

BOARD OF DIRECTORS MEETING

THURSDAY, MAY 28, 2015

A~G~E~N~D~A

<p><u>CALL TO ORDER - 4 PM</u></p>	<p>Mr. Campbell</p>
<p>Call for a Motion to Convene an Executive Session</p>	
<p><u>Executive Session / Facility Governing Body Report</u></p>	
<p>➤Jacobi Medical Center ➤North Central Bronx</p>	
<p>Semi-Annual Governing Body Report (Written Submission Only)</p>	
<p>➤Harlem Hospital Center</p>	
<p>Diagnostic & Treatment Center Annual Quality Assurance Plan / Evaluation 2014 (Written Submission Only)</p>	
<p>➤Gouverneur Diagnostic & Treatment Center</p>	
<p><u>OPEN SESSION – 5 PM</u></p>	<p>Mr. Campbell</p>
<p>1. Adoption of Minutes: April 30, 2015</p>	
<p><u>Acting Chair’s Report</u></p>	<p>Mr. Campbell Dr. Raju</p>
<p><u>President’s Report</u></p>	
<p>➤Information Item: FY 2015 Annual Public Meeting - The Community Speaks Presenter: LaRay Brown, Sr Vice President, Corporate Planning, Community Health & Intergovernmental Relations</p>	
<p>>>Action Items<<</p>	
<p><u>South Manhattan & Generations Plus-North Manhattan Health Networks</u></p>	<p>Ms. Youssouf</p>
<p>2. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with General Vision Services/Cohen Fashion Optical for the continued use and occupancy of space to operate optical stores on the campuses of Harlem Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center and Bellevue Hospital Center at an occupancy fee rate of \$58.00 at Harlem, \$36.00 at Lincoln, \$73.00 at Metropolitan and \$78.00 at Bellevue for a total annual occupancy fee of \$104,318.00 to be escalated by 2.5% per year. <i>(Capital Committee – 05/14/2015)</i> <i>VENDEX: Pending</i></p>	
<p><u>Southern Brooklyn/Staten Island Health Network</u></p>	<p>Ms. Youssouf</p>
<p>3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a five year revocable license agreement with the Grace Foundation of New York for the continued use and occupancy of 5,700 square feet of space in the building designated #9 (the “Isolation Building”) to operate support programs for individuals affected by Autism Spectrum Disorder at the Sea View Hospital Rehabilitation Center and Home with the occupancy fee waived. <i>(Capital Committee – 05/14/2015)</i> <i>VENDEX: Pending</i></p>	
<p>4. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a five year license agreement with the Metropolitan Fire Association, Inc. for its continued use and occupancy of a 2,400-square-foot parcel located behind the “G” Building to conduct vocational training at the Sea View Hospital Rehabilitation Center and Home with the occupancy fee waived. <i>(Capital Committee – 05/14/2015)</i> <i>VENDEX: Approved</i></p>	<p>Ms. Youssouf</p>
	<p><i>(over)</i></p>

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<p><u>North Bronx Healthcare Network</u></p>	<p>Ms. Youssouf</p>
<p>5. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a five year revocable license agreement with the New York City Department of Education for its continued use and occupancy of 160 square feet of space at North Central Bronx Hospital to operate a vocational training program with the occupancy fee waived. <i>(Capital Committee – 05/14/2015)</i></p>	
<p><u>MetroPlus Health Plan, Inc.</u></p>	<p>Mr. Campbell</p>
<p>6. RESOLUTION reappointing Bernard Rosen as a member of the Board of Directors of MetroPlus Health Plan, Inc., a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York, to serve in such capacity until his successor has been duly elected and qualified, or as otherwise provided in the Bylaws. <i>(MetroPlus Board Meeting – 05/05/2015)</i></p>	
<p><u>Committee Reports</u></p>	<p>Ms. Youssouf Mrs. Bolus Mr. Rosen Dr. Calamia Mrs. Bolus</p>
<ul style="list-style-type: none"> ➤ Capital ➤ Community Relations ➤ Finance ➤ Medical & Professional Affairs / Information Technology ➤ Strategic Planning 	
<p><u>Subsidiary Board Report</u></p>	<p>Mr. Rosen</p>
<ul style="list-style-type: none"> ➤ MetroPlus Health Plan, Inc. 	
<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 of April 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:

Dr. Jo Ivey Boufford
Dr. Ramanathan Raju
Mr. Steven Banks
Dr. Gary S. Belkin
Josephine Bolus, R.N.
Dr. Vincent Calamia
Mr. Gordon J. Campbell
Ms. Anna Kril
Mr. Mark Page
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Patricia Yang was in attendance representing Deputy Mayor Lilliam Barrios-Paoli, and Dr. Oxiris Barbot was in attendance representing Dr. Mary T. Bassett, both in a voting capacity. Dr. Boufford chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

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

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Boufford reported that the annual performance

evaluation of Dr. Raju, the President of HHC, resulted in a superior ranking in each of the categories of performance. Dr. Boufford congratulated Dr. Raju on his stellar performance.

Additionally, 1) the Board of Directors, as the governing body of Metropolitan 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 Coney Island Hospital, the Board reviewed and approved its semi-annual written report; 3) as governing body of Sea View Hospital Rehabilitation Center and Home, the Board reviewed and approved its semi-annual written report; and 4) as governing body of East New York Diagnostic and Treatment Center, the Board received and approved its annual quality assurance plan and 2014 evaluation.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on March 26, 2015 were presented to the Board. Then on motion made by Dr. Boufford and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on March 26, 2015, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

Dr. Boufford reported that Dr. Herbert Gretz's Board term expired in March and acknowledged his service as a Board member. She welcomed new Board member, Mr. Gordon J. Campbell.

Dr. Boufford updated the Board on approved and pending Vendex.

Dr. Boufford reported that the remaining annual public meetings in 2015 will take place as follows: May 19th at Jacobi Hospital Center; May 20th at Kings County Hospital Center; and, May 21st at Sea View Hospital Rehabilitation Center and Home.

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

Antonio Martin, Executive Vice President and Corporate Chief Operating Officer, and Paul Albertson, Senior Assistant Vice President, provided an update on the consolidation of HHC's procurement services. Mr. Albertson reported that our supply chain transformation has saved HHC approximately \$50 million in the last 18 months. The next steps will be to launch our value analysis teams and to increase the diversity of our suppliers.

ACTION ITEMS

RESOLUTION

2. Amending a previously adopted resolution on July 25, 2013 to **increase** the authorization for one or more **borrowings to finance various capital projects** from an aggregate not to exceed an amount of \$40,000,000 to a new not to exceed amount of \$60,000,000.

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 execute a **sole source contract** for proprietary software licenses, maintenance and support services agreement with **3M Health Information Systems (3M)** for the Coding and Reimbursement Information System installed at HHC's acute care hospitals, long-term care facilities and MetroPlus. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is \$13,510,101 which includes a contingency of \$643,338.

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 **purchase storage hardware, software, and associated maintenance** from various vendors via Third Party Contract(s) to support the EPIC implementation in an amount not to exceed \$13,220,000 for a one year period.

Dr. Calamia moved the adoption of the resolution which was duly seconded and adopted by the Board by a vote of 12 in favor.

Mrs. Bolus abstained.

RESOLUTION

5. Authorizing the President of the New York City Health and Hospitals Corporation to execute **Indefinite Quantity Construction Contracts** with two firms: **Vastech Contracting Corporation** and **Rashel Construction Corporation, Inc.** that were pre-qualified through the HHC public bid process, to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$6,000,000. The total authorized value of these contracts is \$12 million.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

SUBSIDIARY AND BOARD COMMITTEE REPORTS

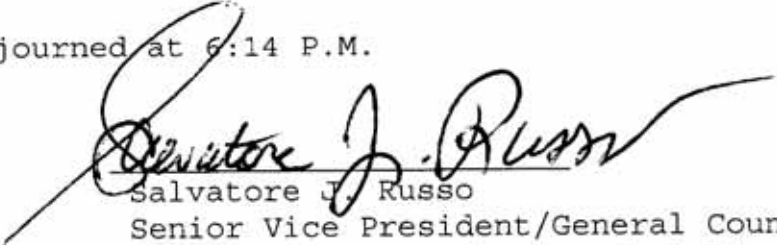
Attached hereto is a compilation of reports of the HHC Board Committees and Subsidiary Boards that have been convened since the last meeting of the Board of Directors. The reports were received by the Dr. Boufford at the Board meeting.

NEW BUSINESS

Dr. Boufford nominated Gordon Campbell to serve as Vice Chair of the Board of Directors and the Board unanimously approved the nomination. Mr. Campbell will take over as Acting Chair until a permanent Chair is appointed. Dr. Boufford served as Vice Chair of the Board and Acting Chair for a year and will continue to serve as a Board member.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:14 P.M.


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

COMMITTEE REPORTS

Audit Committee – April 16, 2015

As reported by Ms. Emily Youssouf

Mr. Chris Telano, Chief Internal Auditor, began with an update on an audit that was presented at the February meeting related to the MetroPlus Health Plan, Inc. - Accounts Payable review. He asked the representative from MetroPlus to approach the table. He introduced himself as John Cuda, Chief Financial Officer for MetroPlus. Mr. Telano then said that just to familiarize everybody with what transpired at the February meeting, there was a suggestion for improving operations and efficiency regarding the processing of invoices. At MetroPlus they still use voucher request forms instead of using the approval by senior management granted through the various systems that have been set up for quite a while. At the last meeting there was no commitment as to which direction MetroPlus was going, and was asked to report back to the Committee on their improvements going forward.

Mr. Cuda stated that they took the Committee and Internal Audits' recommendation very seriously. We did take the time to go back and look at our processes and see why we were using the form, which we agree was overkill in the process. We have eliminated that now. We have held training with our areas that have to do with receiving and purchasing and accounts payable where now we can utilize the GHX or the OTPS system to go in, receive an invoice through the mail. Accounts payable can then take the invoice, take the purchase order number, enter it into the GHX system, identify the receiving number and process the payment through GHX in an orderly fashion.

Ms. Youssouf said thank you and welcome to the 21st century. I am very glad that you were able to do that so quickly.

Mr. Telano then touched upon the external audits that are being done by the City Comptroller's Office. The first one is the affiliation agreement with PAGNY at Lincoln Hospital. In March there was meeting called by the Comptroller's Office to discuss the preliminary issues found by the auditors and they found that subcontractor agreements were paid by PAGNY without adequate supporting documentation. They also noted that the recalculation documents were not completed timely although they have been completed and that the bank accounts for the faculty practice plan were not established timely by PAGNY. We expect to receive a draft report from them sometime soon and we will follow that up with an exit conference and go from there. Since this audit started in July 2013, I could not tell you when we will receive this document.

The other item on the Comptroller's audit is the one regarding patient revenue and accounts receivable, and I talked about the same situation the last three or four meetings. We are kind of at a standstill with the Comptroller's Office. More recently we offered the services of my staff, internal auditing, or to hire other professional auditors to conduct their review and they declined both. At this stage, the resolution is pending.

Ms. Youssouf asked Mr. Russo if legal has anything to add. Mr. Russo responded that most recently, the Comptroller cited standards stating they were unable to allow this delegation of activities. Mr. Telano responded to them and pointed out that those are the same standards by which his very office operates, and to that extent there should not be a problem. This was sent some time ago and we are awaiting a response. I neglected to make a follow up call to remind them that we are waiting for a response. The pivotal issue here is that there is language in our enabling broad access to the Comptroller to our books and records, but specifically exempts out medically-privileged information. We believe that they will need medically-privileged information and in fact have proposed ways in which we can get around this, and yet the Comptroller's Office is not comfortable with it because of their interpretation of the government auditing standards, which we believe should not be an impediment to them. We are going to try to work this out, but it is an important issue and we believe that we have to follow both our enabling statute and all other statutes that protect confidentiality.

Mr. Telano said that there are specific citations within those standards that allows the work to be done by other parties other than the auditors, and as long as the party is valid, such as a CPA firm, they should be willing and ready to accept work done by someone else.

Mr. Telano continued on with the completed audits. The first audit is of PAGNY Corporate Operations and he asked the representatives to approach the table and introduce themselves. They did as follows: Luis Marcos, Chair; Reggie Odom, Chief Human Resources Officer; Anthony Mirdita, Chief Financial Officer; Wendy Vung, Comptroller.

Mr. Telano said that I will go over the findings in the report and then you can respond to them. The objectives of the audit were to evaluate the internal controls in place regarding Corporate PAGNY's operations. Corporate employees are those administrative personnel that are located at the five PAGNY/HHC affiliate facilities and the others that work at PAGNY's corporate headquarters, which is located on 125th Street. In total there are 68 active employees with an average salary of \$96,000 as December 31, 2014. Overall this was a very good audit. We noted only minor recordkeeping inconsistencies and omissions. Specifically, we found that bank reconciliations were not always properly prepared. We found employee human resources files did not always include exit checklists. In addition, two employees began work in November 2013 but they signed their acceptance letters in January 2014. There were some approved policies and procedures that were not implemented for a couple of processes. The ADP human resources and payroll system inaccurately showed termination dates for active employees, and the timesheet of the Chief Executive Officer was signed and approved by him.

Dr. Marcos stated that thanks to the recommendation, his timesheets are being signed by the head of the Human Resources, and the Board of PAGNY is reviewing them.

Mr. Mirdita said that on the banking ones, there are a couple of findings and I have to say that Ms. Rahman and her team were wonderful. It was a very well-run audit. With regard to the banks, there were checks outstanding over six months; we took this finding very serious. In fact that policy was already put in place six months before the audit began and have already corrected it, but this audit did cover 18 months from July 1, 2013 to December 31, 2014 so it was very large in scope, so that is already been fixed in June. We are monitoring all checks, every six months, we will send out a letter to make sure the outstanding checks that we had are in the second letter and then at some point when the outstanding checks are over the three-year threshold, we will remit them to New York State Unclaimed Funds. We have another year before any of checks are returned.

With regard to the bank reconciliation, preparer and reviewer did not date them – they signed them but did not date them. It is another one of those policies that has been corrected, for a good part of the audit we were not dating them. The last finding on the finance side that was highlighted was the bank recs, we have 18 months of bank recs. One of those months, the bank rec was done on the 13th business day and the policy in effect calls for the bank recs to be done by 7 business days. In this case the person was on vacation and we were having some staff changes, so we did not have someone trained to fill in. Since then Ms. Vung and her team have fixed all items either previously to the audit commencing or, in this case, it was while the audit was going on.

Ms. Youssouf asked if the policies and procedures for the receiving and corporate employee exit processes have been implemented.

Mr. Odom responded that they have been implemented throughout the process of the audit and some right after the audit. In regard to Human Resources component, we did not have a formal exit process. It was done in different manners, and now we have a process that includes the exit checklist to make sure that items do not walk away as appropriate. Referring to the two individuals that Mr. Telano mentioned, there was some confusion between the site and the corporate human resources team about who was going to manage the hiring process in terms of the offer letter. It was caught later on, which is why a couple of months later we went back and formalized the offer letters. The other item mentioned was probably just an oversight. We were in a personnel action that I was personally involved in and took care of, and nobody on my staff made sure that I followed the right process and put the forms in. We corrected that and I have advised them to make sure the process is followed.

The last item is related to our Active Directory Protocol (ADP) system. It is going through a lot of changes as you know with PAGNY and what is reflected there is that in the prior system there were five separate kinds of sites-based systems. If a person moved from Jacobi to Lincoln, they were effectively terminated at Jacobi and then rehired at Lincoln. That was because the way the process was set up, you could not transfer from a technological standpoint. We got a new ADP system that was implemented in November 2014, and now you can transfer between sites.

Mr. Telano requested that while we have you at the table, I believe it was at the meeting last October or perhaps September in which the Committee had some outstanding questions related to the status of the recalcs and other issues. Let's take advantage of the opportunity for you to give us an update.

Dr. Marcos answered that the first one was related to the Recalcs for 2011, 2012 and 2013, and was happy to report that all those Recalcs have been completed. It was an opportunity not only to do a better job but also to share with the Committee, and he thanked the Committee for being open to discussions and to the fact that recalcs take more than one entity. Recalcs are a process that includes also the facility and central office, so it is very much a cooperative effort and I have to report that those

have been finished and the recalcs for December 31st 2014 have been sent to the hospital and now the hospital may have questions and central office may have questions, but we hope that that will be resolved timely.

The second issue had to do with contracts, and was happy to report that all the contracts were found to be complete or still with the former contractor – in the case of Downtown Bronx Medical Associates (DBMA), for example, it was DBMA and PAGNY, although from a legal point of view I am told that PAGNY was responsible for it, but we have fixed all of them. There are two or three contracts that involve Columbia University that we are still in cooperation with the facility. Our counsel is here, Mr. Walter Ramos and he confirmed that there are three contracts. Those are still in the process of being negotiated, so they are still open.

Ms. Youssouf stated that I am very happy that guys have worked hard and got through all this and I think your new hires have helped dramatically. Thank you for being so cooperative with us on this – it has been a long process.

Mr. Telano continued with the next audit regarding employee equipment. Although we went to six different sites, because there will be centralized policy being rolled out by the Interim Chief Information Officer, Mr. Sal Guido -- I would like him to approach the table.

Mr. Telano reiterated that IA staff went to six different sites, Kings County, Coney Island, Harlem, Elmhurst and Queens Hospitals and also reviewed the Corporate Department of Enterprise Information Technology Services (EITS). In the summary of findings matrix, strong internal controls do not exist and excessive money is spent as a result of the lack of a centralized function overseeing the issuance, return and disposal of employee equipment. For the purpose of this audit, employee equipment is defined as cell phones, laptops, tablets and pagers.

A summary of the findings are follows; at the facilities, we are using more than one cell phone carrier and there was disproportionate number of plans, lines and monthly costs. For example, at Central Office there were 907 lines, 47 different plans, and the cost of those plans range from a low of \$5.95 to a high of \$172 per month. Due to the high number of lines, the cell phone invoices were too voluminous to be reviewed. However, we contacted the vendors and got a download of the invoices so we were able to review them and we found that there were many lines not assigned to individuals or they were assigned as spares, so we do not know whose possession these cell phones are in.

We also found a lack of centralized cell phone and laptop inventory at these sites, so we did not know the status of either of those items. At all the sites except for Harlem, the local cell phone policies did not adequately cover the purchasing, the issuance, the monitoring and the return of the items. Lastly we noted that issuance forms were either not located or lack proper approval or justification.

Ms. Youssouf asked if they had plan.

Mr. Guido said that they do and over the history of HHC there were eight separate IT functions within HHC. They were decentralized; each one of them had their own processes and their own audit capabilities. Over the last four months, we have combined those organizations into one for realigning. We are now centrally managing the assets that Mr. Telano alluded to. We have a complete inventory of everything right now. We have very strong controls over the approval process for these devices. We are working with Ms. Zurack and her team on the operating procedures to make sure that everything is seamless and auditable. We are putting in a codified framework for all of our controls not only from this audit, but for all of IT. We plan to have a lot of these components in place by the end of the year. We actually have a very good handle on the mobile devices now throughout HHC. We have a full inventory, we have accounted for each one of the devices. We have terminated quite a few of those lines to reduce our costs, so a lot of good work is in progress.

We are also in the process of signing a central cellphone policy with a vendor to eliminate all of these disparate one-off contracts and things like that. We are working with Ms. Zurack and finance group to get that in place. We welcome Mr. Telano and his team once we complete all work to validate that all the controls are actually in place.

Ms. Youssouf stated that I think that is great. It would be good maybe at some point if you can let us know how many devices, phone, laptops we have now and this is what our costs were. It sounds like there is going to be significant savings from this, which is very well done and you should thank Mr. Telano for finding this out.

Mr. Guido thanked Mr. Telano.

Ms. Zurack commented that in all fairness, I do not know the date of the audit, but Mr. Guido has been working with us on this for quite a while. He probably was working on it even before the audit, just to give credit where it is due.

Mr. Guido said that we were just getting there, so we had a couple of other priorities that needed to get handled first, and this was on the list, so as Mr. Telano's team were coming in, we were actually rolling this out. First site it was rolled out, so we are pretty confident that we have the controls in place, and again we welcome Mr. Telano's team back to validate those controls.

Mr. Telano continued on with the next audit and said that this is similar to the employee equipment audit. It was done at various HHC facilities. We went to the Generations Plus Network, South Manhattan Network and North/ Central Brooklyn Healthcare Networks and once again Corporate Support Services. Coincidentally, there was a corporate initiative headed by EITS and Corporate Procurement to centralize and manage the print service solution, Mr. Telano asked the representatives to join Mr. Guido at the table. They introduced themselves as follows: Paul Albertson, Senior Vice President, Material Management; Jim Gomez, Interim AVP at EITS.

Mr. Telano once again stated that I will go through the findings and you can address them. Overall we found that the printing activity is managed differently throughout the Corporation. As a result of those operations, we found the following inconsistencies. Different printer equipment vendors were being used at different prices and for different services. Some sites leased their equipment while others rented them. Half of the sites we visited charged back their internal services to the requesting department while the other half did not. Each facility used their external printing services with Vanguard differently as indicated by the diverse range of printing expenses, and equipment usage and monthly payments were not adequately monitored at all six locations.

Mr. Gomez stated that Mr. Telano knows my appreciation for his auditing efforts and all the things that are uncovered. I am going to go through them, but my answers are going to sound remarkably like Mr. Guido's answers because we are all part of the similar efforts to consolidate under one organization as part of the realignment. The different equipment from different vendors will be addressed by our Request for Proposal (RFP). We currently have an RFP out on the street today with the objective to select one vendor to provide support to all our printing services and printers across the entire Corporation, which includes the six print shops that were part of the audit. Various vendor responses are coming in.

Ms. Youssef asked if the plan would be to replace Vanguard. To which Mr. Gomez answered that it would be replacing our in-house printing work, but it is just a contract for the equipment – it will be standardized equipment. It will be either leased or rented depending on what the vendors bring back as a solution. It will not really impact our need to go externally if we do not have the capability in-house. This is what Vanguard represents. Due to our fractured system, we now have six print shops and six different networks doing six different types of work. There are different organizations in each with different functionality in each, so that is why you see such disparate spending with Vanguard, which will be addressed in the outsourcing agreement. From a charge-back perspective, Mr. Guido has been working with Ms. Zurack for a while on a model to charge back for services.

Mr. Guido added that that is correct. We are looking from a wireless standpoint, a different mechanism of supplying those wireless devices to the resources within HHC. We are looking at a bring-your-own-device (BYOD) policy, and allowing us to secure those devices while allowing our resources to come in use their own devices for access to our environment.

Ms. Zurack commented that all those discussions took place before the Hillary Clinton incident. We thought about it -- would be an efficiency and a major savings to allow people to use their personal devices and we would support their using their personal devices and we can control and save on it.

Mr. Albertson stated that we have really broken our approach to our print servicing into three different components. The biggest one, which Mr. Gomez was talking about, relates to all of the photocopy machines, the desktop printers that we have throughout the corporation. We have about 2,300 different copy machines across the Corporation. We own some, lease some, rent some; we have about 23,000 desktop printers. Between the two of them, the 25,000 devices that we have, we print about 400 million black and white copies a year and another 25 million color copies, so our interest in this opportunity is being able to identify a single vendor who is going to be managing all of our printing. We want this vendor to take all of the existing agreements and manage them and help us in the context of doing so. We have worked with a value-analysis team which has representatives from each of the networks from Mr. Gomez's office, finance and a few other departments to help us put this kind of complicated document together, have identified a series of key performance indicators that relate to what the vendors have to provide, what the future state looks like as it relates to our engagement with EPIC and the fact there will be a natural attrition of paper as an outcome of different applications going up that currently are paper driven now. We will be working with each of the facilities as

we roll this out to right size it with both the IT liaison and the appropriate chief operating officers to make sure we work together to achieve this.

Ms. Youssouf asked that if the point is to eventually get to one contract? To which Mr. Albertson replied yes, it is a single contract and a single vendor. Mr. Gomez added that we will actually manage the contract and provide governance over the contract.

Ms. Youssouf asked if they will keep all of the various contracts. Mr. Guido responded no, that that is not the intent. The intent is to collapse all of the subcontracts into this one major contract. One vendor will manage our printing facilities across HHC thus should reduce our costs, but with that there is more to it. There are also 23,000 printers that we have today – is that necessary? It is more of a process driven as well as a secondary to make sure that we are rightly aligned with the requirements and the capabilities that IT has to provide from standpoint.

Mrs. Bolus asked, you say that you have 2,300 copiers. Mr. Guido answered correct, copiers are about 2,300 and 23,000 printers.

Mrs. Bolus then added that that is difficult then when you consider that you will probably need about ten at least in each of the buildings because each department will want their own and who owns the software because the software has to have HHC letterhead or whatever you are going to put on these objects that you are using. There are people who actually know the software and design what is necessary. Mr. Guido responded that we do have quite a few of these here. We have design folks, communication folks that have been trained in this area with specifically more of these type of features and functionality.

Mr. Martin asked if they did an assessment as to whether or not we need print shops.

Mr. Albertson answered that that is the other component that we are talking about. One is the RFP that is now on the streets relates to the volume of work that we are doing. With the print shops themselves, we know that there will be a reduction in the work they are being asked to do as an outcome of EPIC going up because they currently print a lot of documents that are part of the patients' record that we will not need going forward.

The second piece is, we collected all the information on what every print shop is doing and the variability that they are engaged in. There is going to continue to be a need for internal printing on a more modest rate than what we are currently doing. Some of them do work that others send out to Vanguard or other companies, so we collected all of that information with the intent of reducing the work variability across the facilities, reducing the number of shops that are probably going to be needed and the work that is actually being done.

Ms. Youssouf asked with the advent of EPIC, shouldn't that be a major reduction? Mr. Guido said yes, it is a lot of different areas. The print shop is one the reduction of these 23,000 printers is another.

Ms. Youssouf asked why we still need Vanguard. Mr. Albertson responded as we are evolving the introduction of EPIC, it should be going away, but over the next three or four years while EPIC continues to roll out, there will be some facilities that still need those forms to be part of the patient's record.

Ms. Youssouf stated that that was the question. To which Mr. Guido responded that that it is only for a short term. As we modernize and digitize most of those files and records, the requirement for Vanguard would dissipate over time.

Mr. Martin asked if we have print shops at all of the facilities. Mr. Albertson responded that we have nine print shops in total today -- one in Central Office and eight in the facilities.

Ms. Youssouf stated that we will be looking forward to hearing from you – now that we have all this information. I think that hopefully it would be a nice savings benefit and thank you.

Mr. Guido once again thanked Mr. Telano and said that we do appreciate all the work and look forward to seeing you again.

Mr. Telano continued by stating that on page 10 and 11 of the briefing it gives you the status of audits we have in progress and the status of our follow-up audits and that that concludes my presentation.

Ms. Youssouf directed the meeting to Mr. Wayne McNulty for the Compliance update.

Mr. McNulty introduced himself and saluted everyone. He began his presentation by stating that I am going to follow up on the report that I presented to the Audit Committee back in February on HHC's compliance with the HIPAA Security Rule risk analysis requirement. Under the Health Insurance Portability and Accountability Act of 1996, HHC is required to implement a risk-assessment program, and that particularly means that HHC is required to conduct an accurate and thorough assessment of the potential risks and vulnerabilities of the confidentiality, integrity and availability of electronic protected health information that is accessed for and transmitted by HHC's systems and applications.

I reported back in February to the Audit Committee that our assessment of the Corporation compliance with the risk-analysis requirements were that the inventory of HHC's information systems and applications that access, house and transmit electronic protected health information is a work in progress and therefore is not comprehensive at this junction and that although HHC's Enterprise Information Technology Services has taken numerous and significant measures to enhance and maintain confidentiality, integrity and security of HHC's information systems including the formation of an information governance and security program, the implementation of security controls and the performance of a formal risk analysis on a handful of its application. It appears that further measures must be taken by EITS to fully satisfy the extensive risk analysis and implementation measures required under the security rule.

There are specific eight steps that need to be taken to perform an adequate risk analysis, including the potential risk, threats and vulnerabilities to the confidentiality, availability and integrity of all electronic protected health information that HHC creates, receives, maintains and transmits; collect and gather the information where it is stored; identify and document potential threats and vulnerabilities; access current security measures; determine the likelihood of threat occurrences, the potential impact of threat occurrences, the level of risk present; and document all findings and risk analysis conclusions.

The steps that have been taken since the last time that I reported to the Audit Committee is that EITS has taken steps to procure a third-party vendor to provide among other things the following services: a HIPAA risk analysis on the applications of electronic protected health information, a HIPAA compliance assessment, the application security penetration test, an infrastructure security internal penetration testing, infrastructure internal server penetration assessment and a vendor/third party assessment.

Mr. Sal Guido, the Acting Corporate Information Officer, will inform the Audit Committee of any additional measures that EITS has taken or plans to take.

Mr. Guido stated that we have been working with Mr. McNulty for quite some time now getting a lot of the audit requirements in place, getting external auditors to come in and audit us and have been very closely aligned with Mr. McNulty and his office on getting these things done. As Mr. McNulty has alluded, we have solicitation out to security vendors through City and State contracts to provide services around application security risk assessment from preliminary perimeter as well as the HIPAA requirements from an audit standpoint. We have received those solicitations back and we hope to have those secured within the next 30 days.

Right now from an application standpoint we have conducted an inventory of all of our applications and the Private Health Information (PHI) associated with it, and the way it will work is we have 131 applications that you have PHI on. Over the next three years, we will be taking approximately 40 applications a year doing a risk assessment on them and plus the remediation plans and the remediation implementation of those application where necessary. The reason why we did not take the whole 131 is because it just was not practical for us to that at this time. We wanted to take a higher priority application, make sure we secure those and go on from there.

Ms. Youssouf commented that that is a big job. Mr. Guido answered that a lot of it was in progress over the last six months with the realignment, so we understood where some of the deficiencies were and started to address these things very rapidly. We really secured our infrastructure from the outside world. This is really security it from the inside world.

Mrs. Bolus asked if he thinks we need to reemphasize what is a breach to staff. Mr. McNulty said that the education has to be almost continuous. Although we have HIPAA training and all the employees and workforce members going into the training, we send out periodic notices to employees, we speak to employees at the facilities. I have personally performed walkthroughs throughout the various facilities the Corporation and stopped employees in the hallway and asked them about the different HIPAA procedures, and for the most part they are very familiar with the policies and procedures, but the education has to be continuous, and we have to keep at it and we got to keep our guard up with respect to privacy and security and any other compliance policies.

Mr. Guido added that we have to put some technology in place to help Mr. McNulty out to actually track where PHI goes, internal as well external, so we understand exactly where the data is. It is protected internal and if any of it is going out from an unauthorized matter, so I think from that standpoint we have done a pretty good job. The problem with security is that things change very rapidly, and we just have to keep up on it.

Ms. Youssouf requested that it would be good if you can come and give us a little update in a couple of months because it is a huge amount of issues that are on your plate, and it would be good to keep us informed. We will be completing our fiduciary responsibility to make sure it is all going along.

Dr. Boufford asked if we are managing HIPAA and research and do we have a process to make more people's patient records available to them. To which Mr. McNulty responded that the issue with respect to HIPAA and human-subject research, we have HIPAA operating procedures in place that are specific to research use and disclosure and access of protected health information. Under HIPAA privacy rules, it does allow some access to protected health information by researchers. However, New York law is more stringent, so there are additional controls if you are a hospital or healthcare provider with regard to accessing protected health information for research purposes, but we treat it just like any other protected health information with respect to security and privacy, and clinical research is an area that we will be auditing to ensure there is no inappropriate access for that particular source.

Mr. Guido said that currently we have an operational patient portal that provides those records to the patients. They have to log into our portal in order to do so. We also have capabilities of transferring data of patients from physician to physician through referrals in that system as well. In the future we will be putting something called "My Chart" in place for EPIC, which allows for a little bit more richer content of those patients records for their viewing. With that comes security concern – with the security, we have actually put in place something called federated active directory or a federated way of allowing our patients to come into the portal by authenticating off of a known database like DMZ so we are working with the DMZ to make sure that from identity-management standpoint that the patients that are actually coming into the portal are actually the right people. That has to be worked out with Ms. Zurack and Finance as well as quite a few other organizations within HHC to see how do we start looking at bio-med devices for identification of those patients, which has great benefits to us in a number of different ways. One is we know who the patient is and second is that we would eliminate or greatly reduce the need to clean up data on an annual or semi-annual basis. Those are the technologies that we are looking at to really secure and make our patients feel much safer about accessing that information on line.

Mr. McNulty continued on with Section II, the Compliance Reporting Index – for the first quarter of calendar year 2015 we had 81 compliance-based reports. One was classified as a Priority A report, three were Priority B and 49 were classified as Priority C reports. Because these are ongoing investigations, I will discuss the pertinent reports in executive session. Section III, Privacy Reporting Index for the first quarter of calendar year 2015, we had 45 reports of potential HIPAA violations. Fourteen of them were confirmed breaches of protected health information. At the bottom of page it defines what a breach is. It is the impermissible use, access, acquisition or disclosure of protected health information in a manner that compromises the security and privacy of the protected health information maintained by the Corporation.

To have a breach, we have to do an assessment – the assessment is you look at the nature and extent of the protected health information involved, you look at who accessed the information, the unauthorized person, then you look at whether the protected health information was actually acquired or viewed and last you look at the extent to which the risk to the PHI has been mitigated.

There is a couple of privacy incidents that I just wanted to highlight. One occurred at Harlem Hospital Center where several employees accessed the record of a patient inappropriately. In total it was nine employees, all nine of those employees were disciplined for the improper access, and a breach notification was sent to the affected patient in early April.

Ms. Youssouf asked if they all targeted one patient. Mr. McNulty responded that the patient was an employee, so they accessed the patient's records inappropriately and they were all suspended for those actions. At Coler Nursing Facility we had 27 residents whose medication was being sent from the Henry J. Carter Facility to the Coler Facility. Seven bags of medication fell off the back of the van because the van door was open. Someone pulled the driver over and said that the door was open and when hospital police checked the security camera, the door was actually open so we sent breach notifications. We will be sending breach notifications to those patients before April 20th.

Moving to Section IV, the Monitoring of Excluded Providers, we have not uncovered any excluded providers since the last time the Audit Committee convened. However, we did uncover one vendor that was excluded from the General Service

Administration list, the federal list for vendors, as we referred that to the Office of Procurement for handling. They determined that the vendor is inactive, it is no longer used by HHC, so there is no potential overpayment to address.

Ms. Youssef said that a few years we had a lot of excluded providers and I want to congratulate everybody who is involved in really clearing this up. You all have done a great job.

Mr. McNulty continued with Section V, the Revision of Corporate Policies and Procedures, the status update. As previously communicated, we will be revising Operation Procedure 50-1, which is the Corporate Compliance Program operating procedures, the HHC Corporate Compliance Plan, HHC's Principles of Professional Conduct. Because of all these procedures touch on compliance and corporate governance issues, before we finalize these procedures, we will disseminate these procedures to the President and CEO for review and also the Audit Committee for review and comment before they are finalized and executed and approved by the President.

Dr. Boufford suggested that Mr. McNulty speak to the CEO of Maimonides Hospital on the Principles of Professional Conduct. They have done some really interesting work in this area especially regarding the behavior of physicians relative to other staff. They have implemented something called a code of mutual respect and a number of other steps.

Mr. McNulty said that he will definitely give Maimonides a call. Currently, Principles of Professional Conduct just covers basically fraud, waste and abuse and very little with regard to privacy. It really should cover a code of conduct and a way of doing business and it should cover issues that affect human resources, issues that affect conflicts of interest and so forth. We will be expanding that to cover those particular issues. I will be working with Carolyn Jacobs, Senior Vice President for Human Resources, because it is going to need input, and we will have input from our executive compliance work group with all our leaders on that before we finalize and give it to the Audit Committee and the President for review.

Dr. Boufford commented that I think it is a great opportunity for HHC because especially there are a number of organizations looking at sort of administrative checklists for issues of diversity, cultural competence, and there is a lot of work that is been done in this area and I am glad to hear you thinking in broader terms because I think HHC can set a standard for a lot of things that other organizations are going to have deal with going forward. It is very exciting – look forward to tracking it with you.

Mr. McNulty continued on with Section VI, Compliance Training Update, we are required under the Department of Social Services regulations to provide training and education to all affected employees and persons associated with the Corporation including executives and the governing body members on compliance issues, expectation and the compliance program operation. We have four modules, one for physicians, one for all individuals that are licensed under the Title VIII if the Education Law such as physical therapists, nurses and occupational therapists as well as other individuals involved with patient-care activities. We have compliance training for Group 11 employees. We also have compliance training for the Board members, for the members of the Board of Directors.

We have revised the training modules for the physicians and healthcare providers. Those are currently live. We will be finalizing a Group 11 training module by tomorrow. The training module for the Board of Directors we expect to go live sometime next week. I have been working with Mr. Guido's office; he is going to try to make sure that the Board training will be available for all Board members on their iPads. There has been an issue with that, so he is going to be looking at that.

The Healthcare Professionals Module we have over 20,000 healthcare professionals enrolled. Over 5,000 have completed, we have a 20 percent completion rate. The Physicians Module we have 6,000 enrolled, over a thousand have completed, a 27 percent completion rate. I have reached out to all the chiefs of service at the various location facilities and all the administrative heads at the various facilities to ensure these numbers go up, and I am quite confident the next time I come before the Audit Committee that both of those rates will be somewhere between 75 and 85 percent. By the time June 30th rolls around, we will definitely be at least at 90 percent for both those modules.

I will talk briefly about the Corporate-wide risk assessment process. At some point in May, the Office of Corporate Compliance will begin conducting the Calendar Year 2015 Corporate-wide risk assessment. The results of this risk assessment will be used in pertinent part by the Office of Corporate Compliance to develop the Fiscal Year 2016 HHC Corporate Compliance Work Plan, the risk assessment process is expected to be completed by mid-July. The risk assessment is required under the Department of Social Services regulations. It is also required under the Office of the Inspector General Guidance to Hospitals. We will look at risk throughout the Corporation, we will take three measures. We will interview employees directly and ask them what risks do they observe in their daily work, and they will address those risks. We will conduct a survey of employees asking them what

three things keep you up at night or what three areas that concerns you. We will also be sending to all the various compliance committee and executive compliance work groups a predefined list. The Office of Inspector General, and the Office of the Medicaid Inspector General, send out fraud alerts, they put together a work plan and they put together a list of predefined risks that we assess and see if those risks are applicable to the Corporation.

We will then score those risks and we will prioritize those risks and then we will come back to the Audit Committee because then the next step of that is the Audit Committee and the Board has to accept the risk and develop risk tolerance and appetite strategies. That will be the last step of the risk-prioritization process. KPMG mentioned that in their last management letter just as an information item, so we will definitely address that this year.

Ms. Youssouf then called for the executive session at 1:34 pm. Once over, Ms. Youssouf stated that during the executive session, the Committee discussed confidential matters related to specific patient health information.

Capital Committee – April 16, 2015

As reported by Ms. Emily Youssouf

Senior Assistant Vice President's Report

Roslyn Weinstein, Senior Assistant Vice President, Office of the President, introduced John Jurenko, Senior Assistant Vice President, Intergovernmental Relations, who provided an update on the recent City Council funding response to the Mayors' budget. The City Council requested that \$15 million be added to the Corporation's Women with Disabilities project. Mr. Jurenko explained that in 2013 the Council had given \$5 million in capital funding over a two (2) year period, \$2 million of that funding had been cut last year. The Corporation requested that the money be reinstated and the council had not only agreed, but raised the number to \$15 million. Mr. Jurenko explained that the funding was subject to negotiations between the administration and the City Council but it was promising news.

Ms. Youssouf asked if the Corporation had plans to use the money. Ms. Weinstein explained that the Office of Intergovernmental Relations and the Office of Facilities Development had been working collaboratively to visit Diagnostic and Treatment Center (D&TC) sites, now Federally Qualified Health Centers (FQHC) to establish a complete plan of where the improvements would be performed. Mr. Jurenko said that the Council had been informed that renovation of at least one bathroom and one exam room would be completed for optimal accessibility, however, while meeting the American with Disabilities Act (ADA) requirements is important, the Corporation would go beyond that to be ensure that they were doing as much as possible to accommodate. He advised that his department had been working with Independence Care Systems to do environmental scans of the facilities and ensure that proposed plans were the best.

Committee member, Josephine Bolus asked that signage be in place when work was complete. She explained that she was aware that there were already such spaces in the facilities but no signage to indicate that they existed or where to find them. Mr. Jurenko said he understood.

Ms. Youssouf asked that the plan be shared with the Committee when it was complete, and asked how far the money was expected to go. Mr. Jurenko said the cost would vary at each facility depending on the work to be completed so it was presently unclear how many facilities would be involved. There is currently \$2.5 million available being used to fund projects at five (5) sites.

Committee member, Mark Page asked what type of work was being performed. Mr. Jurenko explained that gut renovation work would be performed on bathrooms and exam rooms, as well as reconfiguration within clinics; lower counters, wider doorways, and moveable equipment such as tables and mammography machines. Mr. Page said thank you, he had a better understanding of the project.

Ms. Weinstein said that project photos would be shared, to show completed work. Ms. Youssouf said a before and after photograph would be nice.

Mrs. Bolus said that she would like to see signage outside of the facilities as well, to identify that the work was done and that the facility was ADA accessible.

Ms. Weinstein advised that the Corporation had received approval to increase primary care sites and that they were working with some existing NYC Department of Health (DOH) sites, as well as within privately owned spaces. She explained that there

were 16 sites identified, and reviews of the sites were being performed. The sites were located in Queens, Brooklyn and the Bronx. She said the construction would be completed on a very fast time table but the City and State were working together, and things were moving forward.

Ms. Youssouf asked if this was related to the Delivery System Reform Incentive Payment (DSRIP) program. Ms. Weinstein said somewhat, but it was more a result of City Hall's program to create more health hubs and get into underserved communities. It did work well with DSRIP though, she noted. She advised that much of the work is to be completed by December, 2015.

Ms. Youssouf asked if funding was being provided to convert the NYC DOH sites into primary care sites. Ms. Weinstein said yes, HHC had construction money, and reviews were underway for the remaining work.

Mrs. Bolus asked if there were any new sites in public housing areas. Mr. Iglhaut said he believed there was one site. Mrs. Bolus asked if that site was Bayview Houses in Brooklyn. Ms. Weinstein said she would take a look. Mrs. Bolus said she had lived there for years and thought that they could use a local site.

Mr. Page asked whether it would be beneficial to review the ADA related project scope and determine which standard the Corporation should be meeting, particularly if constructing new clinic sites. Ms. Weinstein said that would be part of the project design. Mr. Page said that the Corporation should think about whether they want across the board standardization and create a plan accordingly.

Ms. Weinstein explained that there were various ADA requirements, dependent on existing buildings and what the Corporation was doing was a level beyond the minimum requirements. Jeremy Berman, Deputy Council, Legal Affairs, explained that it was not always clear under the ADA, which requirements were applicable. He said that there are a number of determinants; if work is being done in an existing facility; dollars threshold is used to trigger new requirements; and, there are hardships that can be applied to avoid additional work. So, he noted, it is possible to be ADA compliant and not perform any additional work, dependent on the site and a number of attributing factors.

Mr. Page reiterated that if there were new sites being constructed, then the Corporation should ideally have a plan about what standards were being met and what the cost would be. Deputy Counsel Jeremy Berman said there were certain funds available and a mission to do certain work, and the work would be done within those restraints. Mr. Berman said that preliminary reviews were being done and the information gathered would be utilized to determine the extent of the work. Mr. Page said he understood.

Assistant Vice President, Office of Facilities Development, Louis Iglhaut added that part of the review was the type of clientele served at the particular sites. He noted that is a component of the type of construction to be completed and the accommodations that would be needed.

Ms. Youssouf said she was glad to hear about the incoming funding and the new sites.

Mr. Page asked whether there should be an express standard that would be used when establishing new sites and performing work to ensure all visitors to any HHC site will be aware of the accommodations being implemented. Mrs. Bolus agreed, saying that she does not find all sites to be accessible. Mr. Page said it can be expensive in old sites, but at the minimum, perhaps in new construction, a standard be established so that moving forward HHC can confidently say to clients, "if you choose to visit any of our facilities, we can serve you."

That concluded Ms. Weinstein's report.

Action Item:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute Indefinite Quantity Construction Contracts (IQCCs) with two (2) firms: Vastech Contracting Corporation; and Rashel Construction Corporation, Inc.; (the Contractors"), to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$6,000,000. The total authorized value of these contracts is \$12 Million. Louis Iglhaut, Assistant Vice President, Office of Facilities Development, read the resolution into the record.

Ms. Youssouf asked if both vendors had previously performed work for the Corporation. Mr. Iglhaut said yes; Vastech had performed approximately \$4 million of work under their previous contract, and Rashel, \$2.7 million. Ms. Youssouf asked if the work performed was satisfactory. Mr. Iglhaut said yes.

Mr. Page asked what kind of work these contractors provided. Mr. Iglhaut explained that they provide services on time sensitive construction projects and construction projects under \$3 million. He said it was also recently established that they were eligible to work on small FEMA projects as well.

Mrs. Bolus asked why the term Indefinite was used in the resolution but not on the agenda. Ms. Youssouf said the resolution was being voted on. Mr. Berman concurred. Ms. Youssouf asked that the action item on the agenda be corrected to reflect the language in the resolution.

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

South Manhattan Health Network

Michael Rawlings, Associate Executive Director, Bellevue Hospital Center, presented project information on the completion of the Elevator Controls Upgrade in the C & D Buildings at the facility.

Mr. Rawlings shared a presentation with photos of the completed elevator work. He explained that there were 36 elevators, 14 had been renovated. He explained that work was complete on four (4) elevators in the C&D buildings, three (3) were outfitted for passenger service and one was considered a quasi-service elevator, used for passenger service but also as a back-up service elevator. He explained that work performed included new motors, new door operators, new breaks, air conditioning of the motor room, and more, virtually a complete overhaul. There was surveillance equipment installed, and card access that allows employees to use in off hour, as well as monitors to share hospital activities and information.

Mr. Rawlings said that the total project cost of \$1.327 million dollars, completed the modernization work. The Department of Buildings (DOB) was on site that very day to certify the last elevator. He noted that the project was completed within budget and any remaining work would be done in the following four (4) to six (6) weeks and wrapped up before summer starts.

Ms. Youssouf asked if the project was Federal Emergency Management Agency (FEMA) approved. Mr. Rawlings said that this was a separate elevator project but there were others that would be completed with FEMA dollars. FEMA dollars may be used to protect the elevators against flooding by isolating the elevators in the main hospital building to keep them functioning in the event the basement floods. Ms. Youssouf asked if that meant additional work on the same elevators. Mr. Rawlings said no. These elevators were protected by barriers at the loading dock, already in place, and flood barriers to be installed surrounding the entire facility; a long term mitigation project that was yet to be built. Mr. Page asked if one mitigation method was to have the elevators stop above flood level if needed, in an emergency. Mr. Rawlings said yes.

Mr. Rawlings thanked the Committee for their support, concluding his report.

Sal Guido, Senior Vice President, Enterprise Information Technology Services reported on the completion of the Conference and Training Center constructed at Metropolitan Hospital Center.

Mr. Guido advised that Committee that 16 classrooms had been built out for EPIC training of HHC staff. The classrooms would be operational 24 hours a day, seven (7) days a week for training over a four (4) year period. He said the project is intended to reduce training costs by providing that service in house. Mr. Guido noted that construction of the rooms was complete, and the project had been completed on time and within budget. He said it was intended to be fully operational, and ready for training by April 30th.

Ms. Youssouf asked if the rooms were outfitted with computers. Mr. Guido said there were many computers and much clinical equipment; such as, cardiology machines, pumps and rovers, the type of equipment that is required on the clinical side. Ms.

Youssouf asked if the site would be used for a combination of clinical and EPIC training. Mr. Guido explained that it was an integrated system, with medical records were stored in one location and biometric devices integrating with EPIC to secure that data, so they were tied together. Ms. Youssouf said she would like to see pictures of the completed space.

Ms. Youssouf said she was glad to hear about another project that was completed within budget. Ms. Weinstein said the after a number of audits, and a thorough review of the planning processes, it was very clear that establishing a solid scope is most important. Having a good scope, solidly established up front had really helped strengthen outcomes.

Ms. Youssouf agreed and acknowledged that a tremendous amount of effort had been put in, but she felt that benefits were being shown.

Mr. Guido concluded his report by thanking Ms. Weinstein and her staff for a seamless project and great collaboration. Ms. Weinstein extended that thank you to Metropolitan Hospital Center for providing their space for the site.

Southern Brooklyn/Staten Island Health Network

Daniel Collins, Director, Coney Island Hospital Center, provided a status report on the completed Dehumidification and Cooling project for the Operating Rooms at the facility.

Mr. Collins explained that the project was completed on time and within budget. Work had begun in August and was now complete with the unit functional.

Queens Health Network

Dean Mihaltses, Elmhurst Hospital Center, provided a status update on the Women's Pavilion construction project. Mr. Mihaltses was joined by Hal Schnieder, Senior Associate Director, Elmhurst Hospital Center.

Mr. Mihaltses advised that while a previous reporting had announced upcoming completion and occupancy of the site, the facility had in fact not passed necessary inspections as a result of a number of electrical issues that were uncovered. He explained that the electrical contractor was brought back in to correct work and completion was expected by the end of July or early August.

Ms. Youssouf asked why that had happened. Mr. Mihaltses said there were a number of issues; a Construction Manager (CM) was not performing well during the earlier stages in the project and was removed, and both the electrical engineer and the electrical contractor had failed to pick up on things that they should have. Mr. Mihaltses said both participants were being held legally responsible and they were doing all necessary repairs at their own expense. He said that at present the replacement work was 70% complete in exam rooms and all repairs are being actively pursued.

Ms. Youssouf asked if evaluations had been completed to document the inadequate work. Mr. Mihaltses said yes. He added that having construction-at-risk would help in future projects.

Mrs. Bolus asked if any of the related firms had performed, or were performing other work for HHC. Mr. Mihaltses said he did not believe so, but evaluations would document everything. Mr. Iglhaut added that an evaluation must be done prior to final payment being issued which will ensure documentation is completed.

Mr. Page asked if the facility could be used at present. Mr. Mihaltses said no, the facility required sign off and then approvals prior to occupancy. He said if all inspections had been passed, then they would have been able to utilize the site a month or two ago. Mrs. Bolus asked if HHC could argue revenue loss. Mr. Mihaltses said there were ongoing discussions with the Legal Department about how to move forward. Ms. Youssouf noted that there had been a number of delays on the project, from the beginning. Mr. Mihaltses agreed, explaining that the blame was still being sorted out, but there was undoubtedly a loss of revenue as a result of a number of problems. Mr. Page said the Corporation should look into that as a message to future contractors about future performance, but not if it were an exhaustive financial effort to recoup.

Ms. Youssouf agreed. She asked that the vendors all be placed on a "do not use" list. Ms. Weinstein and Mr. Iglhaut agreed.

Equal Employment Opportunity Committee – April 14, 2015
As reported by Ms. Anna Kril

Assistant Vice President's Report

Manasses C. Williams, Assistant Vice President, Affirmative Action/EEO briefed the Committee on the Equal Employment Opportunity Commission's (EEOC) 2014 report on discrimination cases. He reported that for 2014 the EEOC saw a 5.3% percent decrease (93,727 to 88,788) from the previous year charges filed. He further stated that charges based on retaliation, age, sex, race and disability were the leaders in most frequent filed claims, with retaliation as the number one complaint filed.

2015 Conditionally Approved Contractors Update

Sharon Foxx, Assistant Director, Affirmative Action/EEO reported on two conditionally approved contractors. Sodexo Operations, LLC has a total of five underutilizations. They are in Management Job Group 1D and Sales Job Group 4A for females and in Professionals Job Group 2F and Clericals Administrators Job Groups 5A and 5B for minorities. The second contractor she reported on was US Foods, Inc. They had six underutilizations. The underutilized groups as reported are Managers Job Group 1C for females and minorities, Administrative Professionals Job Group 2A for females, Sales Job Group 4A for females and minorities and Operators Warehouse Job Group 7A for females.

2013 Facility Discrimination Complaints Update

Gail Proto, Senior Director, Affirmative Action/EEO reported on the discrimination complaint status of the ten network/facilities that were analyzed. The report showed that the overall number of open complaints in the Corporation increased from 175 in 2013 to 182 in 2014 an increase of 7. New complaints decreased from 229 in 2013 to 217 in 2014. Two hundred and seven cases were closed in 2013 and 198 in 2014. Counseling sessions over the period increased from 199 in 2013 to 896 in 2014 an increase of 350%. Finally, 427 requests were made for ADA Amendments Act of 2008 accommodations and 350 or 82% were granted.

The results also showed that allegations filed in 2014 showed a significant decrease in ten of the fourteen allegations tracked an increase in two and no increase in two.

Finance Committee – April 14, 2015
As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Marlene Zurack informed the Committee that her report would include three items, cash flow, the Soarian project update and an update of the State budget based on the information provided to the Committee a month ago. As of April 10, 2015, HHC's cash flow was at 24 days of cash on hand (COH) and is projected to be at 27 days by the end of current FY 15. The UPL payments which are a major factor in the cash balance are expected in April, May and June 2015. The status of these payments will be reported to the Committee.

Soarian Update

Ms. Zurack stated that a few years ago, HHC began a project to convert from the existing revenue cycle system Unity to the new integrated revenue cycle system, Soarian. Initially, the roll-out included division support, document imaging and scheduling. The final phase of the installation is the financials which is comprised of all the registration and billing functions. On March 23, 2015, HHC had its first "go live" of Soarian at Coney Island and Seaview Nursing Home. The "go live" was supported by a team of approximately fifty staff consisting of representation from revenue management, information technology (IT) and Cerner, the current proprietor of the Soarian product. On all accounts, the installation was a success. However, there were some problems in the installment process of the first "go live." There were some sign in issues for the users. There were users who were not identified as users before the "go live" and therefore were not trained and resulted in "on the spot" training. Also a system for reporting all of the problems that can be tracked corporate wide via SharePoint product was setup and was very effective. In terms of feedback from the users, while the new system offers the ability to access a lot data on line and using analytics, many of the users were not adaptive to that function and preferred having the old reports delivered to them. While there was a post live team resident at Coney Island and Seaview it was determined that there was a need for more hands on support and as a function

of that immediately following the Committee meeting, site visit is scheduled for the CFOs to go to Coney Island to review the install as a lesson learned.

Dr. Raju extended thank to the finance team for managing the installation without any major issues for addressing those issues promptly on-site which was tremendous progress.

Ms. Zurack added that it was a major installation and important not to be overly congratulatory in that the finance team in conjunction with the Coney Island team performed tremendously and the Coney Island team had just undergone a JCAHO survey but were extremely upbeat.

State Budget Update

Ms. Zurack stated that the UPL language that HHC had required was passed. The indigent care was extended; however, HHC's requirement as part of the indigent care for the Affordable Care Act (ACA) and DSH cut did not pass. The global cap was extended. The rate cut restorations were passed which is a positive for HHC. The Basic Health Plan (BHP) passed for this year and the State will be allowed to take the non-federally participating individuals which are the qualified immigrants and put them on the BHP, a tax benefit to the State this year as oppose to a new enrollment benefit. However, the year after, the BHP will increase to 200% of the federal poverty which is an expansion of Medicaid currently at 138% except for children and pregnant women. This will allow additional enrollment market share for MetroPlus. The Medicare/Medicaid crossover cut did not pass which is positive for HHC. The State included monies for vital access providers which for HHC this is not good in that it excludes public hospitals from being eligible for that funding. There is a \$1.4 billion in capital funding of which \$700 million is for central and east Brooklyn and the remainder is for a combination of debt restructuring, PCDC and nonprofits who provide behavioral health managed care transitioning. The additional capital funds requires that those hospitals that applied for the \$1.2 billion in concert with DSRIP to reapply which will be a major task for HHC, in that the projects that were submitted must now be resubmitted. HHC's one city DSRIP, the partnership original capital request totaled \$743 million of which \$449 million was for HHC. HHC must decide whether to reapply for those of any other HHC projects that may be eligible for the \$700 million for central and east Brooklyn and can only apply to one of the two. Christina Jenkins, Senior Assistant Vice President, DSRIP has been working with the group on the completion of the application for HHC.

Ms. Zurack announced the retirement of Marty Genee, Deputy Corporate Comptroller who after forty years of City service is retiring. HHC is losing an incredible employee. Mr. Genee before transferring to HHC worked at OMB. He has worked in the Corporate Comptroller office for thirty two years and has done an exceptional job at monitoring HHC cash, payroll and investments and a variety of other key functions. HHC will miss him.

Dr. Raju extended thanks to Mr. Genee for his dedicated service adding that the greatest asset that HHC has is its employees and employees such as Mr. Genee who worked hard to ensure the integrity of Corporation's finances will be missed.

Mr. Genee thanked Dr. Raju and Ms. Zurack for their leadership and his role in the participation of the various functions of the Corporation's financial performance and his appreciation for having had the opportunity to work at HHC which he views as a great organization.

Mr. Rosen on behalf of the Committee congratulated Mr. Genee on his retirement and for his years of dedicated and committed service to HHC and the City.

The reporting was concluded.

Key Indicators/Cash Receipts & Disbursements Reports

Ms. Krista Olson reported that utilization as of February 2015 was a continuation of the slight downward trend in both ambulatory visits and discharges. Billed ambulatory care visits were down by 2.1%; D&TC visits were down by 2.4%. Discharges were down by 2.3% excluding Coney Island the decline was 3.2% which was a slight improvement from last year which was down by 6.5%. Nursing home days were up by 2.6% which is an improvement over last year's decline. Henry J. Carter was down by 2.4% compared to 25% earlier this fiscal year.

Dr. Raju asked the CFO, Manuela Brito to share with the Committee the status of the facility's workload and actions taken to address the issues.

Ms. Brito stated that in order for the Committee to understand the current status of Coler/Henry J. Cater it was important to share some background of the process that began in 2010 as part of the Corporation's Restructuring Initiatives/The Road Ahead and the modernization of Coler/Goldwater. Prior to the opening of Henry J. Carter, Coler/Goldwater Specialty Facilities located

on Roosevelt Island had a total of 991 beds compared to a decrease of 365 beds. This reduction was achieved through right sizing and redeployment of employees mostly within the existing South Manhattan network. The change in the census is due to an increase in the level of acuity in both the long term care (LTC) and skilled nursing facility (SNF). In November 2013, the LTC occupancy rate was at 57% compared to the current rate of 79%. This calculation is based on the full occupancy of 201 beds by excluding the 38 beds that are not in service, the occupancy would be at 97%. The reason for the increase is that the hospital has developed relationships with some of the voluntaries in the area who have referred or sent their ventilator (vent) patients to the hospital vent unit. On the SNF side at the time of the initial move, the occupancy was at 68% compared to 99% currently including the 20-bed vent unit which has a waiting list. The downsizing of the beds has impacted the hospital's financials, in 2014; a two-year profit and loss (P&L) statement was completed of the hospital's financial whereby a \$6 million deficit was projected for the new facility, HJ Carter. However, currently the deficit is projected to be higher but less than the projected \$50 million deficit in the prior years before the downsizing of the beds. The projected deficit based on the current operating expenses is \$30 million; however, there were some contributing factors. The financial plan did not include certain factors for example; in the plan a 98% occupancy was projected which did not materialize except for the SNF. The LTC is much lower at 79%. Additionally there was a change in the payor mix. The initial projection included no undocumented in the LTC; however, the State has made the emergency Medicaid criteria very restricted whereby patients transferred from within HHC, the hospital was not meeting the criteria. Under the current criteria, twenty patients are not meeting those criteria which translate to a \$5 -\$6 million loss in revenue for FY 15 increasing in FY 16. Additionally, there is an anticipated increase in the rate for the enhanced SNF vent unit. The State is working on this issue and the anticipation is that upon the State' ruling on that appeal, the hospital will be able to bill at the new SNF vent rate which would be at 75% more than the current rate. It is a high cost unit and in 2016 the funding will be forthcoming and the billing will be retroactive to the initial date of occupancy. Another factor is that the CMI was budgeted at 1.14 compared to the current CMI of 1.17 due to the current level of acuity previously noted. This has taken a toll on the nursing resources through the use of overtime. In 2014 the State noted a deficiency in the staffing which the hospital has addressed through the conversion of full time vacancies to part time positions to allow for coverage on the unit as needed.

Committee member, Josephine Bolus asked for clarification of the conversion of the full time position to a part time to cover the shortages on the unit citing some concerns relative to the nursing contract and whether those part timers would be allow to work in that capacity.

Ms. Brito stated that based on the scheduling of the full time nurses on the various unit/tours any shortage due to sick leaves and annual leaves, the nursing department has the flexibility to use the part time nurses where there are shortages on the units. The time is split between two part time/hourly employees to cover the full time vacancy on the unit. The staff was done in conjunction with the labor union.

Senior Vice President & General Counsel, Salvatore Russo, stated a follow up on that issue would be done and reported back to the Committee.

Ms. Brito stated that due to the new capital for the new HJ Cater, the hospital has seen an improvement in its Medicaid rate beginning in 2014 and 2015. The initial capital portion of the Medicaid rate was at \$31.00 per day compared to projected \$248.00 per day. The reimbursement rate increased from \$700 per day to \$920 per day. It is expected that the increase will continue in 2016 once all the capital has been included which will impact the rate significantly by 2016. The hospital realizes its challenges and is making every effort to achieve the projected goal.

HHC President, Dr. Ram Raju in thanking Ms. Brito for the overall insight into the issues and the projected outcome due to the various rate adjustments added that it underscores the difficulty in projecting the financials given some of the underlying factors but it also highlights the importance of achieving some of the tasks that are key to getting the maximum reimbursement for the SNF/LTC hospitals.

Ms. Zurack added that Ms. Olsen and Mr. Fred Covino have been presenting the status of the performance compared to the budget for HJ Cater/Coler hospitals to the Committee and as Ms. Brito noted the deficit has decreased from \$50 million to \$30 million compared to the expected of \$16 million given the issues and the facilities efforts in putting forth a solution to those problems. The objective is to continue to address the issue given the biggest challenge by the State in its change in the rule which is part of the mix that needs to be taken into account.

Mr. Rosen asked if the emergency department visits were included in the total ambulatory visits reported by Ms. Olsen. Ms. Olsen responded in the affirmative. Continuing with the reporting the LOS comparison of the corporate average, one facility was above that average, Coney Island Hospital which is being addressed with the facility. The CMI is up by 3% over last years.

Mr. Covino continuing with the reporting stated that FTEs compared to FY 2014 year end were up by 263. The anticipated increase for FY 15 is 325 FTEs. To-date the increase is comprised of an increase of 56 FTEs at Lincoln due to the expansion of

the emergency department (ED) and psych unit; an increase of 92.5 FTEs at Bellevue due to the transitioning of registry nurses to full time nurses and a transfer of residents from Coler; Gouverneur is up by 55 FTEs due to the new beds and Elmhurst and Queens hospitals are up by 87.5 FTEs due to the transitioning of hourly employees to full time staff. Receipts were \$96 million worse than budget compared to disbursements at \$43 million overspent.

Dr. Raju noted that there has been a significant improvement at Lincoln that should be shared with the Committee. Caswell Samms, Network CFO was asked to present to the Committee the detail of that progress.

Mr. Samms stated that at Lincoln the disbursements were impacted by the receipt of the UPL which allowed the hospital to increase its OTPS budget. Last year a conscious decision was made not to spend the excess fund giving the budget circumstances within the network relative to the underlying deficits for the network as a whole. It was a one-time infusion of funding that may not be available in the future. Additionally, to ensure that the spending remains within the projected expenses, all GHX requisitions must be reviewed and approved by his office which has generated a significant amount of reviews and discussions. In terms of the revenue, on the inpatient side, orthopedic services were expanded through the development of a business plan with the network affiliation, PAGNY. The volume increase in that service has materialized. Multiple joint procedures are done on a daily basis. Additionally, a value stream (VSA) was conducted at Lincoln that included working with the staff to create standard work to improve inpatient outpatient collections. This has worked extremely well due to the daily meetings that are held to address any all issues that occur and resolve those problems as quickly as possible. From an outpatient perspective, the decentralization of registration, initially, Lincoln had centralized registration which created some issues relative to patient experiences. The staff could not specialize in the required area of focus; example dental was an area for improvement whereby, initially collections were at \$17.00 per visit compared to an increase of more than \$1 million due to that change in registration. The most important aspect for the hospital is that more work is required as steps are taken to improve the work flow and revenues by focusing on any and all areas where there might be an opportunity.

Ms. Zurack noted that Mr. Samms leads the corporate dental billing and improvement project whereby the successes at Lincoln are shared with the other HHC facilities.

Dr. Raju asked if the potential areas of opportunities are being implemented at other facilities/networks.

Mr. Samms stated that dental has been implemented across the Corporation and there have been discussions regarding behavioral health as another area of opportunity as well.

Mr. Page commented that it would appear that the efforts on behalf of the hospital in addressing issues and finding solutions are extremely good.

Mr. Covino continuing with the reporting stated that a comparison of the prior year actuals to the current year, receipts were \$102 million higher than last year; DSH and UPL payments were up by \$194 million; Medicare and Managed Care payments were up by \$41 million. Those increases were offset by a reduction in the SubSLIPA pool due to an advancement of a payment that was initially scheduled for FY 2015 due to HHC's cash status. Consequently of the scheduled three payments, one was advanced. MetroPlus risk pool payments are down by \$50 million compared to last year's payment of \$150 million compared to \$100 million received through the period. However, as of March 2015, \$82 million was received which will exceed last year's actual due to a timing issue. Expenses were \$255 million higher than last year; personal services were up by \$139 million of which \$110 million was due to collective bargaining and \$17 million in allowances and hourly expenses. An \$80 million increase in FTEs in total of 263 year to date. Fringe benefits were up by \$13.8 million due to FICA and supplemental welfare fund payments related to collective bargaining. OTPS expenses were up by \$61 million due to a reduction in the number of days in accounts payable from 81 days to 65 days. However, there are significant increases in three major areas, pharmaceuticals are up by \$20 million due to the 340B policy change on mixed use; other professional services are up by \$16 million due to hospital medical home and the DSRIP and Momentum IT consulting contracts. The FEMA contract with Arcadis, purchased services up by \$11 million due to the labs, Cerner IT contract and Meaningful Use contract with QuadraMed. Affiliation expenses are up by \$23 million compared to last due to the change in the payment process whereby payments are made on a biweekly basis as opposed to monthly. Additionally, there were \$3.2 million payment at the Queens Network for performance indicators and a prior year payment at Bellevue for \$4 million based on a recalculation for prior year expenses. The budget variances inpatient receipts are down by \$90 million due to Medicaid fee-for-service down by \$48 million due to a decrease in workload. Paid Medicaid discharges were down by 2,100 days; chronic days were down by 15,000; SNF down by 14,000 and psych by 4,700 days. Outpatient receipts were up by \$4.7 million and all other was down by \$10.7 million due to appeals and settlements that are being tracked for the difference between the paid Medicaid fee-for-service rate paid at 98% of the rate. The 2% retroactive payment is expected this year. PS expenses were \$6.5 million over budget; fringe benefits were \$4.8 million under budget; OTPS expenses were \$41.8 million over budget due to the reduction in the number of days in accounts payable. The reporting was concluded.

Mr. Rosen asked if HHC had received the funding from the City for the collective bargaining payments. Mr. Covino stated that HHC is working with the City on the payments for the collective bargaining, whereby as contracts are settled the funds are transferred. When an agreement is reached the funds are transferred to HHC. It is important to note that the City's payments for retroactivity to HHC are made from the accruals based on actuals.

Mr. Russo updated the Committee on the nursing issue raised by Mrs. Bolus earlier in the meeting. Based on a review of the contract there is specific language that allows for hourly nurses which is within the collective bargaining agreement.

The reporting was concluded.

Action Item

Resolution amending a previously adopted resolution to increase the authorization for one or more borrowings from an aggregated not to exceed amount of \$40,000,000 to a new not to exceed amount of \$60,000,000.

Ms. Dehart stated that the resolution relates to the vouching and equipment financing program for HHC. The goal of that program is to have a very routine mechanism whereby there is a way to respond to the Corporation's equipment financial needs without having to establish a project fund. This authorization is an amendment to a previously approved resolution by the Board for \$40 million borrowing increasing that authority to \$60 million that is expected to meet HHC's spending need through the ends of FY 16.

Mr. Rosen asked if any of the initial \$40 million was spent. Ms. Dehart in response stated the HHC was not able to execute the financing previously, therefore, HHC was worked with the various departments and divisions to identify emergency equipment needs that resulted in the authorization of \$12 million for those emergency needs. Two years ago, HHC received authorization from the Board to establish a financing vehicle but was unsuccessful in getting traditional financing. However, in an effort to identify an alternate funding mechanism a secondary lien structure was developed by working with HHC's bond counsel and financial advisor and members of the Committee, Mr. Page and Ms. Youssef, HHC was successful in getting a structure that was of interest to some lenders that resulted in HHC reaching an agreement with JP Morgan Chase for financing up to \$60 million. The agreement is being finalized and is expected to close by early May 2015. The details of the new structure that has been established and the existing lien have allowed HHC to have a successful bond financing program. Patient revenues are deposited into a daily lockbox and held to cover debt service needs prior to being made available to HHC which is very attractive to lenders. A secondary version of the lien was developed which is subordinate to box of the lien for the bond holders which gives the lenders who are participating in the equipment financing program a secondary lien on those revenues. When those revenues are released from the lockbox for the bond debt services they would be pledged to the new equipment financing. The way this will work is not exactly comparable in that there would not be another lockbox established to hold those funds in reserve unless there was an actual payment default. In that event a lockbox would be triggered. In addition to lenders would have first lien on the assets financed by the funding. The details of the deal with JP Morgan as previously noted will fund up to \$60 million. The funding is available for upgrading equipment purchases, medical equipment, IT systems and to cover the cost of issuance the security on the equipment and secondary lien on patient revenues. In order to meet HHC's needs for flexibility and concerns relative to having funds accruing interest prior to being spent is a twelve month drawdown period whereby HHC can drawdown the funds needed at a variable rate and at the end of the 12 months, the entire amount would be converted to a fixed rate six year loan. The rates are competitive and the current variable rate would be .9249% and fixed at 1.7062%.

Dr. Raju asked if HHC drawdowns the full \$60 million within the twelve month period would HHC only pay the flexible rate.

Ms. Dehart stated that HHC would convert to the fixed rate.

Mr. Page added that the rate are very flexible and the fixed is at a very low rate and asked if HHC get to the end of the twelve months and HHC did not spend the full \$60 million what would happen.

Ms. Dehart stated that HHC would begin additional deals which is the expectation of having multiple deals to cover longer periods of time to avoid a delay in meeting HHC's needs in the future with the expectation of using this structure as a model for future transactions.

Ms. Zurack added that this deal is specific to JP Morgan Chase and would not be transferrable and would therefore require re-negotiations with that bank.

Mr. Page asked what would happen to the unspent funds and whether HHC would drawdown the full amount and keeps the balance or let it go. Ms. Dehart stated that HHC would let it go. However, HHC is seeking two additional deals to have in place

that would allow HHC to have access to additional capacity which would not be in excess of the \$60 million but there is an opportunity to negotiate with other lenders. HHC will continue to report to the Committee the status of this financing.

Dr. Raju asked if there are funding needs that would cover the full \$60 million to which Ms. Dehart responded in the affirmative.

Mr. Rosen asked if HHC spends the \$60 million and repays the loan can HHC re-borrow. Ms. Dehart stated that it would require the approval of the Board to go beyond the initial \$60 million which would be an additional borrowing authorization.

Ms. Zurack added that in terms of the other two banks if there is a need above the \$60 million the Board would need to approve that new need.

Dr. Raju asked if the financing would add to the debt structure and would it have a negative impact on HHC's bond rate. Ms. Zurack in response stated that it is not par.

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

Medical & Professional Affairs Committee – April 16, 2015

As reported by Dr. Vincent Calamia

CHIEF MEDICAL OFFICER REPORT

Ross Wilson MD, Senior Vice President/Corporate Chief Medical Officer, reported on the following initiatives.

Care Management

The 2015 NYS Hospital Medical Home (HMH) Conference was held on March 19th, marking the end of HMH Demonstration pilot funded by the Centers for Medicaid and Medicare Services and the NYS Department of Health. 17 HHC facilities participated in the grant, which saw transformation in the care provided in their outpatient primary care clinics, and the reinforcement of medical home concepts in primary care resident training. 9 HHC presenters (8 facilities, 1 Central Office) participated in the conference poster session to showcase the achievements made by HHC facilities throughout the grant period in the areas of patient-centered medical home, clinical performance, residency continuity training programs, care integration and coordination projects, and inpatient quality and safety projects.

Laboratory Services

General

Cerner Laboratory Information Systems (LIS) - The Cerner Laboratory Master Validation/Implementation Plan has been developed. Initial review by the Laboratory Directors has been completed and finalization is expected by 10 April, 2015. All HHC facilities have named project Champions and technical/administrative subject matter experts. The project teams will support the completion of required activities necessary to implement the LIS. Additionally, clinical leads have been named in the areas of general laboratory, microbiology and anatomic pathology and will focus on standardization of operational activities throughout HHC labs.

Near Patient Testing (Point of Care)

An interdisciplinary project team has been formed to focus on near patient testing. Testing needs of Critical Care Services and outpatient Coumadin Clinics are of immediate interest. Available platforms were viewed by the POC project team during recent vendor presentations.

Office of Population Health

HHC has entered into a formal agreement with Health Leads, a 19-year old non-profit organization that connects patients to social supports. HHC will be re-launching a program with Health leads to address basic resource needs for pediatric patients and their families at 3 sites (Woodhull, Bellevue, Harlem). We will also be conducting a formal evaluation of the impact of these services.

Teen Health Conference

On April 15, HHC hosted a conference at Baruch College on Integration of behavioral health and adolescent primary care. This was a very successful event with more than 150 participants and speakers from within HHC as well as from our academic partners in the city.

E-prescribing

The Governor has signed into law legislation which delays for one year the mandate that medications be electronically prescribed. The new deadline is March 27, 2016. While measures had been put in place to meet the original timeline, this delay will allow us to move forward systematically in deploying e-prescribing across the corporation. Implementing this technology will not only reduce diversion of controlled substances but will also give clinicians valuable new information while affording real convenience to patients. We are on a timeline throughout the month of May to insure all providers are registered and using e-prescribing. On the same time-line, the facility medical, operational and IT leadership are working closely together to identify and address IT, logistic and workflow issues which may impede full implementation.

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 March 1, 2015 was 469,750. Breakdown of plan enrollment by line of business is as follows:

Medicaid		411,536
Child Health Plus	12,287	
MetroPlus Gold		3,441
Partnership in Care (HIV/SNP)		4,802
Medicare		8,587
MLTC		883
QHP		27,557
SHOP		641
FIDA		16

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.

One of our main goals is to have significant membership growth, up to one million members by the year 2020. We have developed a solid strategic plan and started undertaking many initiatives to help us reach this membership goal. One of the next steps in our growth plan is holding a special session with the MetroPlus Board of Directors whereby additional strategies can be discussed and approved.

It is important to point out that despite the 165,710 disenrollments from our Medicaid product in the last twelve months (out of which 91% were involuntary), our Medicaid membership grew by 15% (approximately 53,000 lives). A small portion of the growth is attributed to some of the FHP members rolling into our Medicaid line, while the majority of it is a result of aggressive marketing and retention efforts.

The QHP membership experienced a net growth of 30% in the last twelve months. It peaked at approximately 49,000 in May 2014, then slowly decreased mainly due to member termination for non-payment. Following the 2015 Open Enrollment Period, to date, we continue to see a familiar trend in members choosing our non-standard Exchange product. On average, 80% of the commercial population chose the non-standard package, which includes dental and vision. This is an indicator of our members making informed decisions about their coverage. Compared to 2014, however, the age distribution of the QHP population is different. We now see that only 34% of the members are under the age of 35 (as opposed to 42% in 2014), and 37% are over the age of 50 (as opposed to 32% in 2014). We expect this will balance the cost-sharing, risk corridor amount due in 2016.

As of the date of this report, the FIDA product line has 16 opt-in members. We are expecting another 70 passive members for the month of April 2015. The biggest challenge for FIDA care management is that providers do not have sufficient time to take part in the Interdisciplinary Team (IDT) meetings. Another great challenge is that it takes the Care Manager between 60 and 90 minutes to train each individual that will serve in the IDT meeting for each member.

We have well-defined strategic marketing plans to help us maximize enrollment into our Exchange line throughout the Special Election Period (SEP). In addition, we are closely monitoring the development of a number of immigration executive actions which can help us increase the number of members we serve.

MetroPlus' delegation of all Behavioral Health (BH) and Substance Use Disorder services to Beacon Health Strategies began on January 1st when Beacon began managing the FIDA line of business. Beacon and MetroPlus held HHC specific Clinical Orientation Sessions in all four boroughs for all Psychiatric Directors, Assistant Directors, BH Central Office Staff and other staff delegated by the Psych Directors. Beacon also held ongoing web based trainings for the entire MetroPlus network. By all accounts this has been a very smooth transition for MetroPlus members and providers.

It is important to bring to this Committee's attention that the Affordable Care Act requires every health plan participating in the Exchange to be accredited by an HHS-approved accrediting body by 2016. HHS has approved URAC (Utilization Review Accreditation Commission), NCOA (national Committee for Quality Assurance, and AAAHC (Accreditation Association for Ambulatory Health Care) as accrediting bodies for health plans participating in the Exchange.

We have decided to pursue URAC accreditation. There are 44 health plans that have either been accredited by URAC or are in the process of being accredited. URAC provides cutting-edge quality measures and data analytics capabilities that minimize the burden and cost of data reporting while providing a level of analysis not available in other accreditation programs. Its flexible design allows incorporation of state-specific standards and measures while its collaborative educational approach helps guide health plans in achieving accreditation.

Lastly, the previously announced discontinuance of the online renewal option though ACCESS NYC has been delayed. The option currently remains available to non-disabled, aged, and blind consumers with cases active in WMS, who do not have to supply any documentation at renewal. The Human Resources Administration anticipates that the renewal option will be disabled sometime in mid-April (initially scheduled for March 9, 2015).

Chief Information Officer Report

Sal Guido, Acting Corporate Chief Information Officer, Enterprise Information Systems provided the Committee with the following updates:

I'd like to update the Committee on several key initiatives that are underway: Epic Electronic Medical Records (EMR) New Wave Program Management Approach, the updated Epic Program Governance Structure and the status of Meaningful Use.

New Wave Program Management for the Epic EMR Implementation:

The EMR leadership team is in the process of restructuring the Electronic Medical Record (EMR) program in order to better manage and facilitate the completion of key program milestones over the next twelve (12) months. Our EMR Program Management Office (PMO) was tasked with a "new wave of thoughts and ideas" on how to bring the Epic program from present day to implementation go-live. The EMR PMO has completed a program charter, defined scope of work and an outline of the overall program structure.

The program plan is now broken out into four (4) workstreams (Management, Clinical & Business, Vendor and Infrastructure) and four (4) phases (Prepare, Enable, Get-Set and Go). The methodology being used to manage the EMR program is called Agile and has been used widely throughout many industries including IT. The agile methodology is designed to provide the EMR project team with a high degree of visibility within each area of the program, enable quick decision making as well as facilitate tracking and managing changes seamlessly without affecting critical aspects of the Epic program.

This methodology is a time-tested approach within program management designed to engage the application teams and workgroups as EITS manages the very complex and diverse needs in the Epic EMR program. The major benefit of using this new wave program management is that the team focuses on producing small chunks of results in a very short time timeframe rather than driving the team to deliver all results at once after a long period of time.

Since the adoption of the Agile methodology by the EMR program members in late February, there has been a better understanding by the stakeholders in what is needed to meet the immediate challenges ahead. The methodology was presented at our March IT Executive Committee and endorsed by the committee members. Other divisions within HHC have been introduced to this methodology for adoption as well and have agreed to use it to manage their major initiatives.

In addition to the introduction of the New Wave Program Management for the EMR program, additional governance has been put in place to address outstanding risks, issues and decisions associated with moving the Epic program to go-live.

Epic Program Management Governance:

EITS has developed a layer of senior leadership run steering committees to address and resolve issues identified by the EMR application teams and workgroups and prevent unnecessary escalation to HHC Executive leadership. Three (3) executive steering committees have been created which will address all clinical, financial and data concerns. Dr. Ross Wilson, HHC's Chief Medical Officer will chair the Clinical Steering Committee; Marlene Zurack, CFO, will head the Finance Steering Committee and JoAnn Liburd, Assistant Vice President for Accreditation and Regulatory Affairs will lead the Data Governance Steering Committee. Success for each of these committees will be measured by their ability to resolve EMR program concerns prior to reaching the IT Executive Committee.

EITS has also put a process in place to connect the already existing project level councils, workgroups and committees to Senior EITS leadership. This process will allow for issues identified by these groups dealing with scope, workflow and/or policy to be channeled to one of the three (3) executive steering committees for resolution. If these governance bodies perform correctly, there should be very few unresolved discussion items reaching the IT Executive Committee.

EITS along with HHC Senior Leadership has contracted with an Epic integration partner "Clinovations" to serve as a strategic partner to NYCHHC as the organization seeks to achieve HHC's first Epic go-live date of March 31, 2016 for Queens and Elmhurst hospitals. Clinovations will provide NYCHHC with the services of Interim Executives for 15 months. Towards this end, Clinovations and the Interim Executives will provide services which will support the Epic program and promote clinical enfranchisement, improved quality of care and drive staff engagement and alignment as well as provide as well as to provide strategic support and leadership to NYCHHC for all of its EPIC-related IT services.

Meaningful Use (MU) Update:

Currently, HHC is involved with three (3) phases of Meaningful Use (MU).

For MU Eligible Hospital Stage 2 Year 1, HHC will receive a total of \$16.5M in Eligible Hospital incentive payments from Medicare and Medicaid.

For MU Eligible Hospital Stage 2 Year 2, the QCPR team is working toward meeting the attestation thresholds for a full Federal Fiscal year, which ends September 30, 2015. CMS will be releasing a proposed rule change in the spring that could change the attestation period to ninety (90) days. There will be a third year of Stage 2 extending through September 2016 and Stage 3 will begin in 2017. The challenge remains with maintaining and sustaining the performance threshold to meet the patient portal objective, which is fifty (50%) percent of patients discharged having their visit summaries available within 36 hours. Weekly reports are shared with all involved to encourage transparency. Additionally, a compliance monitoring tool was made available to providers and leadership.

For MU Eligible Professional (EP) Stage 1 Year, this initiative will be introduced to outpatient providers for the first time this year. The immediate goals were to identify these eligible professionals and submit an *Adopt, Implement, Upgrade* attestation by March 31st in order to receive the first payment of Electronic Health Record (EHR) MU incentive dollars this year. A provider is eligible if he/she is fully enrolled in Medicaid; b) had thirty (30) percent Medicaid patient volume in one year and, c) spent over ten (10) percent of the time in the ambulatory care settings. Of the 1700 providers identified, close to 500 providers attested by the March 31st deadline. Because of this effort, HHC is in the process with Legal Counsel to request an Attestation Deadline Extension (ADE) from the State Department of Health (SDOH) to continue the effort of having the remaining providers attest. We have thirty (30) days from the deadline until the end of April to request this. EITS will continue to work very closely with Finance, PAGNY and the SDOH on the very complicated process of identifying and registering all of the Eligible Professionals. HHC anticipates receiving its first payment of \$21,250 for every eligible professional who met the deadline this year.

The team is also working on an additional 800+ providers identified as eligible providers in 2016. Overall, HHC has identified about 2500 providers who met the eligibility criteria set forth by the Centers for Medicare and Medicaid Services to participate in the MU Eligible Professionals EHR incentive programs. Incentive dollars for meeting these criteria will be substantial. HHC anticipates the amount to be over \$150 million which would be distributed over five (5) years up to the year 2020.

Additionally, the QCPR team is working very closely with our vendor Quadramed on the EHR enhancements necessary for EP functionality. Harlem Hospital is the beta site and is currently doing regression testing. New functionality will be available to all facilities by July, 2015.

The team is also deeply focused on managing the complexity associated with EP engagement and demonstration of the EHR MU by meeting the thresholds for 18 objectives by each provider across the enterprise. The Ambulatory Care and Population Health leaderships will assist in the decision making related to the implementation of new workflow and monitoring of compliance. Providing clinical summaries to patients as well as access to the patient portal are expected to be challenging for this MU initiative year.

As you are all aware, all of these activities associated with MU Eligible Professional support our efforts currently underway with HHC's Accountable Care Organization (ACO), Patient Centered Medical Homes (PCMH) and the Delivery System Reform Incentive Payment (DSRIP) programs.

This completes my report today.

Action Items:

A resolution was presented to the committee by Sal Guido, Acting Chief Information Officer, Enterprise Information System and Maxine Katz, Senior Assistant Vice President, Revenue Management.

Authorizing the President of the New York City Health and Hospitals Corporation to execute a sole source contract for software licenses, maintenance and support services agreement with 3M Health Information Systems (3M) for the Coding and Reimbursement Information System installed at HHC's acute care hospitals, long-term care facilities and MetroPlus. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is \$13,510,101 which includes a contingency of \$643,338. Elements of the contract were expressed in a slide presentation.

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

A resolution was presented to the committee by Sal Guido Acting Chief Information Officer, Enterprise Information System.

Authorizing the New York City Health and Hospitals Corporation ("the Corporation") to purchase storage hardware, software, and associated maintenance from various vendors via Third Party Contract(s) in an amount not to exceed \$13,220,000 for a one year period. The EMR storage hardware, software and maintenance purchases backgrounds were shown through a slide presentation.

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

Information Items:

Access to Primary Care

Primary Care is the centerpiece of our population health strategy. It is essential for success in a managed care and ACO environment Hence HHC strategy to move to PCMH model and then improve access.

Since 2013, HHC has made sustained access improvements access improvement strategies have been implemented at all adult medicine and pediatrics practices at our 17 major ambulatory facilities, and at 175 practices in total.

In adult medicine, HHC-average appointment wait for new patients dropped from ~55 days to under 30 days, with ~40% of our sites currently under our 14-day target. In pediatrics, average appointment wait for new patients has dropped from ~14 days to ~8 days, with ~65% of our sites currently under our 5-day target.

Graphs demonstrated:

HHC-wide Access performance: Days to Third Next Available Appointment – Adult Medicine/Pediatrics: New patient appointment wait time and Revisit appointment wait time.

Patient satisfaction: Overall patient satisfaction across HHC facilities is rated the lowest based on National PG average - Adult Medicine Primary Care

Moving the Needle" on Access Performance?: Typical improvement journey: "Quickest wins"- Schedule Optimization; Second wave of improvements – Schedule Optimization, Improve no-show rates and increase clinic throughout; Align supply and demand (or plateau) – Demand management

Primary care access gap and strategies to meet the need

The access gap/need (Demand)

1. Meet needs of existing patients who face long appointment waits
2. Serve unmet demand – like newly insured who are not yet patients
3. Transition reduce-able ED visits to primary care setting

Strategies to meet the need (Supply)

1. Strengthen organizational capabilities to measure and improve access
2. Unlock capacity by optimizing scheduling practices, and route patients intelligently to places with more capacity
3. Add capacity through targeted hiring or community partnerships

1. *In adult medicine, access gaps lead to a reduced ability to see patients in clinic, suggesting a need for additional capacity.*

Adult Medicine Primary Care: Appointment wait time in days - 14 day target

2. *Fill rate analysis indicates that some of this capacity need can still be captured through operational improvements: Adult Medicine Primary Care – Fill rate (utilization of allocated clinic time) – 85% target*

Our immediate gap in meeting current patient needs can be addressed through a combination of "unlocking" and "adding" provider FTE

Provider capacity additions must be accompanied by appropriate PCMH care team staffing

Next steps

For sites that can unlock more capacity:

Plan to improve Fill Rate and Ensure that Coach & Breakthrough resources are being deployed to support this effort

For sites that need to add capacity:

Develop a capacity expansion plan that includes:

Validating existing provider clinical capacity

Assessing the number supporting care team staff needed (RN, PCA, Clerks)

Expanding capacity within existing space using after-hours and weekend sessions

Checking whether existing spaces can be converted to exam swing rooms

Checking whether other space exists in the facility for potential expansion

Assessing the remaining capacity need to be addressed through community partnerships

Strategic Planning Committee – April 14, 2015

As reported Josephine Bolus, NP

Senior Vice President Remarks

FEDERAL UPDATE

Sustainable Growth Rate (SGR – "Doc Fix"): House Passes Bill 392-37, Senate Action Needed

Ms. Brown reported that, on March 27, 2015, legislation concerning the SGR or "Doc Fix" had passed the House of Representatives by a wide margin of 392-37. Ms. Brown explained that the legislation, H.R.2, represented a bipartisan, negotiated agreement between Speaker John Boehner and Minority Leader Nancy Pelosi and their respective leadership teams. She reminded

the Committee that the latest SGR patch was set to expire on March 31, 2015 but that the deadline had been extended until mid-April to allow the Senate to pass legislation following their return from Easter Recess. Ms. Brown reported that the total cost of H.R.2 is estimated to be \$214 billion over 10 years, with approximately \$142 billion added to the deficit. An estimated \$72 billion of this funding would be generated from either revenue raising "payfor" policies or cuts to beneficiaries. In addition, the hospital community will not be on the defensive each year as it has been since 1997 to come up with "offsets" to finance what had been a yearly ritual of "fixing" the SGR.

Key provisions of H.R.2:

The H.R. 2 bill proposes a transitional 0.5% Medicare payment update for physicians for 5 years and will freeze pay in fee-for-service for the next 5 years, while they move towards a value-based, performance-based system and away from a volume-based, fee for service system

- The bill proposes that, starting in 2019, to move to the current pay for performance programs in fee-for-service Medicare with a new "Merit-based Incentive Payment System" that starts with four percent and increases to nine percent of physician pay that is at performance risk
- Also in 2019, it is proposed that physician who participate in two-sided risk alternative payment models, such as ACOs, get a five percent bonus
- It proposes to extend the Children's Health Insurance Program (CHIP) for two years
- Delays Medicaid DSH cuts until FY 2018. The House legislation also includes changes to the current schedule and amount of Disproportionate Share Hospital (DSH) cuts. Current law has DSH cuts starting in FFY 2017 and extending through FFY 2024. The proposed House legislation would postpone the initiation of the DSH cuts until FFY 2018 and extend the DSH cuts through FFY 2025 with more aggressive reductions in funding over the last three years, than what is in current law.
- Extends the delay of the Medicare "Two-Midnight Rule" until September 30, 2015
- Provides \$7.2 billion in funding for FQHCs

Ms. Brown stated that, as a result of the advocacy by the hospital community, two possible cuts that were of great concern to HHC - reductions to Hospital Outpatient Department (HOPD) payments and cuts to Graduate Medical Education-Indirect Medical Education (GME/IME) - were not included in H.R.2. In prior "doc fix" proposals, there have been proposals to make HOPD payments site neutral, which would have cost HHC an estimated \$19 to \$23 million per year; and proposed 10 percent reduction in IME payments which would have cost HHC \$10 million per year. The House bill delays implementation of the Medicare Two-Midnight Rule until FFY 2016. Implementation of this rule would have cost HHC an estimated \$23 to \$38 million in Medicare revenue each year.

HHC ACO Coding Issue

Ms. Brown reported that a Centers for Medicare and Medicaid Services (CMS) rule, finalized in early 2014, had resulted in unintended consequences for HHC's six Elected Teaching Amendment (ETA) hospitals. The six ETA hospitals – Bellevue, Woodhull, Kings County, Queens, Jacobi and North Central Bronx – will no longer have many of the patients they serve counted toward their Accountable Care Organization (ACO) numbers due to a coding change. In addition, on April 1, 2015, this anomaly will result in these patients being automatically reassigned to other entities. Ms. Brown informed the Committee that HHC is requesting that CMS correct this error in applying the Medicare Shared Savings Program (MSSP) beneficiary assignment methodology to these HHC hospitals. A change in the CMS hospital outpatient billing requirements has rendered the majority of eligible patients under HHC's care "invisible" to MSSP attribution. An updated methodology is urgently needed in order for ACOs that include Elected Teaching Amendment (ETA) facilities to continue their participation in the MSSP. Ms. Brown explained that ETA hospitals received reasonable cost basis for direct medical and surgical services for their physicians in lieu of Medicare fee-for-service schedule payments.

Ms. Brown informed the Committee that HHC has contacted CMS' Acting Administrator, Andy Slavitt, and Deputy Administrator, Sean Cavanaugh. HHC has also briefed the NYC Congressional Delegation. HHC has been notified that the "highest levels of management at CMS are reviewing the issue and it is now sitting in the General Counsel's Office for his consideration." Despite the Easter/Passover Recess, HHC continues to press the issue with HHS and CMS.

Ms. Brown added that HHC had established one of the best performing ACOs that treats a large number of the most vulnerable populations -- principally "dual eligible" patients. Using CMS metrics, HHC's ACO was among the highest performing Medicare Shared Savings Programs (MSSP) in 2013.

Ms. Brown explained that there was urgency to HHC's appeal since the New York State Department of Health and CMS had recently begun a Fully Integrated Dual Advantage (FIDA) demonstration program that would passively enroll Medicare-Medicaid beneficiaries into managed FIDA plans starting April 1, 2015. She added that, once patients are enrolled in FIDA, they would no longer be eligible for the ACO attribution. Ms. Brown informed the Committee that, two weeks ago, HHC was notified by NYS Department of Health that the 562 patients that had been manually extracted from the computer system would not be lost as the April 1 deadline loomed.

Reauthorization of James Zadroga 9/11 Health and Compensation Act

Ms. Brown reported that, activities have been launched in support of the reauthorization of the James Zadroga 9/11 Health and Compensation Act of 2010, which is set to expire during the current Congress. These activities include the following:

March 27, 2015:

Senators Kirsten Gillibrand of New York and Kelly Ayotte of New Hampshire announced the passage of an amendment to the Senate budget facilitating the renewal and extension of Zadroga by creating a deficit-neutral reserve fund allowing Congress to consider legislation that would continue to provide treatment and compensation for first responders and survivors of the September 11th terrorism attacks at the World Trade Center, the Pentagon and the Shanksville crash site. Passage of the budget amendment was a critical first step toward re-authorization.

March 30, 2015:

The City Council's Committee on Civil Service and Labor convened a hearing in support of a re-authorization resolution as submitted by Council Member Margaret Chin. Two stakeholder panels presented: one for Responders and the other for Survivors, as well as a Legislative panel with representatives from the offices of Congress Members Jerrold Nadler and Carolyn Maloney. The Survivor panel was comprised by members of HHC's Survivor Steering Committee, who were specifically acknowledged and thanked by the Civil Service and Labor Committee Chair, Daneek Miller, who stated he had never heard the community's perspective on how gravely they have been affected.

Prior to the full Council vote, which was scheduled on April 16th, Council Members Margaret Chin, Paul Vallone, I. Daneek Miller and other Council Members planned to publicly announce the resolution in a press conference on the steps of City Hall as a continued call to action for Congress to re-authorize Zadroga.

On April 8, 2015:

Dr. Joan Reibman, the Medical Director of HHC's WTC Environmental Health Center (WTC EHC), was asked to participate in a call with staffers of the Senate Health, Education, Labor and Pension (HELP) Committee to give an overview of the Survivor WTC Health Program alongside the Medical Directors of the Responder and the Fire Department who summarized their respective programs for the staffers. By educating the HELP Committee, as fully as possible, it is anticipated that committee members would help to engender continued bipartisan support for re-authorization and become advocates for its passage.

Today, April 14, 2015:

Representatives of HHC's WTC EHC's Survivor Program stood alongside Senator Gillibrand in a press conference as she and other legislators announced a Senate bill for re-authorization of Zadroga, which was anticipated to be quickly followed by introduction of a House bill by Representatives Peter King, Carolyn Maloney and Jerrold Nadler. An advocacy presence will be needed on Capitol Hill in the near future by the City, HHC, Fire Department and other WTC Health Program partners to ensure passage. HHC will rely as always on the leadership of the City in such endeavors.

The content of the bill being introduced remained the same as was originally approved in 2010 with the exception that the extended bill would support a permanent program without expiration and with budget-neutral funding sources. It will be exempt

from sequestration and will increase funding for the Scientific and Technical Advisory Committee to better administratively operate and to support scientific studies. It includes some minor technical corrections with a more major one establishing administrative costs to oversee the program to be funded by the program itself instead of through the general NIOSH budget (National Institute of Occupational Safety and Health) that is the immediate federal overseer of the program.

The City has pledged its full support of the bill and that all recent communications regarding re-authorization from any source - be it legislators, union representatives or WTC program advocates of any kind - has mentioned the Survivor population prominently and with parity to Responders, which was not always the case in the initial effort to pass a 9/11-related bill. That inclusion, along with what seems to be a more bipartisan approach than before, supports a cautious optimism that joint efforts to educate and advocate for the bill would result in passage of re-authorization of Zadroga within this calendar year but certainly before the closure of the current Congress.

Mr. Nolan, Board Member, asked if it would be more difficult for the bill to be reauthorized as the Republicans have taken control of the Senate. Ms. Brown responded by stating that the James Zadroga 9/11 Health and Compensation Act is a nationwide program. She reminded the Committee that there were first responders that came from all over the country to help after the 9/11 attack. As such, there are people living in upstate who are suffering the consequences of having been exposed to some of the elements as a result of 9/11. Ms. Brown added that it was a good thing that there are constituents beyond New York City and New York State who were impacted. There will be a great deal of focus on the national program, not the New York City or New York State program to engender the support from Senate Republicans for the bill. Ms. Brown highlighted that this was the reason why Senator Gillibrand did not do this alone, but in collaboration with other Senate colleagues outside of New York.

Ms. Brown stated that the other issue was that, at least in the informal conversations among Senate Health staff, there is recognition that they do not want this debate to be occurring as they are actively campaigning and to have the appearance that Republicans could be perceived as being unpatriotic and not supportive. There seems to be somewhat of a momentum on both sides of the aisle to try to get the reauthorization passed before January where things start up for the presidential election.

Information Item

Presentation: 2015-16 State Fiscal Year Budget Overview

Wendy Saunders, Assistant Vice President, Office of Intergovernmental Relations

Ms. Brown introduced Ms. Wendy Saunders, Assistant Vice President, and invited her to present an overview of the 2015-2016 State Fiscal Year Budget.

Ms. Saunders began her presentation by stating that the budget was on time for the fifth year. She stated that, although the Assembly did not pass the final budget bill until almost 3:00am on April 1, 2015, all parties declared the budget to be "on-time." In addition, it was not only the fifth consecutive on-time budget, but also the fifth in a row to hold increases in state spending to 2% or less for a \$142 billion budget. Ms. Saunders reported that the final budget increases overall spending by 1.7% and includes a significant \$1.3 billion increase in education spending, along with several education reform initiatives, which proved to be quite controversial. She added that another package of controversial reforms that had been included in the final budget was a series of changes meant to strengthen ethics oversight. Ms. Saunders noted that the final budget also spent a surplus of \$5.4 billion that resulted from settlements with major financial institutions. She informed the Committee that the funded items included:

- \$1.5 billion for Upstate Economic Development
- \$1.3 billion for the Tappan Zee Bridge and to stabilize the State Thruway Authority
- \$500 million for Broadband Access
- \$400 million over four years for Health Care Capital Projects
- A variety of smaller initiatives

Ms. Saunders reported that, in terms of Medicaid spending, the final budget included \$86.1 billion in Medicaid spending, a 3.6% increase over last year's Medicaid spending. Ms. Saunders stated that, while there was no inflationary increase or trend factor for Medicaid providers this year, the Legislature rejected the Governor's proposal to permanently eliminate the Medicaid inflation increase - known as the trend fact - but did extend the cut for two additional years through March 31, 2017. Furthermore, the Legislature rejected the Governor's proposal to make permanent the Global Cap on Medicaid spending, but allowed a one year extension (through March 31, 2017). The Global Cap will continue to include annual increases tied to the 10-year rolling Consumer

Price Index (CPI) with authority provided to SDOH to take actions to reduce spending if it appears Medicaid spending will pierce the Global Cap.

Ms. Saunders informed the Committee that providers will continue to be eligible to receive “Global Cap Dividends” for any savings that result if spending remained below the Global Cap. This initiative was first enacted as part of last year’s budget. Dividend payments are based on a calendar year – and the first dividend has not yet been paid. She commented that it was hopeful that dividend payments will be made sometime soon and would be continued into the future as well.

Ms. Saunders reported on some key issues that had also been discussed in the previously held Finance Committee Meeting. The first of these issues is the HHC Upper Payment Limit (UPL). Ms. Saunders reported that the final budget included language to modify the way the state distributes the Upper Payment Limit or UPL for HHC. Ms. Saunders explained that these technical changes were necessary to meet new federal requirements. With this change, HHC will soon receive more than \$1 billion in outstanding payments for services provided in 2011 through 2014.

The second issue is the voluntary hospitals’ outpatient UPL. Ms. Saunders commented that, although HHC wouldn’t typically be concerned about UPLs for voluntary hospitals, HHC was very pleased that the final budget created this new option. It is important to HHC because voluntary hospitals appear to have run out of “room” under the inpatient UPL, which would result in them receiving payments using federal Disproportionate Share Hospital (DSH) funding instead. Those payments would have reduced the DSH funding available for HHC. Ms. Saunders explained that, with the new budget provision, voluntary hospitals would receive up to \$339 million annually in outpatient UPLs, which would ensure the DSH funding would still remain available to HHC.

The third issue is Charity Care Funding through the Indigent Care Pools. Ms. Saunders reported that the final budget continues the methodology for distributing Charity Care funding for three years, including the gradual phase-in of changes enacted in 2012 to increase the proportion of the funding to hospitals that provide care to the uninsured, underinsured and Medicaid populations. These hospitals can also lose funding if caring for fewer uninsured, underinsured and Medicaid populations. Facility losses are capped at 10% in 2016, 12.5% in 2017, and 15% in 2018. Ms. Saunders stated that the Budget also continues to set aside one percent of funding for a financial assistance compliance pool.

Ms. Saunders reported that it was disappointing that the final budget does not provide the State Department of Health (SDOH) with the flexibility that SDOH was seeking to change the distribution methodology should the federal DSH cuts take effect as scheduled. As mentioned by Ms. Brown, Ms. Saunders emphasized that it now appeared that those cuts would be delayed again – until October 2018 – which would provide SDOH with some time to advocate for such change in a future state budget. Ms. Saunders added that without this change, these cuts would take effect next October. Ms. Saunders added noted that, while delaying these cuts was beneficial to HHC right now, when implemented, these cuts would be detrimental to HHC as HHC would be hit hard with the first cut.

Ms. Brown added that it is never too early to begin the conversations. Ms. Saunders agreed and added that we would continue to have these conversations. Mr. Nolan asked if the problem is the Legislature, the Governor, or a combination of both. Ms. Saunders answered that the Legislature was not inclined to give flexibility to the Governor to make changes without coming back to them. She explained that the Governor’s proposal was for SDOH to be able to make administrative changes without coming back to the State Legislature. Ms. Saunders explained that this proposal has not been implemented and that there had not been any change in current federal law.

Ms. Saunders continued her presentation and reported on the proposed new cuts in the State Budget. She reported that the Legislature had partially restored the Medicaid-Medicare Crossover cut proposed by the Governor, which would limit Medicaid payments for co-insurance for certain low income Medicare Beneficiaries who are also eligible for Medicaid. Medicaid will continue to make payments for Part C co-insurance claims but will only pay Part B co-insurance if the total amount billed for the service is equal to or less than what would have been paid under Medicaid. The impact on HHC is still to be determined. The statewide impact is estimated to be \$70 million.

Ms. Saunders reported that the Legislature rejected a proposal to limit billings to Medicaid Managed Care Plans for outpatient pharmaceuticals purchased under the 340-B program to the discounted 340-B invoice price. Providers participating in the 340-B program will continue to be able to bill Medicaid Managed Care Plans at an enhanced level.

Ms. Saunders informed the Committee that HHC was disappointed that the Legislature had also rejected the Governor’s proposal to reduce an assessment or tax on inpatient obstetrical care. The Executive Budget included a 45% reduction in this tax, but since that proposal was not adopted, the tax will remain unchanged.

Ms. Saunders reported that the final budget does include good news in the form of the restoration of two prior rate cuts: 1) the penalty on potentially preventable negative outcomes (PPNOs), which included both potentially preventable readmissions and complications. This should increase reimbursement for HHC by approximately \$4 million; and 2) the across-the-board rate reductions on inpatient obstetrical services. The benefit of eliminating this rate cut is being determined.

Ms. Saunders reported on the capital funding proposal that was included in the budget. She reported that the final budget allocates \$1.4 billion in new capital funding in the following manner:

- \$700 million for Central and East Brooklyn
- \$300 million for Oneida County
- \$355 million for rural communities
- \$19.5 million revolving loan fund for the Primary Care Development Corporation (PCDC)

Ms. Saunders explained that these funds are discretionary and do not need to be competitively bid. She highlighted that the largest allocation of this new funding is for Central and East Brooklyn. The \$700 million in grants will be available for hospitals, nursing homes, diagnostic & treatment centers, primary care providers and home care providers with the goal of replacing, as quoted in the Budget, “inefficient and outdated facilities as part of a merger, consolidation, acquisition or other significant corporate restructuring activity intended to create a financially sustainable system of care.”

Ms. Saunders reported that SDOH will reissue a \$1.2 billion DSRIP-related Request for Applications from 2014. She commented that HHC was pleased to see that applicants are expected to engage the community and would be evaluated based on how community engagement shaped the project. She added that HHC is also pleased that a requirement was added to take into consideration the extent the project would benefit Medicaid enrollees and uninsured individuals. There is a new requirement that funds be awarded regionally in proportion to the applications received. HHC will need to resubmit its application, which was designed to support DSRIP-related projects. There is a prohibition on submitting projects for both this funding opportunity and the new \$1.4 billion capital funding opportunity.

Hospitals

Ms. Saunders reported that HHC’s biggest disappointment in the State Budget concerned the Vital Access Provider (VAP) funding. Ms. Saunders explained that, although the final budget increases VAP funding by \$245 million and targets it to providers in a manner similar to the Interim Access Assurance Funds (IAAF), HHC will not be eligible for this funding. At the last minute, language was added to the final budget that specifically excluded public hospitals operated by public benefit corporations, including HHC. HHC is working with the State to change this prohibition so that HHC could benefit from this funding. However, as it stands right now, HHC will no longer be eligible to receive that funding.

Ms. Saunders reported that HHC should benefit from the \$91 million Quality Improvement Incentive Pool. She informed the Committee that this new program that is designed to incentivize quality improvement in hospitals. She explained that, while initially, the funds are likely to be distributed proportionately to hospitals as non-competitive grants, eventually the program will be based on performance on various quality measures.

Ms. Saunders reported that HHC was pleased that the Excess Medical Malpractice Program was extended with the same eligibility requirements until June 30, 2016. She added that the final budget does not include a policy proposed by the Governor, which would have required physicians to be cleared through the State Tax Department before they could participate in the program.

Lastly, Ms. Saunders reported that the Budget included a change that would alter the notice that SDOH must provide before implementing Medicaid rate changes for hospitals. She added that, while the Governor had originally proposed to eliminate this requirement altogether, the Legislature had instead agreed to reduce the timeframe from 60 to 30 days.

Long Term Care

Ms. Saunders reported on the Long Term Care related provisions of the State Budget. Ms. Saunders stated that the final budget extends the nursing home reimbursable cash receipts assessment through March 31, 2017, along with a four year extension of Home Care Episodic Payments for certified home health agencies. Ms. Saunders added that the final budget also included a new provision that requires Managed Care plans to standardize billing codes for claims for home and community-based long term care

and nursing home services starting on January 1, 2016. This universal coding is particularly important as patients are transitioning to Managed Care and there are varieties of different Managed Care plans using different kinds of billing codes and systems that are very difficult for providers to keep track of. This standardized billing code will be very helpful.

Ms. Saunders reported that the final budget includes a Hospital-Home Care-Physician Collaboration Program. This new voluntary program will allow hospitals, home care agencies, physicians, nursing homes, payers and other providers to design new initiatives to facilitate innovation to improve patient care access and management, health outcomes and cost effectiveness. SDOH can make rate adjustments and provide regulatory waivers to support projects related to care transitions, improving clinical pathways, increasing the use of telehealth/telemedicine and physician house calls for home-bound patients.

Lastly, Ms. Saunders reported that a proposal to allow a new category of licensure for advanced home health aides was not included in the final budget.

Other Issues in the State Budget

Ms. Saunders reported that the final budget continues to provide \$54.4 million for uncompensated care in diagnostic and treatment centers. This does not contain a “reserve fund” to address any possible loss of federal funding due to new outcome requirements being proposed by the Centers for Medicare and Medicaid Services (CMS). However, SDOH is confident that it would get a one-year extension of the current waiver covering this funding.

Mrs. Bolus commented that her understanding regarding the conversion of HHC’s D&TC’s into a Federally Qualified Health Center (FQHC) was to generate more revenue. She asked if that would still be the case. Ms. Brown responded affirmatively. She explained that this was a separate issue related to indigent care funds that the state provides. She added that this issue is still important to HHC as HHC would still receive approximately \$18 million from that pool. Ms. Brown highlighted that HHC’s Gotham strategy would generate an additional \$30 million from reimbursement for being an FQHC look-alike entity.

Ms. Saunders reported that the final budget allows SDOH to implement the Basic Health Plan (BHP). She explained that the BHP will be available immediately for certain immigrants receiving state-only Medicaid pursuant to the Aliessa lawsuit. On January 1st, New Yorkers with incomes up to 200 percent of the federal poverty level who are eligible for coverage through the New York State of Health Exchange (the State’s Health Insurance Exchange) will begin to obtain their coverage through the Basic Health Plan. HHC is pleased that this new program will maintain or expand coverage for low income New Yorkers.

Ms. Saunders reported that the final budget includes a new statutory requirement for Performing Provider Systems (PPS) to establish and maintain Project Advisory Committees (PACs) to consider and advise the PPS on system operations, service delivery issues, elimination of disparities, measurement of project outcomes and goals, and development of plans and programs. Ms. Saunders explained that the PAC must be representative of the community served by the PPS and must include Medicaid consumers attributed to the PPS. Since HHC’s PAC already includes consumers, this should not require any changes.

Ms. Saunders also reported that the Legislature had rejected the Governor’s proposal to implement a new assessment on health plans to support the continued operations of the New York State of Health Exchange. Instead, the Exchange will be funded through existing Health Care Reform Act (HCRA) resources.

Items Not Included in Final Budget

Ms. Saunders concluded her presentation by highlighting other budget proposals that were not included in the final budget:

- *Private equity pilot proposal:* The Assembly once again rejected the Governor’s proposal to allow business corporations to provide capital investment in health care facilities. This is the third time the Governor included a similar proposal.
- *Limited services “retail” health clinics and urgent care centers:* As with the private equity proposal, the Legislature also rejected changes to license limited service clinics and require full accreditation of urgent care providers.
- *Certificate of Need (CON) changes:* For the third year, the Legislature rejected changes to streamline the CON process. It is anticipated that this may be taken up later in the Legislative Session.

- *Audit of Resident Work Hours:* The final budget once again rejected the proposal to eliminate the requirements that hospitals report to SDOH on working hours for residents. SDOH will continue to be required to perform an annual audit of hospitals regarding compliance with state regulations related to working conditions and limits.

Mr. Rosen, Board Member commented that the State's Medicaid spending was more than half of the State's Budget. Ms. Saunders responded that it was more than half of the State's budget including all funds. However, looking at State spending it is a little bit less, merely a third of the State-only funds.

Mr. Rosen asked if the \$142 billion was the total State Budget. Ms. Saunders answered that it only includes State funds. It does not include all the federal funds.

Mr. Rosen asked about the provisions of the Governor's proposal on "limited services retail health clinics and urgent care centers" that was not included in the final budget. Ms. Saunders responded that it would have required licensure and the establishment of new standardized rules that they all would have to meet in order to operate urgent care centers and restrict people's ability to hold themselves out as urgent care centers unless they have received approval from the State to do so among other requirements.

Mr. Rosen referred back to discussion concerning capital funding and asked if it was disclosed which hospitals in Brooklyn would receive \$700 million. Ms. Saunders responded that no specific hospital designation was made concerning these funds. She added that, originally it was just proposed for hospitals; however, the Legislature added other providers such as, nursing homes, diagnostic and treatment centers, primary care and home care. Ms. Brown informed the Committee that HHC would apply for these funds.

SUBSIDIARY BOARD REPORT

HHC Assistance Corporation-CSO - Thursday, April 23, 2015

- As reported by Dr. Ross Wilson

Old Business

Mr. Russo reported that in the December 2014 meeting of the New York City Health and Hospitals Corporation ("HHC") Board of Directors, the HHC Board of Directors had passed the resolution authorizing HHC to cause the CSO to provide technical assistance to the PPS in the capacity of a centralized service organization and to nominate from among the officers and senior managers of HHC the directors of the CSO, provided that the HHC President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of HHC provided further that such outside directors never exceed 25% of the total CSO directors.

New Business

Mr. Russo read an omnibus resolution providing that the number of directors of the CSO shall be 7, that the directors of the CSO shall be,

Ramanathan Raju, M.D.
 Antonio D. Martin
 Ross Wilson, M.D.
 Marlene Zurack
 Salvatore J. Russo
 Christina Jenkins, M.D.
 Michael A. Stocker, M.D.

That Dr. Ross Wilson shall serve as Chairman of the Board of the CSO, that Dr. Christina Jenkins be nominated to serve as President and Chief Executive Officer of the CSO. A motion was made and duly seconded to adopt the resolution.

The motion was unanimously approved. There was no further discussion of the motion.

At this point the newly elected directors of the CSO continued the meeting with a discussion of the status of the DSRIP program.

Dr. Christina Jenkins, Senior Assistance Vice President and Project Lead of HHC's DSRIP effort made a report. Dr. Jenkins discussed the background of DSRIP as a delivery system transformation program to reduce avoidable hospital use by 25% and to improve other health measures. Dr. Jenkins reported that the DSRIP reporting timeline started on April 1, 2015, though the OneCity Health Performing Provider System ("PPS") need to take the time to properly plan. Dr. Jenkins further reported on the structure of the PPS, which is a collection of community partners and organizations. HHC serves as the fiduciary of the PPS and governance structures. The PPS consists of 4 borough-based hubs which are designed to meet local needs. The governance structure of the PPS consists of an Executive Committee with HHC staff as a minority in headcount and partner representatives as a majority in headcount. There are 3 subcommittees that report to the Executive Committee – Care Models, Business Operations & IT, and Stakeholder & Patient Engagement. Each of the hubs will also have a Hub Steering Committee.

Dr. Jenkins stated that the CSO is a wholly-owned subsidiary of HHC, reports to HHC, and works in service to the entire PPS and partners, which also includes HHC. CSO services will help to support implementation of DSRIP programs across HHC and partner organizations. Mr. Russo clarified that the CSO Board reports to HHC as the fiduciary, the funds from the state go to HHC as the PPS fiduciary and then from HHC to the CSO for use in DSRIP and distribution to partners. All CSO employees are employees of HHC, and as such the CSO is subject to HHC policies.

Dr. Jenkins reported that the CSO is also in support of the PPS governance structure and provided details for the nomination of members to the governance committees, which involves a nomination process from partners followed by a standard application and interview process set forth by the PPS Executive Committee. A subset of the PPS Executive Committee, named the Nominating Committee, conducts the process and reports to the PPS Executive Committee.

The Board agreed that the next meeting will take place 8-12 weeks from April 23, 2015 and on a regular basis after.

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

RAMANATHAN RAJU, MD
HHC PRESIDENT AND CHIEF EXECUTIVE OFFICER
REPORT TO THE BOARD OF DIRECTORS
APRIL 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.

OneCity Health Update

I will begin my report with a brief update on the extensive work being done by our DSRIP Performing Provider System (PPS), OneCity Health.

The New York State budget approved on April 1 includes \$1.4 billion in new DSRIP-related capital funding. Partners can submit a request for either the new \$1.4 billion fund or resubmit for the original \$1.2 billion fund, but not both. We are seeking additional clarification and information from the state on these two funding pools.

The high-level, standardized clinical templates for each of our DSRIP projects are near completion. Kick-off meetings for each local hub planning team have been scheduled for early May.

During Phase 1 of partner contracting we will finalize and execute the OneCity Health Master Services Agreement. This agreement describes the roles and responsibilities of OneCity Health governance and operational entities as well as the general roles and responsibilities of our partners. We anticipate that the final Master Services Agreement will be sent to partners for review and signature in early May. In Phase 2 of contracting we will define project-specific roles and responsibilities, and we will enter into the discussions and contract negotiations about performance and financial terms.

OneCity Health has developed a tool called the Partner Readiness Assessment Tool, or PRAT, to develop an accurate and comprehensive understanding of our resources. Customized versions of the PRAT, to reflect specific partner services, will be sent to each attested Partner, with responses due back to OneCity Health by mid-May.

Sustainable Growth Rate (SGR) Passed by Congress and Signed into Law

Earlier this month, Congress passed and President Obama signed a repeal of the Medicare Sustainable Growth Rate (SGR). For 20 years, the SGR used a formula to limit physician payments under Medicare. Without legislation, Medicare payments to doctors would have been reduced by 21 percent on March 31st. Congress had delayed the reduction every year, often paying for it through reductions to hospital reimbursement.

Importantly for our corporation, other beneficial language was included in the bill that repealed the SGR. Specifically, the new law postpones the start of Medicaid Disproportionate Share Hospital funding cuts for one year or until 2018. However, it also extends and increases the DSH cuts through 2025. The originally scheduled 2017 DSH reductions to Health and Hospitals Corporation could have amounted to \$181 million.

The new law also extends the delay of Medicare's "two-midnight" rule until September 30, 2015. Implementation of this rule would have cost HHC an estimated \$23 to \$38 million in Medicare revenue each year.

Other provisions of the law include:

- Provision of \$7.2 billion in funding for Federally Qualified Health Centers,
- Extension of the Children's Health insurance Program for two years,
- Initiation of a program to shift the current pay for performance programs in fee-for-service Medicare with a new "Merit-based Incentive Payment System" that starts with 4 percent and increases to 9 percent of physician pay that is at performance-risk beginning in 2019.
- Institution of an initiative to provide a 5 percent bonus to physicians who participate in two-sided risk alternative payment models, such as ACO's, in FFY 2019.

Zadroga World Trade Center Health Reauthorization Introduced

Two weeks ago, a bill was introduced to re-authorize the James L. Zadroga Health and Compensation Act of 2010 (Zadroga), which funds HHC's World Trade Center Environmental Health Center. HHC's program, known as the Survivor Program, is designated to care for community residents, area workers, students and passers-by who were affected by the environmental effects of 9/11. This effort is being spearheaded by Senators Gillibrand and Schumer in the Senate and Representatives Maloney, Nadler, King, Velazquez and other members of the New York Delegation in the House. The goal is to pass the bill by the upcoming 14th anniversary of 9/11 or by the end of this calendar year.

It's important to note that HHC's current program is fully funded until December 31, 2016. Future funding depends on reauthorization. Language in the reauthorization bill remains largely the same. The critical differences are that the bill would create a permanent program, with budget-neutral funding sources and the program would be exempt from sequestration.

Mayor de Blasio released a statement of New York City's support of the legislation, including continuation of funding for 10 percent of the total cost.

HHC's World Trade Center program has 8,300 patients enrolled with approximately 100 new enrollees each month. They share conditions such as post-traumatic stress disorders, respiratory diseases, gastrointestinal disorders and cancers. In many cases patients will require care and treatment for the rest of their lives.

On behalf of HHC and the thousands of patients who will need care for their 9/11-related conditions well into the future, HHC thanks Senators Gillibrand, Schumer, Kirk, and Murkowski, as well as Representatives Maloney, Nadler, King and other members of Congress for their leadership on this critical legislation. I also want to thank the City Council, specifically Council Member Margaret Chin, for unanimously approving a resolution on April 16th in support of the reauthorization.

CMS Moves to Resolve HHC ACO Issue

In my report last month, I reported on an unintentionally problematic rule issued by the Centers for Medicare and Medicaid Services (CMS). The rule would have resulted in coding issues for our Accountable Care Organization (ACO) and six of our hospitals -- Bellevue, Woodhull, Kings County, Queens, Jacobi and North Central Bronx -- whereby they would no longer have many of the patients they serve counted toward their ACO.

Recently, we heard positive news from CMS that they are working to resolve this issue, and once fixed, this will be retroactively effective. I want to thank CMS for their efforts to rectify this as well as members of the New York City Congressional Delegation who contacted CMS on our behalf.

I also thank the Commissioner of the New York State Department of Health and staff for their advocacy.

State Budget Adopted

The new State Budget includes some of HHC's priorities. Although staff gave a comprehensive overview at the Strategic Planning meeting, I do want to update you on a few key issues.

First, I am pleased to say that the final budget includes technical modifications to the way the State distributes the Upper Payment Limit (UPL) which were required by the Centers for Medicare and Medicaid Services (CMS). With these changes now in place, we should soon be receiving more than \$1 billion in outstanding payments for services provided from 2011 to 2014.

Second, although the methodology for distributing Charity Care funding was extended for three years, the State Health Department cannot make further changes without legislative approval. There are two more State Budget cycles during which we can seek changes to protect our Corporation from absorbing a disproportionate amount of federal Disproportionate Share Hospital (DSH) funding cuts.

And last, we were very disappointed that public hospitals are not eligible for new Vital Access Provider (VAP) funding that is available for struggling voluntary Safety Net hospitals. It appears that the State was concerned that there was not enough funding available in this allocation, but they have committed to work with us to find other ways to assist us.

With the Budget behind them, the Legislature returned from their spring recess last week. Our staff will be busy monitoring legislative activity and advocating on behalf of the Corporation until the Legislative Session ends in mid-June.

Deviations from Operating Procedures

I want to advise the board that I approved two deviations from our standard operating procedures.

Our launch of the Epic EMR system is a major strategic goal of the Corporation and we are committed to implementing it on time. To bring on a nationally reputable leadership team with Epic experience, we entered into a 15-month consulting agreement with Clinovations division of The Advisory Group for \$4,008,000 inclusive of all expenses. Clinovations is now on board with us and has started assessing the current state of the Epic rollout and establishing a strict schedule to assure the timely launch of the program.

I also approved a license to the Human Resources Administration (HRA) for space at Lincoln Hospital at no cost for the NYC ID Program. As you know, this is an important program for the City. HRA has paid all costs of adapting the site to the program. Currently, the program is up and running and is serving a steady stream of New Yorkers who are eager to obtain the identification cards being issued by it.

New York City Gives Strong Safe Sleep Message

As part of the City's "Safe Sleep" initiative, a press conference was held at Harlem Hospital. I was pleased to appear there with the Deputy Mayor, and the Commissioners of Health, Administration for Children Services (ACS), and Dept. of Homeless Services (DHS), and several mothers of babies born at Harlem Hospital. As part of the program, our hospitals will expand our already robust safe sleep education beyond the prenatal care and post-partum units, displaying the new safe sleep campaign materials throughout our hospitals to help reach the broader hospital community.

New Chief Medical Officers in Jacobi, North Central Bronx and Metropolitan Hospitals

Recently, the health and Hospitals Corporation appointed new Chief Medical Officers in several of our facilities.

Dr. John Morley, has been appointed Chief Medical Officer of Jacobi Medical Center and North Central Bronx Hospital. Dr. Morley will oversee all medical staff and medical affairs for these two Bronx public hospitals serving over 150,000 combined patients each year.

Dr. John T. Pellicone was appointed Chief Medical Officer of Metropolitan Hospital Center. He will lead efforts to improve the patient experience, expand access, and continue providing excellent preventive care and chronic disease management to improve community health.

Congratulations to our hospitals for recruiting such outstanding doctors for these leadership positions.

Featured Program:

Asthma Care at the Health and Hospitals Corporation

One of the hallmarks of the Health and Hospitals Corporation is that over many years, we've done a great job of helping to control asthma in New York City. We embarked on a journey many years ago to battle this disease and we have achieved great results. Because we don't just treat asthma purely as a medical problem, we also treat it as an environmental and social issue.

Our social workers work effectively with care coordination to mitigate environmental factors that trigger attacks. For example, at Lincoln Hospital the Respirar program links medical services with environmental factors. Social workers visit patient homes and work to make sure that asthma-producing conditions are eliminated. This hands-on, socially conscious, patient-centric approach is what differentiates Health and Hospitals Corporation from other providers. We want to thank and congratulate Dr. Diana Weaver and Desire LaTempa, who have been doing phenomenal work on asthma care, and many other HHC clinicians and social workers who work to control this disease and create a healthier New York City.

Featured Individual:

Barbara Duckett, Volunteer, HHC Bellevue Hospital

It's Volunteer Appreciation month which is a good time to thank the 8,000 volunteers who donate 1,000,000 hours of their time each year.

Think of all the smiles, phone calls, classes, handshakes and connections that means for our patients. We are fortunate to have an outstanding and unique network of committed volunteers that help us to carry out our mission to deliver compassionate, quality care to all New Yorkers.

And none is more devoted than Barbara Duckett.

Barbara immigrated to New York from Jamaica in 1950, when she landed a job in the Radiology Department at Bellevue in 1959. That first job kicked off her amazing 50-year career in administrative positions at Bellevue.

Six years ago Barbara retired. She may have come off the payroll, but she certainly didn't leave Bellevue. Instead, she returns several days a week as a volunteer, where she is inspired by her personal motto "Don't Say No."

Barbara has logged 5,000 volunteer hours so far, visiting patients who appreciate a volunteer making them feel a little more at home. She also devotes much of her time to service as President of the Bellevue Daycare Center.

Last month she was named as Volunteer of the Year by Bellevue at a city-wide luncheon sponsored by the United Hospital Fund. We are delighted to take this opportunity to recognize Barbara Duckett, and so many other volunteers in our networks. We thank you for all you do, for never saying no when our patients are in need.

HHC In the News Highlights

Broadcast

East Village Building Collapses, NY1 News, Bellevue, Steven Alexander, Executive Director

Expert Sheds Light on Brain Aneurysms, News 12 Brooklyn, Kings County, Dr. Ali Sadr, Neurosurgeon

SNUG Program Expands to Soundview, News 12 Bronx, Jacobi: Dr. Noe Romo, Medical Director, Stand Up to Violence (SUV); Erika Mendelsohn, Program Director and Social Worker, SUV; Darius Covington, SNUG Member

Gouverneur Health Completes Modernization Project, - NY1 Noticias, Gouverneur: Martha Sullivan, DSW, Executive Director; Dr. Denise Infante, Pediatrician

Effects of Hookah Smoking, NY1 Noticias, Bellevue: Dr. Michael Weitzman, Attending Physician

VIP Talk Sessions Help Boost Brain Development, Bellevue: Dr. Alan Mendelsohn, Pediatrics and Population Health; Adriana Weisleder, Director, Bellevue Project for Early Language Literacy and Education Success

City's New HHC Leader Ready to Usher in New, Kinder Era, NY1, Dr. Ram Raju, President

Carbon Monoxide Safety Tips, WNBC, Bellevue, Dr. Raj Gulati, Chief of Emergency Medicine

NYC Launches "Safe Sleep" Campaign to Reduce Infant Fatalities, WNBC and WABC, Harlem, Metropolitan, Dr. Raju, HHC President, Harlem Hospital: Dr. Mary Marron-Corwin, Chair of Pediatrics

NYPD Officers Help Deliver Baby Boy in Brooklyn Apartment, WNBC, Woodhull

Help Me Howard battles Bellevue over \$11k in bills, WPIX, Bellevue

Dangers of synthetic marijuana, News12 Brooklyn, Woodhull: Dr. Robert Chin, Chief of Emergency Department

Jacobi offers monitoring device for patients with cardiac arrhythmia, News12 Bronx, Jacobi: Dr. Michael Grushko

Print

City's public-hospital system sets goals for improvement by 2020, Crain's New York Business, Dr. Ram Raju, President; MetroPlus

City Hospital head lays out ambitious vision, Capital New York, Dr. Ram Raju, President; MetroPlus

HHC 2020 Vision, Crain's Health Pulse, Dr. Ram Raju, President; MetroPlus

Paging Doctor de Blasio: New York City's Health and Hospitals Corp. needs emergency care for the mayor, Daily News, Dr. Ram Raju, President; MetroPlus

Letter to the Editor: BdB, M.D., New York Daily News. Dr. Raju, HHC President

50 Most Influential Physician Executives and Leaders 2015, Modern healthcare, Dr. Ram Raju, President

"Safe Sleep" initiative aims to end New York City infant deaths, New York Daily News, Harlem, Metropolitan

Lincoln Medical Receives "Baby Friendly" Designation, Amsterdam News, HHC, Lincoln, Harlem: Milton Nunez, Executive Director

The Bronx Free Press - Lincoln Baby-Friendly, HHC, Lincoln: Dr. Ronald Bainbridge, Associate Director of Neonatology

Gouverneur Health Completes \$257 Million Modernization Project, The Lo-Down, HHC: Dr. Ram Raju, President; Gouverneur: Martha Sullivan, DSW, Executive Director

NYC system appoints CMO for two Bronx hospitals, Modern Healthcare, Jacobi, NCBH: Dr. John Morley

NYC Health and Hospitals Corporation names Dr. John Morley CMO of 2 hospitals, Becker's Hospital Review, Jacobi, NCBH

Meet the 2015 New York/New Jersey Metro GEM Awards finalists, Nurse.com, Lauren Johnston, HHC Chief Nursing Executive

Op-Ed: Past 50? It's Time to Get a Colonoscopy – Don't Put Your Health At Risk,

- Courier Life: Coney Island: Dr. Francis Steinheber, Director of Gastroenterology
- Queens Times Ledger: Elmhurst Hospital: Dr. Joshua Aron, Gastroenterologist
- Bronx Times Reporter: Lincoln: Dr. Sulaiman Azeez, Chief of Gastroenterology

Extended Enrollment Period for Affordable Care Now in Effect, Norwood News, MetroPlus: Seth Diamond, COO

Jacobi offers modern cardiac monitoring device, Bronx Times Reporter, Jacobi: Dr. Michael Grushko, Attending Electrophysiology

A RESOLUTION AMENDING A PREVIOUSLY
ADOPTED RESOLUTION ON JULY 25, 2013 TO INCREASE
THE AUTHORIZATION FOR ONE OR MORE
BORROWINGS TO FINANCE VARIOUS CAPITAL PROJECTS
FROM AN AGGREGATE NOT TO EXCEED AMOUNT OF \$40,000,000 TO
A NEW NOT TO EXCEED AMOUNT OF \$60,000,000

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 Procedure”) relating to the delegation of certain powers for the incurrence of debt for 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 the Operating Procedure, have determined that it is necessary and desirable to increase the authorization previously approved by the Board of Directors on July 25, 2013 for the incurrence of debt for equipment financing from an aggregate amount from time to time not exceeding \$40,000,000, to an aggregate amount from time to time not exceeding \$60,000,000, 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 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 Procedure;

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 Procedure.

Section 102. Principal Amount. The incurrence of debt is hereby authorized in the aggregate principal amount of not more than \$60,000,000, from time to time, for the purpose of financing 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 Procedure.

Section 104. Authorization of Related Documents. The Corporation is authorized to enter into one or more debt contracts, such as loan 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.

Adopted: April 30, 2015 Board of Directors of the Corporation

April 14, 2015 Finance Committee of the Board of Directors

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation to execute a sole source contract for proprietary software licenses, maintenance and support services agreement with 3M Health Information Systems (3M) for the Coding and Reimbursement Information System installed at HHC's acute care hospitals, long-term care facilities and MetroPlus. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is \$13,510,101 which includes a contingency of \$643,338.

WHEREAS, the Corporation requires a new contract to continue its software license, maintenance and support services agreement in order to protect its investment in the 3M Coding and Reimbursement Information System; and

WHEREAS, 3M is the owner of the proprietary software and maintenance software and interfaces for which this agreement is required and, as such is the only source able to maintain the software in a timely, reliable, and efficient manner; and

WHEREAS, the Corporation continues to use 3M's Coding and Reimbursement System in daily patient record management and has invested in interfaces between 3M and the Corporation's two financial information systems in operation in 2015; and

WHEREAS, the Corporation invested significantly in Health Information Management employee training and education and upgrading 3M's Coding and Reimbursement System to prepare for ICD-10 implementation.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation to execute a sole source contract for proprietary software licenses, maintenance and support services agreement with 3M Health Information Systems (3M) for the Coding and Reimbursement Information System installed at HHC's acute care hospitals, long-term care facilities and MetroPlus. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is \$13,510,101 which includes a contingency of \$643,338.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (“the Corporation”) to purchase storage hardware, software, and associated maintenance from various vendors via Third Party Contract(s) to support the Epic implementation in an amount not to exceed \$13,220,000 for a one year period.

WHEREAS, the current EPIC installation upgrade to version 2015 requires the predicted additional storage capacity to support the virtual desktop environment for EPIC and to support several EPIC related application installations; and

WHEREAS, contractors able to provide the needed goods and services are available to the Corporation through the New York State Office of General Services and Federal General Services Administration (“Third Party Contracts”); and

WHEREAS, the Corporation is soliciting proposals from manufacturers and authorized resellers via Third Party Contract(s); and

WHEREAS, Third Party Contracts offer discounted pricing compared to the market price for such equipment; and

WHEREAS, the overall responsibility for managing and monitoring the agreement shall be under the Interim Corporate 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 purchase storage hardware, software, and associated maintenance from various vendors via Third Party Contract(s) to support the Epic implementation in an amount not to exceed \$13,220,000 over a one year period.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute Indefinite Quantity Construction Contracts (IQCCs) with two (2) firms: Vastech Contracting Corporation; and Rashel Construction Corporation, Inc.; (the Contractors"), that were pre-qualified through the HHC public bid process, to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$6,000,000. The total authorized value of these contracts is \$12 Million.

WHEREAS, the facilities of the Corporation may require professional construction services, such as, General Contracting (GC) services; and

WHEREAS, the Corporation has determined that such needs can best be met by utilizing outside firms, on an as-needed basis, through a requirements contracts; and

WHEREAS, the Corporation's Operating Procedure No. 100-5 requires approval by the Board of Directors contracts of \$3,000,000 and above; and

WHEREAS, the Corporation published a request for bids for professional GC services, bids received were publicly opened on December 16, 2014 and December 18, 2014 the Corporation determined that the Contractors are the lowest responsible bidders for these contracts; and

WHEREAS, the Contractors have met all, legal, business and technical requirements and are qualified to perform the services as required in the contract documents.

NOW, THEREFORE, be it

RESOLVED, the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute Indefinite Quantity Construction Contracts (IQCCs) with two firms; Vastech Contracting Corporation; and Rashel Construction Corporation, that were pre-qualified through the HHC public bid process, to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$6,000,000. The total authorized to be spent under these contracts is \$12 Million.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable license agreement with General Vision Services/Cohen Fashion Optical (the "Licensee") for the continued use and occupancy of space to operate optical stores on the campuses of Harlem Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center and Bellevue Hospital Center (the "Facilities") at an occupancy fee rate of \$58.00 at Harlem, \$36.00 at Lincoln, \$73.00 at Metropolitan and \$78.00 at Bellevue, for a total annual occupancy fee of \$104,318.00 to be escalated by 2.5% per year.

WHEREAS, in April 2010, the Board of Directors of the Corporation authorized the President to enter into a license agreement with the Licensee to continue to operate optical stores on the campuses of Harlem Hospital Center, Lincoln Medical and Mental Health Center, and Metropolitan Hospital Center, and Bellevue Hospital Center; and

WHEREAS, the Licensee provides optical services, including but not limited to filling new prescription eyeglasses, examining eyes, prescribing and fitting contact lenses, and selling contact lens supplies, and;

WHEREAS, the optical services provided by the Licensee's stores has benefited the patients and communities served by the Facilities.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with General Vision Services/Cohen Fashion Optical (the "Licensee") for use and occupancy of space to operate optical stores on the campuses of Harlem Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center and Bellevue Hospital Center (the "Facilities") at an occupancy fee rate of \$58.00 at Harlem, \$36.00 at Lincoln, \$73.00 at Metropolitan and \$78.00 at Bellevue, for a total annual occupancy fee of \$104,318 to be escalated by 2.5% per year.

EXECUTIVE SUMMARY

HARLEM HOSPITAL CENTER, LINCOLN MEDICAL AND MENTAL HEALTH CENTER, METROPOLITAN HOSPITAL CENTER & BELLEVUE HOSPITAL CENTER

LICENSE AGREEMENT GENERAL VISION SERVICES/COHEN FASHION OPTICAL

OVERVIEW: Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable license agreement with General Vision Services/Cohen Fashion Optical ("GVS/Cohen") for the continued use and occupancy of space to operate optical stores on the campuses of Harlem Hospital Center, Lincoln Medical and Mental Health Center, Metropolitan Hospital Center and Bellevue Hospital Center (the "Facilities").

**NEED/
PROGRAM:** In April 2010, the Board of Directors authorized the President to enter into a license agreement with GVS/Cohen to operate optical stores on the campuses of Harlem Hospital Center, Lincoln Medical and Mental Health Center, and Metropolitan Hospital Center. The optical services provided by the GVS/Cohen stores has benefited the patients and the communities served by the Facilities.

GVS/Cohen will provide optical services, including but not limited to filling new prescription eyeglasses, examining eyes, prescribing and fitting contact lenses, selling contact lens supplies.

TERMS: GVS/Cohen will be granted use and occupancy of a total of approximately 1,731 square feet of space at the Facilities (the "Licensed Space"). GVS/Cohen will pay a total occupancy fee of approximately \$104,318.00 per annum for its use and occupancy of space at the four sites. GVS/Cohen will pay an occupancy fee of approximately \$58.00 per square foot at Harlem, \$36.00 per square foot at Lincoln, \$73.00 per square foot at Metropolitan and \$78.00 per square at Bellevue. The occupancy fees will be escalated by 2.5% per year. The occupancy fees at each facility are the fair market value rate. The occupancy fee for each facility under the prior license agreement was calculated using the facility cost rate contained in Selected Cost Rates of Service Report. The fair market value rates used in the new agreement will ensure compliance with regulatory guidelines. The total annual occupancy fee using the fair market value rates is approximately 2% higher than the existing total occupancy fee. The Facilities shall provide hot and cold water, electricity, heating, air conditioning and routine security to the Licensed Space.

GVS/Cohen will indemnify and hold harmless the Corporation and the City of New York from any and all claims arising by virtue of its use of the Licensed Space and will also provide appropriate insurance naming each of the parties as additional insureds.

Page Two – Executive Summary
GVS/Cohen Fashion Optical

The license agreement will not exceed five (5) years without further authorization from the Board of Directors and shall be revocable by either party upon thirty (30) days notice. The license agreement shall contain one (1) five-year renewal option, which may only be exercised with authorization from the Corporation's Board of Directors.

Facility	Floor Area (sf)	Rate	Per Year
Harlem Hospital Center	100	\$58	\$5,800
Lincoln Medical & Mental Health Center	600	\$36	\$21,600
Metropolitan Hospital Center	700	\$73	\$51,100
Bellevue Hospital Center	331	\$78	\$25,818

VENDEX: Pending

Cohen Fashion Optical/General Vision Services

	<u>FY 13 Selected Cost Rate (psf)</u>	<u>Floor Area (sf)</u>	<u>Total</u>	<u>FMV (psf)</u>	<u>Floor Area (sf)</u>	<u>Total</u>
<u>Facility</u>						
Bellevue	\$55.90	331	\$18,502.90	\$78.00	331	\$25,818.00
Harlem	\$55.40	100	\$5,540.00	\$58.00	100	\$5,800.00
Lincoln *	\$62.23	600	\$37,338.00	\$36.00	600	\$21,600.00
Metropolitan	\$58.17	700	\$40,719.00	\$73.00	700	\$51,100.00
Total			\$102,099.90			\$104,318.00

* Decrease in rate is a result of change in calculation method.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year revocable license agreement with the Grace Foundation of New York (the "Licensee") for its continued use and occupancy of 5,700 square feet of space in the building designated #9 on the attached map (the "Isolation Building") to operate support programs for individuals affected by Autism Spectrum Disorder at the Sea View Hospital Rehabilitation Center and Home (the "Facility") with the occupancy fee waived.

WHEREAS, in October 2009, the Board of Directors authorized a license agreement with the Licensee; and

WHEREAS, over one million people in the United States have been diagnosed as having Autism Spectrum Disorder ("ASD"), a term used to describe a variety of neurological disorders; and

WHEREAS, the Licensee, a non-profit organization based in Staten Island, was established to improve the lives of individuals and families affected by ASD; and

WHEREAS, the Licensee's program located on the Facility's campus has allowed it to expand its community services which include recreation and social skill programs, in-home respite services, support groups, Medicaid services coordination and administrative offices; and

WHEREAS, the Isolation Building was built in 1932, was never renovated and the improvements made incident to the Licensee's program affect overdue repairs and reduce maintenance expenses; and

WHEREAS, City of New York has authorized a capital appropriation of approximately \$3,130,000, including \$1 Million in New York City Council funds for the Facility to finance improvements to the Isolation Building and the licensed space; and

WHEREAS, the City funding allows for improvements to the Isolation Building generally beyond just those parts used by the Licensee such as the replacement of the entire roof and all windows; and

WHEREAS, in conjunction with the funding for the licensed space, \$180,000 was approved to fund elevator upgrades that have been completed at the Robitzek Building and \$200,000 approved for road improvements on the Facility campus; and

WHEREAS, the Facility was not using the licensed space prior to the 2009 license to the Licensee and continues to be able to devote the space to accommodate the Licensee's program.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a revocable license agreement with the Grace Foundation of New York for its continued use and occupancy of 5,700 square feet of space in the building designated #9 (the "Isolation Building") on the attached map to operate support programs individuals with Autism Spectrum Disorder at the Sea View Hospital Rehabilitation Center and Home with the occupancy fee waived. Licensee shall have a with a five year option to renew upon the Corporation's Board's approval.

EXECUTIVE SUMMARY

LICENSE AGREEMENT THE GRACE FOUNDATION OF NEW YORK

SEA VIEW HOSPITAL REHABILITATION CENTER AND HOME

OVERVIEW: The President seeks authorization from the Board of Directors of the Corporation to execute a revocable license agreement with the Grace Foundation of New York (the "Grace Foundation") for its continued use and occupancy of space to operate support programs for individuals with Autism Spectrum Disorder ("ASD") at the Sea View Hospital Rehabilitation Center and Home ("Sea View").

**NEED/
PROGRAM:** In October 2009, the Board of Directors authorized the President to enter into a five year revocable license agreement with the Grace Foundation. The Grace Foundation is a non-profit organization based in Staten Island established to improve the lives of individuals and families affected by ASD. Over one million people in the United States have been diagnosed as having Autism Spectrum Disorder ("ASD"), a term which is used to describe a variety of neurological disorders. The rate of newly diagnosed children is 1 in 91.

The Grace Foundation has expanded its community services by establishing an operation on Sea View's campus that includes recreation and social skill programs, in-home respite services, support groups, Medicaid Services Coordination, and administrative offices. The Grace Foundation's goal is to enable individuals with ASD to lead independent and productive lives.

TERMS:

The Space: The Grace Foundation will be granted the continued use and occupancy of approximately 5,700 square feet in the building designated #9 (the "Isolation Building") on the attached map (the "Licensed Space"). The Isolation Building was largely unused by Sea View prior to the 2009 license to the Grace Foundation. Sea View had, and still has, no current need for the Licensed Space for its own operations.

The Isolation Building was constructed in 1932 and had never been renovated. In 2009, the Isolation Building was in such poor condition, it was not fully useable and Sea View was incurring ongoing maintenance expenses to prevent further deterioration. During the term of the 2009 license agreement, the Sea View made substantial renovations

to the space using approximately \$3,750,000 in capital funds provided by the City of New York City including \$1 Million in City Council funding.

Rent:
Benefits to
Sea View

The occupancy fee will be waived as it was during the prior term of the license in view of the benefit to the community of the program.

Sea View, however, has benefited from the license agreement in several ways. First, funding the improvements to the Isolation Building and the Licensed Space also motivated the City to fund \$180,000 for elevator upgrades at the Robitzek Building and \$200,000 for road repairs at the Sea View campus including around the building that will house the Grace Foundation. Second, important repairs to the Isolation Building funded by the City have benefited the Isolation Building generally including new windows throughout the building and an entire new roof. Third, the Isolation Building was in such poor shape prior to the 2009 License, that Sea View had to spend money to merely keep the building from further deteriorating whereas under the proposed license agreement, the building has been modernized and the Grace Foundation has assumed responsibility for its maintenance.

Services:

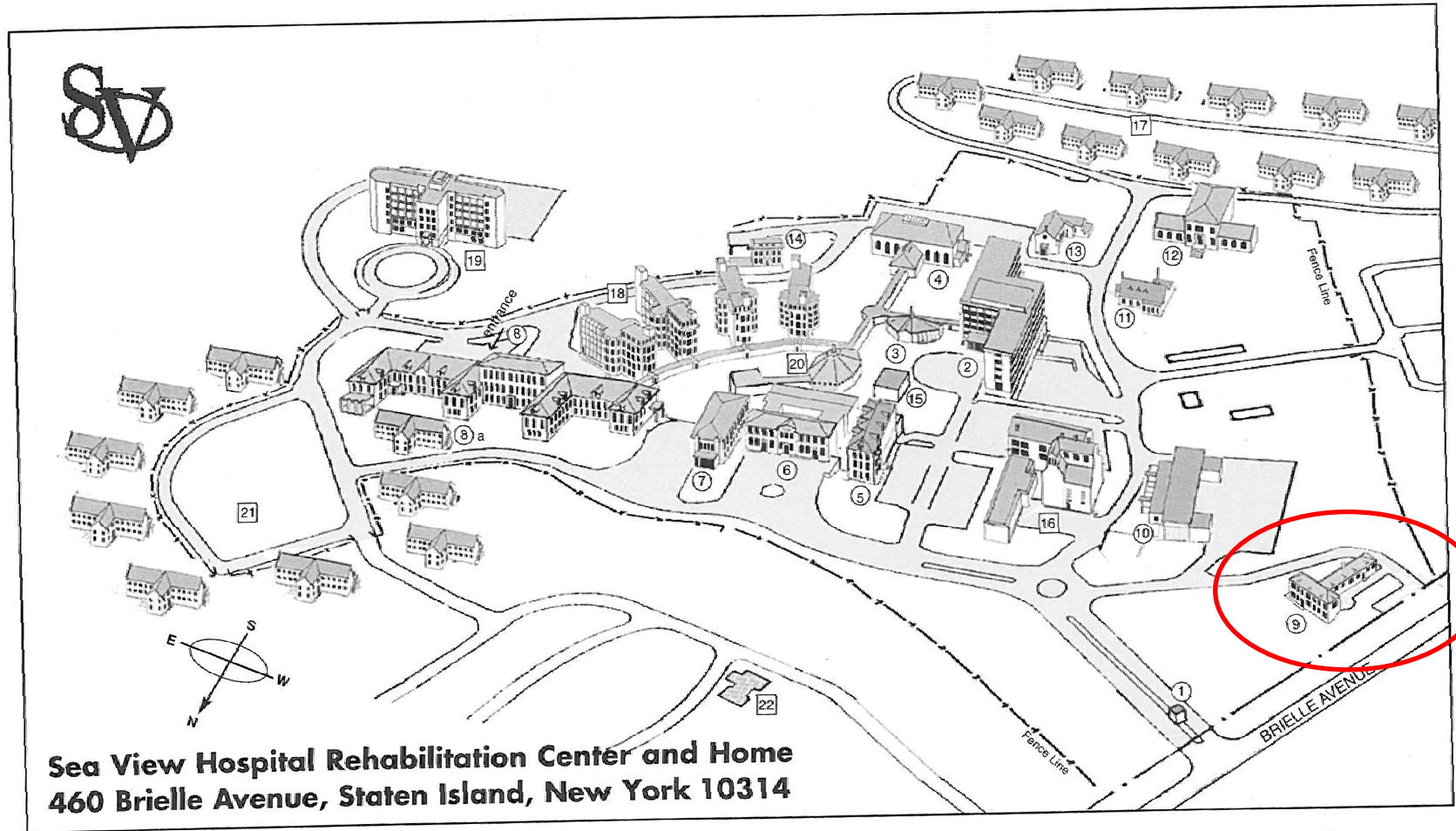
Sea View will provide electricity and gas to the Licensed Space. The Grace Foundation is responsible for providing maintenance for the Licensed Space and the surrounding grounds.

Insurance:

The Grace Foundation will be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of the use of the Licensed Space and will provide appropriate insurance naming the Corporation and the City of New York as additional insureds.

Term:

The license agreement shall not exceed a term of five years without further authorization by the Board of Directors of the Corporation and shall be revocable by either party on ninety days prior written notice. The license agreement shall contain an option to renew for an additional five year term which shall require approval of the Board of Directors prior to the option being exercised.



**Sea View Hospital Rehabilitation Center and Home
460 Brielle Avenue, Staten Island, New York 10314**

Occupied Buildings: ○

- 1. Gate House
- 2. Robitzek Building
- 3. Chapel
- 4. Colony Hall
- 5. Staff House
- 6. Administration Building
- 7. Surgical Pavilion & Sea View Medical Museum
- 8. Park Lane at Sea View senior housing.
- 8a. Park Lane at Sea View Cottage
- 9. Police Surgeon Building & Grace Foundation

- 10. FDNY / EMS / OCME
- 11. Sea View Playwrights Theatre
- 12. Camelot
- 13. Community Board # 2
- 14. Staten Island Ballet Offices and Studios
- 15. Power Plant Building

Unoccupied Buildings: □

- 16. Old Power Plant & Laundry Building
- 17. Men's Tuberculosis Dormitories
- 18. Women's Open Air Pavilions
- 19. Children's Hospital
- 20. Kitchen Building
- 21. Women's Tuberculosis Dormitories
- 22. Ruin of the Director's House

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to execute a five year license agreement with the Metropolitan Fire Association, Inc. (the "Licensee") for its continued use and occupancy of a 2,400-square-foot parcel located behind the "G" Building to conduct vocational training at the Sea View Hospital Rehabilitation Center and Home (the "Facility") with the occupancy fee waived.

WHEREAS, in July 2010, the Board of Directors authorized the President to enter into a license agreement with the Licensee to continue to conduct vocational training at Sea View Hospital Rehabilitation Center and Home; and

WHEREAS, since 1973, the Licensee has been providing this type of training to the Staten Island community; and

WHEREAS, the Licensee shall provide vocational training to those interested in pursuing careers as firefighters, police officers, or emergency medical technicians; and

WHEREAS, the Facility continues to have available space on the grounds behind the vacant "G" Building to accommodate the Licensee's vocational training programs.

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 license agreement with the Metropolitan Fire Association, Inc. (the "Licensee") for its continued use and occupancy of a 2,400-square-foot parcel located behind the "G" Building to conduct vocational training at the Sea View Hospital Rehabilitation Center and Home (the "Facility") with the occupancy fee waived.

EXECUTIVE SUMMARY

LICENSE AGREEMENT METROPOLITAN FIRE ASSOCIATION, INC.

SEA VIEW HOSPITAL REHABILITATION CENTER AND HOME

The President seeks the authorization of the Board of Directors of the Corporation to execute a revocable license agreement with Metropolitan Fire Association, Inc. ("Metropolitan Fire") for its continued use and occupancy of space to conduct vocational training at Sea View Hospital Rehabilitation Center and Home ("Sea View").

The Metropolitan Fire Association, Inc. is a federally registered not-for-profit Corporation that was established in 1976 and is funded through grants and fundraising efforts. Their programs expose participants to the benefits of careers in firefighting, law enforcement, and emergency medical services. The programs also provide youth with an ethical framework which will help them make proper choices in life, boosts self-confidence, and increases the likelihood of success at school and work.

In the past 30 years, approximately 60 of their alumni have become firefighters, police officers, or emergency medical technicians.

Many of Metropolitan Fire's members are retired police officers or firefighters. They maintain a working relationship with the Fire Department of the City of New York and have assisted the Fire Department with starting similar programs citywide. They have also provided fire prevention training at various local schools.

Metropolitan Fire provides the use of its bucket lift equipment to Sea View for campus landscaping, provides painting of the fire hydrants, pull-boxes and flag poles, maintains the grounds behind the "G" Building and the access road, and has helped Sea View with fallen trees during storms, supplemented security on certain occasions, and responded during water main breaks. They also stand fire watch for Sea View.

Metropolitan Fire shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of the use of the Licensed Space and shall provide appropriate insurance naming the Corporation and the City of New York as additional insured parties.

The license agreement shall be revocable by either party on sixty (60) days prior notice, and shall not exceed a term of five years without further authorization by the Board of Directors of the New York City Health and Hospitals Corporation.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a five year revocable license agreement with the New York City Department of Education (the "Licensee") for its continued use and occupancy of 160 square feet of space at North Central Bronx Hospital (the "Facility") to operate a vocational training program with the occupancy fee waived.

WHEREAS, in April 2010 the Board of Directors authorized the President to enter into a license agreement with the Department of Education; and

WHEREAS, the Licensee operates a work/study vocational training programs staffed by a teacher and para-professionals, and the students participating in each program provide services within various Facility departments; and

WHEREAS, the Facilities have space available to continue to accommodate the Licensee's program requirements.

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 the New York City Department of Education (the "Licensee") for its continued use and occupancy of 160 square feet of space at North Central Bronx Hospital (the "Facility") to operate various training programs with the occupancy fee waived.

EXECUTIVE SUMMARY

LICENSE AGREEMENT THE NEW YORK CITY DEPARTMENT OF EDUCATION

NORTH CENTRAL BRONX HOSPITAL

The President of the New York City Health and Hospitals Corporation seeks authorization from the Board of Directors to execute a revocable license agreement with the New York City Department of Education (the "DOE"), for the continued use and occupancy of space to operate a program at North Central Bronx Hospital ("NCBH").

The DOE operates the Jeffrey Rapport School for Career Development at JMC. The program occupies approximately 160 square feet of space on the 15th floor of NCBH's Main Building. The program hours are Monday – Friday, 8:00 a.m. - 2:50 p.m. The three students participating in the program spend the majority of their day working in various facility departments. The students are overseen by one teacher and three para-professional who assist students in preparing resumes and job applications.

NCB will provide electricity, heat, air conditioning, routine maintenance, security, hot and cold water, and housekeeping services. The occupancy fee will be waived.

The DOE will 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.

VENDEX: Not required. DOE is a public entity.

RESOLUTION

Reappointing Bernard Rosen as a member of the Board of Directors of MetroPlus Health Plan, Inc., a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York ("MetroPlus"), to serve in such capacity until his successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

WHEREAS, a resolution approved by the Board of Directors of the New York City Health and Hospitals Corporation ("HHC") on October 29, 1998, authorized the conversion of MetroPlus from an operating division to a wholly owned subsidiary of HHC; and

WHEREAS, the Certificate of Incorporation of MetroPlus designates HHC as the sole member of MetroPlus and has reserved to HHC the sole power with respect to electing members of the Board of Directors of MetroPlus; and

WHEREAS, the Bylaws of MetroPlus authorize the Chairperson of HHC to select three directors of the MetroPlus' Board subject to election by the Board of Directors of HHC; and

WHEREAS, the Chairperson of HHC has selected Mr. Rosen to serve an additional term as a member of the Board of Directors of MetroPlus; and

WHEREAS, the Board of Directors of MetroPlus has approved said nomination;

NOW, THEREFORE, be it

RESOLVED, that the HHC Board of Directors hereby reappoint Bernard Rosen to the Board of Directors of the MetroPlus Health Plan, Inc. to serve in such capacity until his successor has been duly elected and qualified, or as otherwise provided in the Bylaws of MetroPlus.

EXECUTIVE SUMMARY

Mr. Bernard Rosen has served as Chairman of the Board of Directors of the MetroPlus Health Plan since it was established as a separate subsidiary and we are pleased that he has agreed to serve for a new five year term.

Mr. Rosen has been an HHC Board member since 1998 when appointed by Mayor Rudolph Giuliani. He sits on a number of subcommittees of the HHC Board, including the Finance Committee.

Mr. Rosen retired from New York City Government after 35 years of service. For 27 of those years, Mr. Rosen was employed by the New York City Office of Management and Budget (OMB) as a Senior Analyst, and rose through the ranks to First Deputy Director.

In addition to his role as a member of both the HHC and MetroPlus Board of Directors, Mr. Rosen remains very active in various public sector activities since his retirement from OMB. Mr. Rosen also spent time as a part-time consultant at the Metropolitan Transit Authority.

Mr. Rosen has been an outstanding Board member. In addition to his role as Chairman, he has served as an ex officio member of four of the Board's committees. His knowledge and commitment to the mission and vision of HHC and MetroPlus will continue to make him a valued member of the MetroPlus Board.