms and provisions of the debt contracts, between the Corporation and a Lender, providing for the incurrence of such debt, shall be approved by an Authorized Officer (defined below) of the Corporation, as evidenced by his or her signature thereon. The President, the Senior Vice President of Finance/Chief Financial Officer, or any other authorized officer of the Corporation under the by-laws of the Corporation (each an “Authorized Officer”) is authorized and empowered for and on behalf of the Corporation to execute, acknowledge and deliver the debt contracts, and the Secretary or any other Authorized Officer of the Corporation is hereby authorized and empowered to affix the seal of the Corporation and to attest to the same for and on behalf of the Corporation.

The President, the Senior Vice President of Finance/Chief Financial Officer, or any other Authorized Officer of the Corporation are each hereby authorized to take any action, execute any document, or give any consent which may from time to time be required by the Corporation under this Resolution or any such debt contracts. Any such action taken or document executed or consent given by such officer in his or her capacity of an officer of the Corporation shall be deemed to be an act by the Corporation.

Section 105. Effective Date. This Resolution shall take effect immediately upon its adoption by the Board of Directors of the Corporation, subsequent to its adoption by the Finance Committee of such Board.

EXECUTIVE SUMMARY

Amending a Previously Adopted Resolution to Increase the Authorization for One or More Borrowings in an Aggregate Not To Exceed Amount from \$60,000,000 to \$120,000,000 and to Expand the Scope of Allowable Uses to Include Non-Equipment Capital Projects

The resolution amends a resolution previously adopted on April 30, 2015 to increase the authorization for the Corporation to borrow from one or more lenders, from time to time, in an aggregate not-to-exceed amount of \$60 million to \$120 million and to expand the scope of allowable uses for the proceeds of such borrowing to capital projects other than equipment. The overall negotiation, execution, and management of the borrowing under this resolution are delegated to the Corporation's Chief Financial Officer (CFO). Any borrowing under this resolution will be reported quarterly by the CFO to the Finance Committee.

The Corporation funds the vast majority of its major capital expenditures with the proceeds of tax-exempt bonds issued by the Corporation or the City of New York. However, corporate bond issuances result in the establishment of large capital project funds causing the Corporation to incur interest expense and face investment risk on unspent bond proceeds. The Corporation has previously determined that it is more suitable to finance shorter useful life projects such as equipment with loans provided by banks and/or leasing providers. This type of borrowing allows the Corporation to borrow in smaller amounts, as the need arises, incur minimal cost of issuance and minimize investment risk on borrowed proceeds. The Corporation now has the opportunity to also use this type of borrowing to fund non-equipment short-term capital projects and to provide initial financing for longer-term projects. This would minimize the need to establish capital project funds even for longer useful projects, as bond issuances could be used to convert or "fix out" amounts initially financed through these vehicles to longer term bond financing.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (HHC), through its President, to delegate to each hospital's Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through each hospital's Quality Assurance process to the Board of Directors.

WHEREAS, HHC and its facilities are committed to the delivery of high quality Health services in an atmosphere of dignity and respect; and

WHEREAS, the Board of Directors has continuing responsibility for the effective operation of HHC's facilities; and

WHEREAS, the Board of Directors serves as the Governing Body of HHC's facilities;

NOW, THEREFORE, be it

RESOLVED that HHC, through its President, will delegate to each hospital's Grievance Committee responsibility for the prompt resolution of grievances and complaints from patients and/or their families. The activities of the Grievance Committees will be reviewed and reported through the Quality Assurance Committee process to the HHC Board of Directors.

EXECUTIVE SUMMARY

Resolution to delegate the review and resolution of patient and family grievances and complaints to patient grievance committees at HHC hospitals.

HHC acute care hospital has a well-developed process for responding to concerns raised by patients and their families. HHC's operating procedure 90-1 sets out the responsibility and authority of the Office of Patient Relations at each HHC facility, and a 1992 resolution sets out additional HHC policies on patients' rights. These procedures apply to all of the Corporation's facilities. In addition, the Corporation's hospitals must adhere to the conditions of participation for hospitals established by the Centers for Medicare and Medicaid (CMS) in 42 CFR § 482.13. (2) (a). The regulation requires that:

"The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's Governing Body must approve and be responsible for the effective operation of the grievance process and must review and resolve grievances, unless it delegates the responsibility in writing to a Grievance Committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization."

Each HHC acute care hospital has established a committee that reviews and resolves complaints and grievances as defined by CMS. The activities of those committees will be reviewed by the facility hospital-wide quality assurance committee, and data collected regarding patient complaints and grievances must be incorporated in the hospital's Quality Assessment and Performance Improvement Program. These data are currently reported to the Quality Assurance Committee of the Board of Directors.

This process conforms to every aspect of the regulation except the requirement that the Governing Body delegate responsibility in writing to a Grievance Committee. CMS has cited some HHC hospitals because of the lack of a written delegation from the Governing Body.

This resolution is the written delegation of responsibility required by the CMS regulation. Hereafter complaints and grievances will be reported to the Quality Assurance Committee of the Board of Directors and the hospital's Governing Body.

Resolution

Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to enter into a sole source agreement with SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed \$4,769,555 (which includes a contingency reserve of \$229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms.

WHEREAS, New York State Public Health Law and Education Law mandate the implementation of e- prescribing for all medications including controlled substances by March 2016; and

WHEREAS, the Corporation is adopting the Surescripts LLC e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system; and

WHEREAS, Surescripts LLC operates the nation’s only health information network with the capability to electronically transmit prescriptions and refill requests, which network will allow the Corporation to connect the Corporation’s prescribers with community pharmacies in order to enable the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests; and

WHEREAS, the contract with Surescripts LLC will provide all software and services necessary for the Corporation to implement e-prescribing in compliance with NYS mandate requirements; and

WHEREAS, the funding for this contract will be provided through the Epic EMR budget previously presented to the Board of Directors; and

WHEREAS, the contract will be managed and monitored under the direction of the Senior Assistant Vice President/ Interim Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED, THAT the President of New York City Health and Hospitals Corporation be and hereby is authorized to enter into a sole source agreement with SURESCRIPTS, LLC for e-prescribing software and related services for an amount not to exceed \$4,769,555 (which includes a contingency reserve of \$229,817 for additional services that may be required) over a three-year term with up to two one-year renewal terms.

EXECUTIVE SUMMARY

The accompanying Resolution requests approval to enter into a sole source contract with Surescripts LLC (“Surescripts”) for enterprise-wide e-prescribing system in an amount not to exceed \$4,769,555 (which includes a contingency reserve of \$229,817) for the contract term of 3 years with up to 2 one-year renewals upon mutual consent of the parties. The funding for this contract will be provided through the Epic EMR budget previously presented to the Board of Directors.

New York State Public Health Law and Education Law mandate the implementation of e-prescribing for all medications including controlled substances by March 2016. The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements. HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system.

Enterprise Information Technology Services (“EITS”) received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation’s only health information network with the capability to electronically transmit prescriptions and refill requests. E-Prescribing is the secure transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan. E-Prescribing includes two way transmissions between the point of care and the dispenser.

Surescripts will provide the foundation infrastructure including interface specifications, transaction routing infrastructure, software licenses, participant management services, and error management services. In addition to the prescription routing services to a large network of community pharmacies, Surescripts also connects to a Benefits Manager and Medication History of the patient that further strengthen HHC’s patient safety and patient satisfaction measures.

HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system to enable the Corporation’s prescribers to electronically access:

- the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests to patient designated pharmacies. These pharmacies can be within the HHC facility or neighborhood pharmacies that are not part of the facility.
- patient prescription benefit plan information, both formulary and eligibility, allowing the prescriber to choose medications that are covered by the patient drug benefits at the lowest cost, as a result pharmacies receive fewer prescriptions that require changes;
- with a patient’s consent, electronically access a patient’s medication history to obtain critically important information of the patient’s current and past prescriptions to allow the prescriber to better assess potential medication issues (i.e. potential harmful drug interactions, allergies, adherence) and improve patient safety.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Surescripts E-Prescribing
Project Title & Number: Epic/E-Prescribing
Project Location: EITS
Requesting Dept.: Central Office - EITS

Successful Respondent: SURESCRIPTS LLC
Total Not to Exceed: \$4,769,555 (includes \$229,817 contingency)
Contract Term: 3 years with up to 2 one year renewal terms

Number of Respondents: Sole Source
(If Sole Source, explain in Background section)

Range of Proposals: N/A

Minority Business Enterprise Invited: Yes If no, please explain: N/A

Funding Source: General Care Capital
 Grant: explain
 Other: explain

Method of Payment: Lump Sum Per Diem Time and Rate
 Other: Monthly Fees based on number of Certified Beds as well as additional transaction fees

EEO Analysis: Approved

Compliance with HHC's McBride Principles? Yes No Pending

Vendex Clearance Yes No Pending

(Required for contracts in the amount of \$100,000 or more awarded pursuant to an RFP, NA or as a Sole Source, or \$100,000 or more if awarded pursuant to an RFB.)

CONTRACT FACT SHEET (continued)

Background (include description and history of problem; previous attempts, if any, to solve it; and how this contract will solve it):

This contract is required for the Epic EMR project. New York State Public Health Law and Education Law mandate the implementation of e-prescribing for all medications including controlled substances by March 2016. The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements.

Enterprise Information Technology Services (“EITS”) received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation’s only health information network with the capability to electronically transmit prescriptions and refill requests. E-Prescribing is the secure transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan. E-Prescribing includes two way transmissions between the point of care and the dispenser.

Contract Review Committee

Was the proposed contract presented at the Contract Review Committee (CRC)? (Include date):

CRC approval was received September 2, 2015.

Has the proposed contract’s scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC? If so, please indicate how the proposed contract differs since presentation to the CRC:

N/A.

CONTRACT FACT SHEET (continued)

Selection Process (attach list of selection committee members, list of firms responding to RFP or NA, list of firms considered, describe here the process used to select the proposed contractor, the selection criteria, and the justification for the selection):

This is a sole source contract.

Enterprise Information Technology Services (“EITS”) received approval from the CRC to initiate negotiations for a sole source contract with Surescripts which operates the nation’s only health information network with the capability to electronically transmit prescriptions and refill requests.

Scope of work and timetable:

Surescripts will provide the software and services necessary for the foundation infrastructure including interface specifications, transaction routing infrastructure; participant management services, and error management services. In addition to the prescription routing services to a large network of community pharmacies, Surescripts also connects to a Benefits Manager and Medication History of the patient that further strengthen HHC’s patient safety and patient satisfaction measures.

HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system to enable the Corporation’s prescribers to electronically access:

- the secure, reliable transmission and delivery of electronic prescription orders and refill authorization requests to patient designated pharmacies. These pharmacies can be within the HHC facility or neighborhood pharmacies that are not part of the facility;
- patient prescription benefit plan information, both formulary and eligibility, allowing the prescriber to choose medications that are covered by the patient drug benefits at the lowest cost, as a result pharmacies receive fewer prescriptions that require changes;
- with a patient’s consent, electronically access a patient’s medication history to obtain critically important information of the patient’s current and past prescriptions to allow the prescriber to better assess potential medication issues (i.e. potential harmful drug interactions, allergies, adherence) and improve patient safety.

CONTRACT FACT SHEET (continued)

Provide a brief costs/benefits analysis of the services to be purchased.

E-Prescribing is a regulatory requirement.

The costs of the contract for the five year period is \$4,769,555.41 which includes a contingency of \$229,817.38. The annual cost is based on 3,181 Certified beds, billable monthly at the rate of \$ 136.00 per bed for the approximately 3,181 Certified beds (HHC Corporate Planning Services, prepared 2/13/2015) within the Corporation's facilities. Other components and transaction fees include:

- One Time Fees – Staging fee \$1,500 and \$25,000 to establish connectivity to the Surescripts system to meet Clinical Network Services requirements.
- Faxing fees, Prior Authorizations for registered providers and Clinical Network services fees – all fees have been incorporated into the total 5 year budget.

Provide a brief summary of historical expenditure(s) for this service, if applicable.

Not applicable.

Provide a brief summary as to why the work or services cannot be performed by the Corporation's staff.

E-Prescribing is a regulatory requirement.

Will the contract produce artistic/creative/intellectual property? Who will own It? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

Not applicable.

Contract monitoring (include which Senior Vice President is responsible):

This contract will be administered by Sal Guido, Senior AVP / Interim CIO.

Equal Employment Opportunity Analysis (include outreach efforts to MBE/WBE's, selection process, comparison of vendor/contractor EEO profile to EEO criteria. Indicate areas of under-representation and plan/timetable to address problem areas):

Received By E.E.O. 5/19/14
Date

Analysis Completed By E.E.O. 9/23/14
Date

Manasses Williams, Senior AVP
Name

AMENDED

31857

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: Hilary Miller,CO
EITS IT Financial Administration
Office of Information Technology

FROM: Manasses C. Williams 

DATE: September 23, 2014

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Surescripts, LLC**, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): Corporate

Contract Number: _____

Project: Pharmaceutical Services

Submitted by: Office of Information Technology Services

EEO STATUS:

1. Approved
2. Approved with follow-up review and monitoring
3. Not approved
4. Conditionally approved subject to EEO Committee Review

COMMENTS:

MCW/srf



SURESCRIPTS SOLE SOURCE CONTRACT FOR E-PRESCRIBING

BOARD OF DIRECTORS

September 24, 2015

Background



- **The CMS definition of e-prescribing ...”the transmission, using electronic media, of prescription or prescription related information between a prescriber, dispenser, pharmacy, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two way transmissions between the point of care and the dispenser.”**
- **The New York State Public Health Law and the Education Law mandate the implementation of electronic prescribing by March 27, 2016.**
- **The contract with Surescripts will provide all software and services necessary for HHC to implement e-prescribing in compliance with NYS mandate requirements. HHC is adopting the Surescripts e-prescribing technology to work in conjunction with the Epic Electronic Medical Record system.**
- **Surescripts operates the nation’s largest health information network with the capability to electronically transmit prescriptions and refill requests.**



PURPOSE OF CONTRACT

The purpose of the contract is to procure the essential Surescripts e-prescribing software and services that uniquely provides the following benefits:

- **Electronically Access Patient's Prescription Benefit Information:** Prescribers can choose medications that are covered by the patient's drug benefit as well as those of lower-cost. Pharmacies receive fewer prescriptions that require changes.
- **With Patient's Consent, Electronically Access Patient's Medication History:** Prescribers receive critically important information on their patients' current and past prescriptions which assists with patient safety. Prescribers can also can gain insight into a patient's medication compliance.
- **Electronically Route the Prescription to the Patient's Choice of Pharmacy:** Exchanging prescription information electronically between prescribers and pharmacies improves the accuracy of the prescribing process reducing the need for pharmacy staff to key in prescription data reducing errors.

Clinician E-Prescriber Workflow



- **Verifying Benefits in EPIC – Clinician queries the Surescripts database to display the patient’s pharmacy benefits.**
- **Ordering Medications – Once the patient’s pharmacy benefits have been selected, all medications purchased using their coverage will be displayed in EPIC. Once the primary coverage is selected, the patient’s medication purchase will display.**
- **Routing to Pharmacy – Once the order is placed, the prescription is transmitted through the Surescripts server to the patient’s preferred pharmacy within the Network.**
- **HHC generates over 20 million prescription annually - 3.5 are filled within HHC pharmacies – the remaining 16.5 are filled at external pharmacies.**



CONTRACT BUDGET

ESTIMATED COSTS BY CONTRACT YEAR

Contract Year	\$ Amount
Year 1 *	\$876,616
Year 2	\$875,619
Year 3	\$901,842
Year 4 (Renewal)	\$928,897
Year 5 (Renewal)	\$956,764
<i>Contingency</i>	\$229,817
Five Year Estimated Total	\$4,769,555

* Assumes 10/1/15 start date. Year One includes initial one time fees.



6 YEAR EPIC EMR IMPLEMENTATION BUDGET

EMR Project - Six Year Implementation Budget					
[Expenditures include Invoices Paid or In-Process]					
	Item		Total Implementation Dollars (in millions)		
			Total Budget	Expenditures [Paid or in Process] as of 8/31/2015	Balance
1	Epic Contract	Includes Software and Implementation and Training Services.	\$144	\$67	\$77
2	Third Party & Other Software	Includes Endoscopy, Fetal Monitoring Systems, ePrescribing, Patient Education.	\$30	\$5	\$25
3	Hardware	Includes Servers, Storage, Server Licensing, Network Switches.	\$84	\$26	\$58
4	Interfaces	Includes Interface Software/Biomed Middlewares.	\$39	\$4	\$35
5	Implementation Support	Third party vendor staff augmentation, go-live support and training (includes costs associated with backfilling non-IT staff and temps).	\$355	\$38	\$317
6	Application Support Team	New HHC FTE staff to be used through the implementation period including fringe benefits. These costs will become on-going after implementation period.	\$113	\$30	\$83
	Clinicals-Only Total	[Without QuadraMed Transition/Existing Application/Existing Staff Costs]	\$764	\$169	\$595

E-Prescribing was included in in Third Party and Other Software Costs



Note: :

1. 5 year current cost projection for Revenue Cycle was an additional \$125 million. Budget is under review. Further evaluation required.
2. \$160 million has been paid through 8/31/15. An additional \$9 million is in process to be paid for a total of \$169 million.

Questions



Questions?

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to procure and outfit eighty-nine (89) ambulances in Fiscal Year 2016 on behalf of the Fire Department of the City of New York ("FDNY"), through City-wide Requirements Contracts for a total amount not-to-exceed \$34.8 million.

WHEREAS, on January 19, 1996, the Corporation and the City of New York (the "City") executed a Memorandum of Understanding ("MOU") allowing the transfer of the Corporation's Emergency Medical Service ("EMS") ambulance and pre-hospital emergency medical service functions to the Fire Department of the City of New York ("FDNY") to be performed by FDNY for the benefit of the City; and

WHEREAS, the MOU requires that the FDNY have access to and use of the Corporation's property to the same extent that EMS had prior to the transfer; and

WHEREAS, a major portion of the Corporation's property used and maintained by the FDNY is the ambulance fleet formerly managed and operated by EMS; and

WHEREAS, to maintain an appropriate ambulance and pre-hospital emergency medical service, vehicles in the ambulance fleet must be periodically replaced when such vehicles have exceeded their useful life, requiring more than routine repairs and maintenance; and

WHEREAS, 89 vehicles out of the FDNY's active fleet of 460 ambulances have reached the end of their useful life and must be replaced at a cost not-to-exceed \$34,769,000; and

WHEREAS, the City provides the funding for ambulance replacement to the Corporation for allocation to the FDNY; and

WHEREAS, the City has allocated \$27,417,000 in Fiscal Year 2016, and \$25,386,000 in Fiscal Year 2017 in the Corporation's Capital Commitment Plan, on behalf of the FDNY for the purpose of purchasing and outfitting ambulances; and

WHEREAS, sufficient uncommitted funds are available in the Corporation's Fiscal Year 2016 Capital Commitment Plan for this purpose.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and is hereby authorized to procure and outfit eighty-nine (89) ambulances in FY 2016 on behalf of the Fire Department of the City of New York ("FDNY"), through City-wide Requirements Contracts for a total amount not-to-exceed \$34.8 million.

EXECUTIVE SUMMARY
EMS AMBULANCES & INITIAL OUTFITTING EQUIPMENT
FISCAL YEAR 2016
FIRE DEPARTMENT OF THE CITY OF NEW YORK

OVERVIEW: The Fire Department of the City of New York (“FDNY”) operates the Corporation’s Emergency Medical Service (“EMS”) program on behalf of HHC under a 1996 Memorandum of Understanding (“MOU”). The MOU requires the FDNY to operate and maintain the City’s active fleet of 460 ambulances as part of the EMS program.

As part of the MOU between the Health and Hospitals Corporation and the City of New York, the Corporation collects Medicaid funds for each fee-for-service patient that is admitted to one of its facilities including transports through EMS based on a longstanding agreement between HHC and the New York State Department of Health. Included in the Medicaid funding arrangement with the State DOH is the depreciated value of the ambulances. The Corporation, in turn, reimburses FDNY through payments on a quarterly basis for the provision of ambulance services. The reimbursement represents EMS’s pro rata share of Medicaid revenues of which depreciation on the ambulances is included.

NEED: Ambulances have an expected useful life of five (5) years and must be replaced after reaching the five-year period in order to maintain a high-performance fleet. The FDNY has advised the Corporation eighty-nine (89) ambulances have reached the end of their useful life and need to be replaced. Included in this amount are twelve (12) Hazardous Material Tactical Rescue Units (HazTac) which are larger than the 450 chassis used to construct Type 1 Ambulances. The HazTac ambulances have an increased number of compartments for the additional initial outfitting equipment required for response to specialized rescue situations, such as hazardous materials, which include hazmat monitoring equipment, hazmat suits and rescue equipment. Finally, initial equipment must be purchased to outfit the vehicles for a total acquisition cost of \$34,786,915, which includes the inspection fee and a ten percent contingency.

SCOPE: Procurement of eighty-nine (89) ambulances and initial outfitting equipment.

COST: \$34.8 million (Non-HHC funds)

FINANCING: New York City General Obligation Bonds (No debt service impact to HHC)

SCHEDULE: FDNY is expected to obtain the ambulances and complete outfitting within 12 months.

NEW AUTHORIZATION FY 2016

	Unit Price	# of Units	Total	Contingency	Total	Per Unit	\$/Equipped Unit
<u>Ambulances (Excluding Initial Equipment):</u>							
Ambulance 4 x 4:	258,001	77	19,866,077	\$1,986,608	\$21,852,685	\$283,801	
Ambulance Rescue HazTac:	301,789	12	3,621,468	\$362,147	\$3,983,615	\$331,968	
Total Ambulances:		89	23,487,545	2,348,755	25,836,300		
							<u>Type I Ambulances</u>
<u>Initial Equipment for 119 Ambulances:</u>							
BLS Initial Equipment	50,895	60	3,053,700	\$305,370	\$3,359,070	\$55,985	\$363,869 BLS
ALS Initial Equipment	93,300	17	1,586,100	\$158,610	\$1,744,710	\$102,630	\$626,371 ALS
Rescue HazTac Initial Equipment	289,533	12	3,474,396	\$347,440	\$3,821,836	\$318,486	
Total Initial Equipment:		89	8,114,196	\$811,420	\$8,925,616		
Inspection Fee			\$25,000	\$0	\$25,000		
Total			31,626,741	3,160,174	\$34,786,915		
Total (Rounded)					\$34,787,000		
<i>BLS: Basic Life Support</i>							
<i>ALS: Advance Life Support</i>							

Past Authorizations FYs 2014, 2012 and FY 2010

FY 2014 Ambulances

	Unit Price	# of Units	Total	Contingency	Total	Per Unit	\$/Equipped Unit
<u>Ambulances (Excluding Initial Equipment):</u>							
Ambulance F-450 4 x 2	211,624	35	7,406,840	\$740,684	\$8,147,524	\$232,786	
Ambulance F-450 4 x 4:	212,824	35	7,448,840	\$744,884	\$8,193,724	\$234,106	
Total Ambulances:		70	14,855,680	1,485,568	16,341,248		
							<u>Type I Ambulances</u>
<u>Initial Equipment for 119 Ambulances:</u>							
BLS Initial Equipment	40,272	49	1,973,328	\$197,333	\$2,170,661	\$44,299	\$277,746 BLS
ALS Initial Equipment	81,005	21	1,701,105	\$170,111	\$1,871,216	\$89,106	\$322,552 ALS
Total Initial Equipment:		70	3,674,433	\$367,443	\$4,041,876		
Inspection Fee			\$25,000		\$25,000		
Total			18,555,113	\$1,855,511	\$20,408,124		
Total (Rounded)					\$20,408,000		

FY 2013 Ambulances

	Unit Price	# of Units	Total	Contingency	Total	Per Unit	\$/Equipped Unit
<u>Ambulances (Excluding Initial Equipment):</u>							
Ambulance F-450 4 x 2	198,879	99	19,689,021	\$1,968,902	\$21,657,923	\$218,767	
Ambulance F-450 4 x 4:	200,079	20	4,001,580	\$400,158	\$4,401,738	\$220,087	
Total Ambulances:		119	23,690,601	2,369,060	26,059,661		
							<u>Type I Ambulances</u>
<u>Initial Equipment for 119 Ambulances:</u>							
BLS Initial Equipment	38,526	79	3,043,554	\$304,355	\$3,347,909	\$42,379	\$262,466 BLS
ALS Initial Equipment	79,074	40	3,162,960	\$316,296	\$3,479,256	\$86,981	\$307,068 ALS
Total Initial Equipment:		119	6,206,514	\$620,651	\$6,827,165		
<u>Initial Equipment for 77 Ambulances:</u>							
BLS Initial Equipment	38,526	52	2,003,352	\$200,335	\$2,203,687	\$42,379	\$84,757 BLS
ALS Initial Equipment	79,074	25	1,976,850	\$197,685	\$2,174,535	\$86,981	\$129,360 ALS
Total Initial Equipment:		77	3,980,202	\$398,020	\$4,378,222		
Total			33,877,317	\$3,387,732	\$37,265,049		
Total (Rounded)					\$37,266,000		

* Fiscal FY13 funding rolled into FY 2014

FY 2012 Ambulances

<u>Ambulances (Excluding Initial Equipment):</u>							
Type I Ambulances:	160,656	80	12,852,480	\$1,285,248	\$14,137,728	\$176,722	
Total Ambulances:		80	12,852,480	\$1,285,248	\$14,137,728		
							<u>Type I Ambulances</u>
<u>Initial Equipment:</u>							
BLS Initial Equipment	22,000	60	1,320,000	\$132,000	\$1,452,000	\$24,200	\$200,922 BLS
ALS Initial Equipment	46,000	20	920,000	\$92,000	\$1,012,000	\$50,600	\$227,322 ALS
Total Initial Equipment:		80	2,240,000	\$224,000	\$2,464,000		
Total			15,092,480	\$1,509,248	\$16,601,728		
Total (Rounded)					\$16,600,000		

EQUIPMENT FOR ONE (1) FDNY RESCUE AMBULANCE

MEU ALS READY

EQUIPMENT DESCRIPTION	QTY	COST	EXT
BP UNIT - INFANT	2	\$19.00	\$38.00
BP UNIT - PEDS	2	\$19.00	\$38.00
BP UNIT - ADULT	2	\$19.00	\$38.00
BP UNIT - OBESE	2	\$22.00	\$44.00
CAN, GARBAGE	1	\$30.00	\$30.00
CASE ALS DEFIBRILLATOR	1	\$300.00	\$300.00
CHAIR, STAIR	1	\$2,700.00	\$2,700.00
CUSTOMIZATION FDNY LOGO	1	\$31.00	\$31.00
COT FOLDING	1	\$452.00	\$452.00
CUSTOMIZATION FDNY LOGO	1	\$31.00	\$31.00
Defibrillator / Monitor Kit Includes: Philips Heartstart MRx Monitor/Defibrillator Lithium Ion Battery Module Bay Analyzer/Charger for Heartstart Li-Ion Batteries Reusable NIBP Pediatric Cuff Reusable NIBP Large Adult	1	\$44,329.00	\$44,329.00
Intubation Kit Complete Includes: All Intubation Kit Items Are Stainless Steel & Reusable Laryngoscope Blade Macintosh #1 Laryngoscope Blade Macintosh #2 Laryngoscope Blade Macintosh #3 Laryngoscope Blade Macintosh #4 Laryngoscope Blade Miller #0 Laryngoscope Blade Miller #1 Laryngoscope Blade Miller #2 Laryngoscope Blade Miller #3 Laryngoscope Blade Miller #4 Laryngoscope Blade Adult Handle Laryngoscope Blade Pediatric Handle Magill Forceps Adult Magill Forceps Pediatric Kelly Clamp	2	\$500.00	\$1,000.00
MATTRESS, AMB STRETCHER	1	\$243.00	\$243.00
CUSTOMIZATION FDNY LOGO	1	\$31.00	\$31.00
OXIMETER, CARBON MONOXIDE	1	\$4,500.00	\$4,500.00
OXYGEN "D" CYL BRACKET	2	\$150.00	\$300.00
OXYGEN FLOWMETER	3	\$175.00	\$525.00
OXYGEN PRESSURE REDUCER	1	\$252.46	\$252.46
OXYGEN REGULATOR	4	\$257.28	\$1,029.12
OXYGEN MONITOR W/2' HARNESS & PLUGS	1	\$173.50	\$173.50
OXYGEN TRANSDUCER W/2' HARNESS & PLUGS	1	\$275.75	\$275.75
OXYGEN HARNESS ASSEMBLY 17' W/ PLUGS	1	\$43.50	\$43.50

EQUIPMENT FOR ONE (1) FDNY RESCUE AMBULANCE

SPLINT, TRACTION COMBO	1	\$1,200.00	\$1,200.00
CUSTOMIZATION FDNY LOGO	1	\$31.00	\$31.00
PEDIATRIC IMMOBILIZATION DEVICE	1	\$400.00	\$400.00
STEP STOOL	1	\$30.00	\$30.00
STRETCHER - RAIL	1	\$360.00	\$360.00
ANTLER ASSEMBLY FOR STRETCHER	1	\$270.00	\$270.00
FLAT HEAD POUCH FOR STRETCHER	1	\$130.00	\$130.00
STRETCHER - ROLLING	1	\$6,115.00	\$6,115.00
STRETCHER - SCOOP	1	\$766.00	\$766.00
SUCTION UNIT, CHARGING BRACKET	1	\$350.00	\$350.00
SUCTION UNIT ,PORTABLE	1	\$995.00	\$995.00
SUCTION UNIT, ON-BOARD	1	\$475.00	\$475.00
MEU TOTAL			\$67,526.33

MSU ALS READY

EQUIPMENT DESCRIPTION	QTY	COST	EXT
BACKBOARD, LONG	2	\$145.00	\$290.00
BACKBOARD, SHORT	1	\$50.00	\$50.00
BAG, WMD ANTIDOTE WITH MODULES/CASE (BAGS ONLY)	1	\$360.00	\$360.00
BAG, OXYGEN (BAG ONLY)	2	\$120.00	\$240.00
BAG, TECHNICIAN (BAG ONLY)	2	\$110.00	\$220.00
CYLINDER, OXYGEN "D" SIZE	4	\$48.00	\$192.00
CYLINDER, OXYGEN "M" SIZE	3	\$210.00	\$630.00
EXTINGUISHER, 5LB ABC FIRE WITH VEHICLE BRACKET	2	\$41.00	\$82.00
EXTRICATION DEVICE WITH CARRY CASE	2	\$170.00	\$340.00
LANTERN, LED WITH 6VOLT BATTERY	1	\$13.00	\$13.00
MAP, 5 BOROUGH	1	\$60.00	\$60.00
POUCH, EPI-PEN (POUCH ONLY)	1	\$35.00	\$35.00
SHOVEL, METAL FOLDING	1	\$22.00	\$22.00
SHOVEL, PLASTIC SNOW	1	\$20.00	\$20.00
SKED STRETCHER, YELLOW W/STRAP SET	1	\$328.00	\$328.00
SKED CASE	1	\$102.00	\$102.00
HARNES STRAPS FOR STRETCHERS	3	\$69.00	\$207.00
STRAPS, 9' 1PC FOR BOARDS	2	\$6.00	\$12.00
STRAP, 5' 2PC FOR BOARD/COT/SCOOP	12	\$6.00	\$72.00
EXTRICATION 9' STRAP, 2PC	2	\$10.00	\$20.00
TRANSLATOR, VISUAL MULTI LANGUAGE	2	\$30.00	\$60.00
TOURNIQUET WITH 1.5" BAND	2	\$30.00	\$60.00
CASE, TOURNIQUET	2	\$10.00	\$20.00
CASE, ALS DEFIBRILLATION FR (BAG ONLY)	1	\$260.00	\$260.00
BAG, DRUG (BAG ONLY)	1	\$255.00	\$255.00
BAG, TRAUMA (BAG ONLY)	1	\$135.00	\$135.00
CASE, CYANO CARRY/DRILL (BAG ONLY)	2	\$60.00	\$120.00
CASE, MINI MEDICATION (BAG ONLY)	1	\$55.00	\$55.00
CASE, MEDICATION INSERT (BAG ONLY)	3	\$90.00	\$270.00
CASE, INTUBATION ROLL (BAG ONLY)	1	\$60.00	\$60.00
MSU TOTAL			\$4,590.00

EQUIPMENT FOR ONE (1) FDNY RESCUE AMBULANCE

RADIOS	2	\$4,150.00	8,300.00
ROSETTA BOX	1	\$2,000.00	2,000.00
		TOTAL RADIOS	10,300.00

HAZMAT

PD31 METER			
CO METERS	2	\$350.00	\$700.00
RAD57	2	\$300.25	\$600.50
Thermo Fischer RadEYE GF10 EX PRD			
	1	\$4,583.00	\$4,583.00
	2	\$2,500.00	\$5,000.00
		TOTAL HAZMAT	10,883.50

MEU ALS READY	\$67,526.33
MSU ALS READY	\$4,590.00
RADIOS	10,300.00
HAZMAT	10,883.50
ALS AMB TOTAL	\$93,299.83

HAZTAC READY

DESCRIPTION

RESPIRATORY	QTY	COST	EXT
SCBA Frame	2	\$5,000.00	\$10,000.00
SCBA cylinders, 60-minute	4	\$1,800.00	\$7,200.00
Scott Epic Voice Amplifiers	2	\$424.00	\$848.00
Scott communication bracket adpt	2	\$28.00	\$56.00
Scott PAPR	2	\$700.00	\$1,400.00
Scott PAPR batteries - rotational	2	\$90.00	\$180.00
Face Piece Bag	2	\$50.00	\$100.00
Scott AV-3000 Facepiece	2	\$300.00	\$600.00
Bata boots, green chemical (Level A)	4	\$70.00	\$280.00
Boots, Orange (Level A) size 18	4	\$100.00	\$400.00
Tingley Orange Level A Boot	6	\$70.00	\$420.00
Butyl gloves /pair	6	\$25.00	\$150.00
DOT Emergency Response Book	1	\$25.00	\$25.00
Jane's Chem/Bio Handbook	1	\$75.00	\$75.00
Hazard Action Guides	1	\$50.00	\$50.00
NIOSH pocket guide	1	\$35.00	\$35.00
MSDS Pocket Dictionary	1	\$2.00	\$2.00
NYC Street Atlas	1	\$60.00	\$60.00
Thermo Fischer RadEYE GF10 EX PRD	2	\$2,600.00	\$5,200.00
Lion MT-94 L	1	\$2,223.00	\$2,223.00
Lion MT-94 XL	1	\$2,223.00	\$2,223.00
Lion MT-94 XXL	1	\$2,223.00	\$2,223.00
Lion MT-94 XXXL	1	\$2,223.00	\$2,223.00
Lion MT-94 XXXXL	2	\$2,223.00	\$4,446.00
Decon brush, 20 in.	3	\$8.00	\$24.00

EQUIPMENT FOR ONE (1) FDNY RESCUE AMBULANCE

Custodian Hydrant Wrench	1	\$500.00	\$500.00
3/4" x 50' Garden Hose	3	\$15.00	\$45.00
2-1/2" to garden hose adaptors	2	\$15.00	\$30.00
Garden Hose Nozzle	3	\$10.00	\$30.00
Garden Hose adapter 1-2	3	\$5.00	\$15.00
Shower Wand	2	\$35.00	\$70.00
Decon Buckets, 5 gal	3	\$10.00	\$30.00
Storage Cabinet (Haz-Tac)	1	\$250.00	\$250.00
Handie-Talkie radios	2	\$3,500.00	\$7,000.00
Binoculars, waterproof	1	\$160.00	\$160.00
Push to Talk Radio	2	\$750.00	\$1,500.00
Command Post Radio	1	\$10,000.00	\$10,000.00
800 MGHZ Radio-- Portable	1	\$3,500.00	\$3,500.00
DigAlert 200	1	\$465.00	\$465.00
Black Equipment Bags for CPC	4	\$45.00	\$180.00
Solvex gloves \$/pair	6	\$20.00	\$120.00
Thermo Fischer RadEYE GF10 EX PRD	2	\$2,500.00	\$5,000.00
Decon stretcher pools -RMC 3/cs	2	\$185.00	\$370.00
Big Shears	2	\$122.00	\$244.00
seatbelt cutter:	2	\$45.00	\$90.00
RAD Eye ER survey Radiological meter	4	\$2,500.00	\$10,000.00
Thermo Fischer RadEYE GF10 EX PRD	2	\$2,500.00	\$5,000.00
HazMat SKED w/ straps	2	\$325.00	\$650.00
Oximeter Kit Carbon Monoxide	1	\$4,390.00	\$4,390.00
		HAZTAC READY	\$90,082.00

RESCUE READY**DESCRIPTION**

Glidescope Video Laryngoscope	QTY	COST	EXT
Glidescope GVL 2 ea Med/Large	2	\$8,700.00	\$17,400.00
Corpsman ENT Kit	4	\$500.00	\$2,000.00
Thermal Angel Pump	2	\$125.00	\$250.00
Philips MP2 Vital Signs Monitor	3	\$750.00	\$2,250.00
MTP IV Infusion Pump	2	\$11,100.00	\$22,200.00
MTP IV Infusion Pump Case	2	\$2,700.00	\$5,400.00
EPV200 Portable Ventilator	2	\$106.00	\$212.00
Non Disposable High pressure Hose	2	\$470.00	\$940.00
Universal Flow Meters	2	\$36.00	\$72.00
Regulator w/DSS Ports	2	\$54.19	\$108.38
SCBA Regulator	2	\$110.00	\$220.00
Rescue Helmets	2	\$200.00	\$400.00
Rescue Helmet Lights	2	\$160.00	\$320.00
Rescue Gogglesw/ cover	2	\$37.00	\$74.00
Rescue Rope Gloves	2	\$75.00	\$150.00
Petzl Full Body Harness	2	\$29.00	\$58.00
Blackhawk STOMP Pack	2	\$255.00	\$510.00
Petzl Full Body Harness	2	\$250.00	\$500.00
Pneumothorax Kit	2	\$255.00	\$510.00

EQUIPMENT FOR ONE (1) FDNY RESCUE AMBULANCE

EZ IO Driver	2	\$75.00	\$150.00
Collapsible BVM	2	\$580.00	\$1,160.00
Sharps Shuttle	2	\$40.00	\$80.00
Amplified Stethoscopes	4	\$25.00	\$100.00
Soft W Tourniquet	2	\$320.00	\$640.00
Adult Stethoscope	8	\$25.00	\$200.00
Pediatric Stethoscope	2	\$15.00	\$30.00
ET Intubation Kits	2	\$15.00	\$30.00
Adult Blood Pressure Cuff	2	\$250.00	\$500.00
Pediatric Blood Pressure Cuff	2	\$16.02	\$32.04
Infant Blood Pressure Cuff	2	\$16.02	\$32.04
Big Shears	2	\$16.02	\$32.04
Bridge Securement Lanyards	2	\$75.00	\$150.00
Personal Flotation Devices	4	\$185.00	\$740.00
Pelican Case	5	\$105.00	\$525.00
Amputation Instrument kit	5	\$195.00	\$975.00
Hackzell M13 (for amputation kit)	1	\$1,000	\$1,000.00
Mustang Immersion Suit	1	\$350	\$350.00
Bariatric SKED	5	\$1,100	\$18,000.00
Confined Space SKED Orange w/ straps	2	\$500	\$500.00
Yates SPEC-PAC	2	\$700	\$700.00
Large Carabiners	2	\$1,200.00	\$1,200.00
Large Cyalume Chemlights	8	\$50.00	\$200.00
Sonosite Sonogram portable	15	\$50.00	\$2,600.00
Stryker Intracompartmental monitor	1	\$3,500.00	\$3,501.00
MCV 1000 Vent	1	\$1,000.00	\$1,000.00
Albuterol/bottle	5	\$3,600.00	\$18,000.00
Lidocaine 2%-vial	2	\$2.00	\$4.00
Lidocaine 4%-syringe	8	\$2.00	\$16.00
Sodium Bicarb Peds-vial	2	\$6.00	\$12.00
Sodium Bicarb Adult-vial	10	\$8.00	\$80.00
Calcium Gluconate-vial	2	\$11.00	\$22.00
	2	\$8.00	\$16.00
RESCUE READY			\$106,151.50

ALS AMB TOTAL	\$93,299.83
HAZTAC READY	\$90,082.00
RESCUE READY	\$106,151.50
EQUIPMENT FOR ONE (1) FDNY RESCUE AMBULANCE	\$289,533.33



FIRE DEPARTMENT

9 METROTECH CENTER

BROOKLYN, NY 11201-3857

Barry Greenspan
Director
Bureau of Fiscal Services

Room 5W-4

August 24, 2015

Roslyn Weinstein
Senior Assistant Vice President
HHC, Office of Facilities Development
55 Water Street
New York, NY 10041

Re: Request for HHC Board Resolution

Dear Ms. Weinstein:

This letter represents a formal submission, to be presented to HHC's Board of Directors at their next meeting. The FDNY hereby requests approval to purchase eighty-nine (89) ambulances of the below descriptions and quantities, plus initial equipment. Detailed initial equipment lists are attached.

	Unit Price	# of Units	Total	Contingency	Total
<u>Ambulances (Excluding Initial Equipment):</u>					
Ambulance 4 x 4:	258,001	77	19,866,077	\$1,986,608	\$21,852,685
Ambulance Rescue HazTac:	301,789	12	3,621,468	\$362,147	\$3,983,615
Total Ambulances:		89	23,487,545	2,348,755	25,836,300
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Rescue HazTac Initial Equipment	289,533	12	3,474,396	\$347,440	\$3,821,836
Total Initial Equipment:		89	8,114,196	\$811,420	\$8,925,616
Inspection Fee			\$25,000	\$0	\$25,000
Total			31,626,741	3,160,174	\$34,786,915
Total (Rounded)					\$34,787,000

Please be advised that the procurement process is performed in accordance with HHC's operating procedures and Procurement Policy Board rules. If you require additional information in order to secure HHC board approval, please contact me at 718/999-1221.

Thank you for your cooperation

Sincerely,

Barry Greenspan

ecl.

c: Stephen G. Rush, FDNY
James Booth, EMS
Mark Aronberg, FDNY
Patricia Mims, FDNY
Terry Fiorentino, FDNY
Dean Moskos, HHC
Jawwad Ahmad, HHC

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to proceed with the construction and procurement necessary for renovation of an existing 23,000 square foot space on the 13th floor in the Martin Luther King (MLK) Pavilion, to create an inpatient geriatric friendly unit at Harlem Hospital Center (the "Facility") for an amount not-to-exceed \$3,261,000.

WHEREAS, the proposed renovation will upgrade the existing unit, bringing it to compliance with Department of Health (DOH) code and allowing it to better serve geriatric patients; and

WHEREAS, it is necessary to provide an environment that includes handicap accessible bathrooms, activity and therapy rooms along with rehabilitation rooms; and

WHEREAS, it is required by the state DOH and Center for Medicaid Services (CMS) to bring the current unit up to code by installing sprinklers, and required electrical and medical gases; and

WHEREAS, the revision of Operating Procedure 100-5 requires that construction projects with budgets of \$3 million or more shall receive approval of the Board of Directors through Capital Committee; and

WHEREAS, the proposed total project budget, inclusive of all contingencies, is estimated to be \$3.2 million; and

WHEREAS, the overall management of the construction contract will be under the direction of the Facility's Senior Associate Director, Planning and Design and the Assistant Vice President, Facilities Development at Central Office

NOW THEREFORE, be it

RESOLVED, the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to proceed with the construction and procurement necessary for the renovation of an existing 23,000 square foot space on the 13th floor in the Martin Luther King (MLK) Pavilion, to create an inpatient, geriatric friendly unit at Harlem Hospital Center (the "Facility") for an amount not-to-exceed \$3,261,000.

EXECUTIVE SUMMARY

HARLEM HOSPITAL CENTER RENOVATION OF 13TH FLOOR FOR INPATIENT GERIATRIC FRIENDLY UNIT

- OVERVIEW:** The Corporation is seeking to renovate the existing area of approximately 23,000 square feet of space on the 13th floor of the Martin Luther King Pavilion in order to create an inpatient geriatric friendly unit. The project will allow the unit to meet best practices for an inpatient Geriatric Unit, in addition to upgrading the Emergency Electrical System (EES) which will bring into compliance as required by the Department of Health (DOH) and the Center for Medicaid Services (CMS). The project will be designed and bid in accordance with the Corporation's Operating Procedure 100-5. The project cost will not-to-exceed \$3,261,000.
- NEED:** The proposed inpatient geriatric friendly unit, consisting of four two-bedded rooms, will be designed to meet the special needs of hospitalized adults over the age of 62.
- SCOPE:** The scope of work to execute the inpatient geriatric unit project includes:
- ❖ Minor demolition of walls to accommodate new bathrooms with safety handrails and raised toilets.
 - ❖ Demolition of ceilings to allow for sprinklers and Type 1 Emergency Electrical System (EES) installation.
 - ❖ Installation of new headwalls to accommodate required electrical and medical gases.
 - ❖ Installation of new acoustical ceilings.
 - ❖ Installation of safety handrails and signage to assist in way finding
 - ❖ Construction of new Activity Therapy/Community room and Rehabilitation gym for physical therapy.
 - ❖ Installation of multi-functional LED lighting for patient care.
 - ❖ Upgrade of the nurse call system, with enhanced functionality to alert clinical staff when patients attempts to get out of bed without assistance.
- COSTS:** \$248,992.86 annually for 20 years, which includes the principal (\$3,261,000) and debt service (\$1,718,857) at an interest rate of 4.5%.
- FINANCING:** New York City General Obligation Bonds in the City Council budget line for \$2,761,000 and the Manhattan Borough President budget line for \$500,000.
- SCHEDULE:** The project is scheduled for completion by July 2016. The Certificate of Need (CON) Application has been submitted to the DOH and is pending their approval.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable license agreement with the New York City Police Department ("NYPD" or "Licensee") for its use and occupancy of approximately seventy-five square feet of space to operate radio communications equipment at Elmhurst Hospital Center (the "Facility") with the occupancy fee waived.

WHEREAS, in May 2012 the Board of Directors authorized the President to enter into a license agreement with the New York City Police Department for the installation of radio communications equipment at the Facility designed to enhance the performance of its city-wide radio operations network; and

WHEREAS, the NYPD desires to install additional radio communications equipment at the Facility to further enhance the performance of its city-wide radio operations network, and the Facility has the space to accommodate the NYPD communications system; and

WHEREAS, the Licensee's radio communications system shall not compromise Facility operations, and it complies with applicable federal statutes governing the emission of radio frequency signals and, therefore, poses no health risk.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to execute a revocable license agreement with the New York City Police Department ("NYPD" or "Licensee") for use and occupancy of approximately seventy-five square feet of space to operate radio communications equipment at Elmhurst Hospital Center (the "Facility") with the occupancy fee waived.

EXECUTIVE SUMMARY

LICENSE AGREEMENT NEW YORK CITY POLICE DEPARTMENT ELMHURST HOSPITAL CENTER

The President of the New York City Health and Hospitals Corporation seeks authorization to execute a revocable license agreement with the New York City Police Department (“NYPD”) for use and occupancy of space to operate radio communications equipment at Elmhurst Hospital Center (“EHC”).

The NYPD currently operates radio communications equipment at EHC that supports the City’s emergency response network. NYPD will install additional radio communications equipment at the Facility to further improve the performance of this network. NYPD’s radio communications system will not compromise facility operations, and it complies with applicable federal statutes governing the emission of radio frequency signals and, therefore, poses no health risk.

The NYPD will have use and occupancy of approximately seventy-five square feet of space on the roof of the Main Building. Public safety is enhanced by the system’s operation, therefore the occupancy fee will be waived. Elmhurst Hospital Center will provide electricity to the licensed space. The operation and maintenance of the system will be the responsibility of the NYPD.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of its use of the Licensed Space.

The license agreement shall not exceed five (5) years without further authorization by the Board of Directors of the Corporation and shall be revocable by either party upon ninety (90) days written notice.

RESOLUTION

Amending the June 2014 Resolutions of the Board of Directors of the New York City Health and Hospitals Corporation (the "Corporation") by which the President of the Corporation was authorized to execute five successive one-year revocable license agreements with the New York City Human Resources Administration ("HRA") for the use and occupancy of space for primary care programs located at 413 E. 120th Street, Borough of Manhattan and 114-02 Guy Brewer Boulevard, Borough of Queens administered by Metropolitan Hospital Center and Queens Hospital Center (the "Facilities") to (a) increase the base occupancy fee to be paid by \$1.00 per square foot for a total annual occupancy cost of \$96,873 or \$35.38 per square foot for the East 120th Street clinic and for a total annual occupancy cost of \$270,593 or \$27.25 per square foot for the Guy Brewer Boulevard clinic where in both cases the total annual occupancy fees are inclusive of surcharges for electricity, air conditioning and after-hour uses; and (b) extend the authorization for the President to execute renewals for an additional year to allow for renewals through 2020.

WHEREAS, HRA manages Multi-Service Centers throughout the City that it makes available to other City agencies and not-for-profit corporations to use for the provision of community oriented services (the "MSCs") pursuant to one-year license agreements; and

WHEREAS, HRA charges users of its MSCs basic occupancy fee with additional surcharges for electricity, air conditioning and after-hours operations; and

WHEREAS, the management of the Corporation has generally sought the approval of the Corporation's Board of Directors to enter into five successive one-year license agreements for the MSC to avoid having to return for new authority each year; and

WHEREAS, in June 2014, the Board of Directors of the Corporation authorized the President to execute five successive one-year revocable license agreements with HRA allowing for the Corporation's use and occupancy of space at 413 E. 120th Street at \$23 per square foot, which, together with additional charges for electricity, air conditioning and after-hours operations resulted in a total annual occupancy cost of \$96,873; and

WHEREAS, in September 2014, the Board of Directors of the Corporation authorized the President to execute five successive one-year revocable license agreements with HRA, allowing for the Corporation's use and occupancy of space at 114-02 Guy Brewer Boulevard at \$24 per square foot, which, together with additional charges for electricity and air conditioning resulted in a total annual occupancy cost of \$270,593; and

WHEREAS, HRA has implemented a one dollar per square foot increase in the occupancy fee for all of its MSCs across the City including the two occupied by the Corporation effective July 1, 2015; and

NOW, THEREFORE, be it

RESOLVED, that the June and September 2014 Resolutions of the Board of Directors of the New York City Health and Hospitals Corporation (the "Corporation") by which the President of the Corporation was authorized to execute five successive one-year revocable license agreements with the New York City Human Resources Administration ("HRA") for the use and occupancy of space for primary care programs located at 413 E. 120th Street, Borough of Manhattan and 114-02 Guy Brewer Boulevard, Borough of Queens administered by Metropolitan Hospital Center and Queens Hospital Center be amended to (a) increase the base occupancy fee to be paid by \$1.00 per square foot for a total annual occupancy cost of \$96,873 or \$35.38 per square foot for the East 120th Street clinic and a total annual occupancy cost of \$270,593 or \$27.25 per square foot for the Guy Brewer Boulevard clinic where in both cases the total annual occupancy fees are inclusive of surcharges for electricity, air conditioning and after-hour uses; and (b) extend the authorization for the President to execute renewals for an additional year to allow for renewals through 2020.

EXECUTIVE SUMMARY

QUEENS HOSPITAL CENTER AND METROPOLITAN HOSPITAL CENTER NYC HUMAN RESOURCES ADMINISTRATION MULTI-SERVICE CENTERS

OVERVIEW: The President seeks authorization to execute successive one year revocable license agreements with the New York City Human Resources Administration ("HRA") for its use and occupancy of space for primary care programs located at 413 E. 120th Street, Borough of Manhattan and 114-02 Guy Brewer Boulevard, Borough of Queens administered by Metropolitan Hospital Center and Queens Hospital Center

**NEED/
PROGRAM:** In June 2014, the Board of Directors of the Corporation authorized the President to execute five successive one-year revocable license agreements with the New York City Human Resources Administration ("HRA") for use and occupancy of space at 413 E. 120th Street. In September 2014, the Board of Directors authorized the President to execute five successive one-year revocable license agreements with HRA for use and occupancy of space at 114-02 Guy Brewer Boulevard.

HRA oversees Multi-Service Centers ("MSCs") located in City-owned buildings. The MSCs are managed by non-profit organizations and space is leased to non-profit community groups who provide services which include health care, education, housing assistance, vocational training and mental health services. The Corporation operates primary care programs at the MSCs located in Queens and Manhattan.

During the use and occupancy period authorized by the Board, the Corporation executes one year occupancy agreements with HRA, effective July 1st at each of the MSC sites. If there is no increase in the occupancy fee, no further authorization from the Board is needed during the occupancy period authorized. But HRA has implemented a one dollar per square foot increase in the occupancy fee effective July 1, 2015 at each of the MSC sites occupied by the Corporation.

TERMS: The Corporation shall be granted the continued use and occupancy of space in the two HRA operated MSCs for programs managed by the Facilities. The base occupancy fee for each site shall be increased by \$1 per square foot effective July 1, 2015. The total annual occupancy costs including the increase shall be approximately \$270,593 or \$27.25 per square foot for the space at 114-02 Guy Brewer Boulevard and \$96,873 or \$35.38 per square foot for the space at 413 E. 120th Street. There will be no change in the utility surcharge or cooling season surcharge.

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HRA Multi-Service Centers

	Site	Occupancy Fee (psf)	Utility Surcharge (psf)	Seasonal Cooling Charge (psf)*	Extended Hours Charge (NTE)	Floor Area (sf)	Total Occupancy Fee
New Term	114-02 Guy Brewer Blvd.	\$25	\$2	\$1	n/a	9,930	\$270,593 or \$27.25/sf
	413 E. 120 th St.	\$24	\$2	\$1	\$25,000 (per year)	2,738	\$96,873 or \$35.38/sf
	Total				\$25,000	12,668	\$367,466
Prior Term	114-02 Guy Brewer Blvd.	\$24	\$2	\$1	n/a	9,930	\$260,663
	413 E. 120 th St.	\$23	\$2	\$1	\$25,000 (per year)	2,738	\$94,135
	Total				\$25,000	12,668	\$354,798

*Seasonal Cooling Charge only applies for three months of the year

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve a Capital Project for an amount not to exceed \$3,885,000 for planning, pre-construction, design, construction management and project management services necessary for the Installation of two (2) new electric air cooled chillers for Operating Rooms (the "Project") at Bellevue Hospital Center (the "Facility").

WHEREAS, in September 2014, the City mandated a 80% reduction in greenhouse gas emissions in City-owned properties by 2050, managed by Division of Energy Management within Department of Citywide Administrative Services ("DCAS"); and

WHEREAS, in December 2009, as part of PlaNYC 2030, the City passed major legislation known as the "Greener, Greater Buildings Plan" that included more stringent code requirements; required installation of lighting upgrades and tenant meters in non-residential spaces; and required all buildings over 50,000 square feet to undertake benchmarking and audits; and implement retro-commissioning measures. Local Law 87 mandated Comprehensive Energy Audits be completed within a 10 year time frame (2013 – 2023); and

WHEREAS, the City, through DCAS, has allocated funding under the Accelerated Conservation and Efficiency ("ACE") program for improvements and upgrades to increase energy efficiency and energy cost savings at City-owned facilities in line with the PlaNYC initiative to reduce energy and greenhouse gas emissions of municipal operations 80% by 2050; and

WHEREAS, the Corporation has determined that it is necessary to address the cooling requirements of the Operating Rooms at the Facility by undertaking the project at a not-to-exceed cost of \$3,858,653, to enhance the reliability of its systems, as well as increase the comfort and safety of the Operating Room patients; and

WHEREAS, DCAS has deemed this ACE project to be eligible under the PlaNYC initiative and has allocated \$3,885,000.00 in the PlaNYC capital budget; and

WHEREAS, Kallen & Lemelson Consulting Engineers, LLP (HHC's Requirement Contractor) has demonstrated that the project will produce total annual cost savings to the Facility estimated at \$1,082,054; and

WHEREAS, the proposed new electric air cooled chillers will provide required cooling to maintain proper temperature and humidity levels which will correct existing deficiencies and conform to current codes and standards; and

WHEREAS, the overall management of the construction contract will be under the direction of the Assistant Vice President - Facilities Development.

NOW THEREFORE, be it

RESOLVED, the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve a Capital Project for an amount not to exceed \$3,885,000 for planning, pre-construction, design, construction management and project management services necessary for the Installation of two (2) new electric air cooled chillers for Operating Rooms (the "Project") at Bellevue Hospital Center (the "Facility").

EXECUTIVE SUMMARY

INSTALLATION OF TWO NEW CHILLERS FOR OPERATING ROOMS BELLEVUE HOSPITAL CENTER

OVERVIEW: The Corporation is seeking to install two (2) new electric air-cooled chillers to provide cooling to the Operating Rooms at Bellevue Hospital Center. The project has been designed, estimated, and bid in accordance with the Corporation's Operating Procedure 100-5. The project cost is not-to-exceed \$3,885,000.

NEED: The Facility's existing chiller plant consists of three (3) electric chillers and one (1) steam driven turbine chiller. Currently, the Facility Operating Rooms (ORs) cooling load is 530 tons, and during the winter and intermediate seasons, cooling is required only for the ORs resulting in less than optimal part-load operation for the main chillers. Based on a Comprehensive Energy Efficiency Audit of the Facility's campus, it was recommended that the installation of two new air-cooled chillers with a capacity of 760 tons each should be used during all load conditions to provide cooling to the ORs at the Facility. The chillers will be capable to provide more efficient cooling at very low load conditions and are designed to operate at ambient temperature of 55°F. The chillers will be equipped with variable speed drive compressors.

SCOPE: The scope of work for this project includes the following:

- ❖ Purchase and installation of two (2) new air cooled chillers with total capacity of 760 tons each
- ❖ Demolition of existing chilled water supply and return piping, as required
- ❖ Installation of new chilled water circulating pumps and piping to existing air handling units (AHUs)
- ❖ Installation of new dunnage steel on roof to support new chillers
- ❖ Removal of select electrical equipment such as existing circuit breakers from inside the vault level electrical room
- ❖ Miscellaneous general construction work for cutting and patching
- ❖ Adding emergency electric power for the new chillers and pumps

COSTS: \$3,885,000

SAVINGS: This project will reduce steam energy consumption by 33,379 Mlbs (million pounds) resulting in a total estimated savings of \$1,082,054. It is estimated that this project's ROI will be 3.5 years. In addition, there will be a reduction of 1,800.66 tons of CO₂ moving the city towards its goal for the PlaNYC initiative.

FINANCING: PlaNYC Capital

SCHEDULE: This project is scheduled for completion by June 2016.