

<p><u>CALL TO ORDER - 4 PM</u></p>	<p>Dr. Barrios-Paoli</p>
<p>Call for a Motion to Convene in Executive Session</p>	
<p><u>Executive Session / Facility Governing Body Report</u> ➤ Harlem Hospital Center</p>	
<p>Semi-Annual Governing Body Report (Written Submission Only) ➤ Metropolitan Hospital Center</p>	
<p><u>OPEN SESSION – 5 PM</u></p>	
<p>1. Adoption of Minutes: October 22, 2015</p>	<p>Dr. Barrios-Paoli</p>
<p><u>Chair’s Report</u></p>	<p>Dr. Barrios-Paoli</p>
<p><u>President’s Report</u></p>	
<p>➤ Information Item: * Ambulatory Care Transformation Towards the Triple Aim Presenter: Ross Wilson, MD, Senior VP / Chief Medical Officer</p>	<p>Dr. Raju</p>
<p>>>Action Items<<</p>	
<p><u>Corporate</u></p>	
<p>2. RESOLUTION authorizing the President of the NYC Health + Hospitals to enter into a contract with CareTech Solutions, Inc. for Epic Service Desk Support in an amount not to exceed \$14,694,651 (includes a 7.5% contingency of \$1,024,673) for the contract term of five years with two one-year options to renew, at the Corporation’s exclusive option. (Med & Professional Affairs / IT Committee – 11/12/2015) EEO / VENDEX: Pending</p>	<p>Dr. Calamia</p>
<p>3. RESOLUTION authorizing the President of NYC Health + Hospitals to negotiate and execute a contract with McKesson Technologies Inc. to provide Radiology Integration and Practice Management Services for a period of three years with two, one-year options to renew, exercisable solely by NYC Health + Hospitals, in an amount not to exceed \$16,684,855, inclusive of all costs and expenses. (Med & Professional Affairs / IT Committee – 11/12/2015) EEO / VENDEX: Pending</p>	<p>Dr. Calamia</p>
<p><u>Coney Island Hospital</u></p>	
<p>4. RESOLUTION authorizing the President of the NYC Health + Hospitals to execute a five year lease agreement including one five year option with Harlene Realty Corporation for approximately 600 square feet of ground floor space at 2101 Mermaid Avenue, Borough of Brooklyn, to house the Women, Infants and Children Program (WIC Program) operated by Coney Island Hospital at a rate of \$16.66 per square foot, or \$9,996 per year to be escalated by 2.25% per year for a total rent amount over the five year initial term of \$52,280. (Capital Committee – 11/12/2015)</p>	<p>Ms. Youssouf</p>
<p></p>	<p>(over)</p>

<p><u>Various Facilities</u></p> <p>5. RESOLUTION authorizing the President of the NYC Health + Hospitals to execute an amendment to the existing Memorandum of Understanding (MOU) with the New York City Department of Information Technology and Telecommunications (DOITT) that permits the installation and maintenance of communication equipment at eight of the Corporation's facilities required for the operation of the City-wide Radio Network at no cost to DOITT to both expand the list of facilities at which DOITT equipment is sited to include Harlem Hospital Center, Metropolitan Hospital Center and Sea View Hospital Rehabilitation Center and Home and to expand the area at several Facilities for DOITT to use and the type of equipment to be installed and maintained. <i>(Capital Committee – 11/12/2015)</i></p> <p><u>Committee Reports</u></p> <ul style="list-style-type: none"> ➤Capital ➤Community Relations ➤Finance ➤Medical & Professional Affairs / Information Technology ➤Strategic Planning <p><u>Subsidiary Board Report</u></p> <ul style="list-style-type: none"> ➤HHC Accountable Care Organization (HHC ACO) ➤>>Old Business<< ➤>>New Business<< <p>Adjournment</p>	<p>Ms. Youssouf</p> <p> </p> <p>Ms. Youssouf Mrs. Bolus Mr. Rosen Dr. Calamia Mrs. Bolus</p> <p> </p> <p>Dr. Raju</p> <p> </p> <p>Dr. Barrios-Paoli</p>
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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals (the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 22nd day of October 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. Lilliam Barrios-Paoli
Dr. Ramanathan Raju
Dr. Mary T. Bassett
Dr. Gary S. Belkin
Mrs. Josephine Bolus
Dr. Jo Ivey Boufford
Dr. Vincent Calamia
Mr. Gordon J. Campbell
Ms. Anna Kril
Mr. Robert Nolan
Mr. Mark Page
Mr. Bernard Rosen
Ms. Emily A. Youssouf

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

Dr. Barrios-Paoli received the Board's approval to convene an Executive Session to discuss matters of quality assurance.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Barrios-Paoli reported that, 1) the Board of Directors, as the governing body of Coney Island Hospital,

received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report presented; 2) as governing body of Seaview Rehabilitation Center and Home, the Board received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report; 3) as governing body of Coler Rehabilitation and Nursing Care Center, the Board reviewed and approved its semi-annual written report; 4) as governing body of the Henry J. Carter Specialty Hospital and Nursing Facility, the Board reviewed and approved its semi-annual written report; and 5) as governing body of Renaissance Healthcare Network Diagnostic and Treatment Center, the Board reviewed its annual quality assurance plan and 2014 evaluation.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on September 24, 2015 were presented to the Board. Then on motion made by Dr. Barrios-Paoli and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on September 24, 2015, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

Dr. Barrios-Paoli updated the Board on approved and pending Vendex and reported that the calendar for the 2016 Board and committee meetings was included in the Board package.

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

John Levy, President, Base Tactical, provided the Board with a progress report on the status of capital projects and improvements related to ensuring the safety of patients and HHC facilities in an event like Superstorm Sandy. He highlighted FEMA's involvement in providing funds to HHC aiding in the completion of capital projects.

ACTION ITEMS**RESOLUTION**

2. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute an agreement with the Physician Affiliate Group of New York, P.C. (PAGNY) for the furnishing of staff required to provide physical and behavioral health services to inmates in the custody of the New York City Department of Correction and certain other individuals for two years, starting January 1, 2016 for an amount not to exceed \$192,843,453 with three, two-year renewal options exclusive to the Corporation; AND further authorizing the President to make adjustments to the contract amounts consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in payments to PAGNY in any fiscal year that exceed twenty-five percent of the not-to-exceed amount specified in this resolution.

Dr. Barrios-Paoli 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 negotiate and execute an agreement with Correctional Dental Associates (CDA) for the provision of dental health services to inmates in the custody of the New York City Department of Correction for three years, starting January 1, 2016 for an amount not to exceed \$13,413,150; AND further authorizing the President to make adjustments to the contract amounts consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in payments to CDA in any fiscal years that exceed twenty-five percent of the not-to-exceed amount specified in this resolution.

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

RESOLUTION

4. Approving the application for verification by the American College of Surgeons of Harlem Hospital Center as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and authorizing the President of the New York City Health and Hospitals Corporation, or his designee, to execute any and all documents necessary to verify trauma center designation for Harlem Hospital Center through the American College of Surgeons, Committee on Trauma.

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

RESOLUTION

5. Approving the application for verification by the American College of Surgeons of Jacobi Medical Center as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the

multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and authorizing the President of the New York City Health and Hospitals Corporation, or his designee, to execute any and all documents necessary to verify trauma center designation for Jacobi Medical Center through the American College of Surgeons, Committee on Trauma.

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

RESOLUTION

6. Approving the application for verification by the American College of Surgeons of Kings County Hospital Center as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and authorizing the President of the New York City Health and Hospitals Corporation, or his designee, to execute any and all documents necessary to verify trauma center designation for Kings County Hospital Center through the American College of Surgeons, Committee on Trauma.

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

RESOLUTION

7. Approving the application for verification by the American College of Surgeons of Lincoln Medical and Mental Health Center as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and authorizing the President of the New York City Health and Hospitals Corporation, or his designee, to execute any and all documents necessary to verify trauma center designation for Lincoln Medical and Mental Health Center through the American College of Surgeons, Committee on Trauma.

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

RESOLUTION

8. Approving the application for verification by the American College of Surgeons of Bellevue Hospital Center as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and authorizing the President of the New York City Health and Hospitals Corporation, or his designee, to execute any and all documents necessary to verify trauma center designation for Bellevue Hospital Center through the American College of Surgeons, Committee on Trauma.

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

RESOLUTION

9. Approving the application for verification by the American College of Surgeons of Elmhurst Hospital Center as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and authorizing the President of the New York City Health and Hospitals Corporation, or his designee, to execute any and all documents necessary to verify trauma center designation for Elmhurst Hospital Center through the American College of Surgeons, Committee on Trauma.

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

RESOLUTION

10. Authorizing the President of the New York City Health and Hospitals Corporation to use the 20 requirements contracts that were awarded for a two year term with three one-year options to

renew to purchase health information related professional IT consultant services as needed to meet non-Epic EMR related IT consulting needs for an amount not to exceed \$43 million for the initial two year term.

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

RESOLUTION

11. Authorizing the President of the New York City Health and Hospitals Corporation to enter into a **Cisco Enterprise License Agreement ("ELA")** through a Third Party Contract as part of the **LAN Migration/Network Infrastructure refresh project** in an amount not to exceed \$11,410,000 for a five year period.

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

RESOLUTION

12. Authorizing the President of the New York City Health and Hospitals Corporation to execute a **Memorandum of Understanding between HHC and the New York City Department of Investigation** to create an **Office of the Inspector General** for HHC under the authority and control of DOI to replace the existing office within HHC.

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

RESOLUTION

13. Authorizing the Executive Director of **MetroPlus Health Plan, Inc.** to negotiate and execute a contract with **Greenberg Traurig, LLC** to provide **legal services** for a term of three years with two 1-year options to renew, each solely exercisable by MetroPlus, at hourly payment rates which shall be the following: \$350 per hour for services performed by partners; \$325 per hour for services performed by associates with more than six years of experience; \$300 per hour for associates with three to six years of experience; \$250 per hour for services performed by associates with fewer than three years of experience; and \$150 per hour for services performed by a paraprofessional.

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

RESOLUTION

14. Authorizing the Executive Director of **MetroPlus** Health Plan, Inc. to increase the spending authority for the contract with **Milton Samuels Advertising Agency, Inc.** dated February 14, 2011, and to allocate additional funds for advertising for the fulfillment of the contract, for an amount not to exceed \$4,075,000 for the term which expires on February 13, 2016.

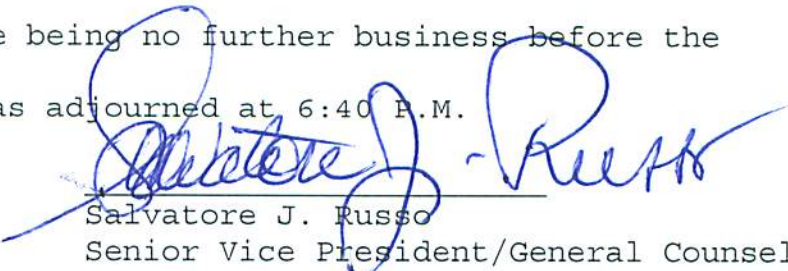
On the recommendation of Ms. Youssouf, Mr. Russo proposed that the resolution be revised to indicate that the authorization was to allocate additional funds in the amount of \$1.2 million. Rosen moved the adoption of the revised resolution which was duly seconded and unanimously adopted by the Board.

SUBSIDIARY AND BOARD COMMITTEE REPORTS

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

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:40 P.M.


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

COMMITTEE REPORTS

Audit Committee – September 17, 2015

As reported by Ms. Emily Youssouf

Mr. Chris Telano, Chief Internal Auditor, began with the summary of the audit report issued by the New York City's comptroller's office of the audit of the Lincoln affiliation agreement with PAGNY. We have spoken about this the last few meetings. The only reason it's still in the briefing is that it was issued in final about two weeks after our last meeting; nothing has changed. The same exact findings they noted on the draft reports regarding subcontractor agreements being paid without supporting documents and the recalculation document not completed timely and bank accounts for the faculty practice plan were not established timely by PAGNY. This report is closed and issued in final on June 19th.

At this point in time there are no ongoing audits being conducted by either the state or the city comptroller's office, so we have nothing else pending.

Mr. Telano said the completed audits that have been done since the last meeting in June, and the first audit is of the Mount Sinai affiliation within the Queens Health Care Network. He asked for the representatives to approach the table. Ms. Katrina Borruso introduced herself as the Security Officer for Queens Health Network.

Ms. Borruso stated that per this audit, we were given 17 personnel that were listed as active after 12 termination. Four of them were still active employees. Seven of them we were notified by the affiliation after they had separated. Two of them the corporate account manager was notified on a Friday. The corporate account manager is 18 not a 24 hour process. If they were notified Friday after four, they have a 72 hour turnover. They might not have gotten to it until Monday, Tuesday or even Wednesday.

Ms. Youssouf asked what a 72-hour turnover means. To which Ms. Borruso responded that there is a 72 hour turnover for responses from the corporate account manager. So if I submit a request to create or remove an account today they have up to 72 hours to process it.

Ms. Youssouf asked who sets the 72 hours. Ms. Borruso answered that that would be the corporate account manager.

Mr. Telano then asked if there were other representatives from Queens. Ms. Youssouf asked them to come to the table and introduced themselves. They did as follows: Brian Stacey, Network Chief Financial Officer; Ken Feifer, Associate Dean, Mount Sinai; Caryn Pannone, Finance Director, Mount Sinai; Lisa Stager, Network Deputy Chief Financial Officer.

Mr. Telano said that we will start at item B, and the findings are that, at the Queens Network 12 of 30 terminated employees still had active status to Group Wise, which is our email system. And of the 12, eight were at Elmhurst and four at Queens. One even logged into the system 30 days after their termination date. The second bullet point refers to ID cards in which we checked 15 ID cards at Elmhurst and 15 at Queens and 12 of the 15 at Elmhurst were not deactivated timely. While only one at Queens was not deactivated timely. Although that one was never deactivated and after 130 days it expired automatically.

Ms. Youssouf asked who is responsible at Elmhurst and Queens for the deactivation -- for these two matters. I'm trying to figure out what department it's in.

Ms. Borruso said that we are notified by the two HRs, Mount Sinai and HHC. They usually send an email to myself and to certain key individuals. Once I receive that email it is automatically forwarded with all pertinent information to the separation teams and the corporate account manager, where a ticket is opened for them to process the deactivation.

Ms. Youssouf asked who is the corporate manager and is that person here. Ms. Borruso answered no. Ms. Youssouf then asked if there is somebody that person reports to present.

Ms. Borruso answered that they are not Queens Health Network that they are corporate IT.

Ms. Youssouf then asked if Mr. Martin's group has 72 hours to do something with this information.

Ms. Borruso responded yes.

Ms. Youssef asked Mr. Martin if it is possible that when it comes to a deactivation, that that 72 hours could be changed to immediate. To which Mr. Martin responded absolutely, I will make sure that that happens now that I understand the process.

Ms. Borruso added that it is done by the corporate account manager but they are not a 24 hour operation.

Ms. Youssef said I think IT is a 24 hour operation. Mr. Martin added that it sure is.

Ms. Youssef stated that it is open 24 hours, there seems to be some confusion. To which Mr. Martin that he will take care of it.

Mr. Russo asked was there a timely transmission of the information to them. Ms. Borruso answered yes, for all but three.

Mr. Martin said let me be clear, you got the information right away? Ms. Borruso said correct, for all but three.

Mr. Martin then said that the fault is here.

Ms. Youssef asked if the three you did not submit was there any particular reason. Ms. Borruso answered that for the first time in five years I took a vacation and when I forwarded my messages there was a problem with the forwarding and so there was an overflow and they got delayed because of that. It was a mistake in my forwarding. I accidentally had it forwarding everything and the mailboxes got flooded and they were overloaded. That was my mistake.

Mr. Telano continued by stating that the other finding, A in our briefing, states that the recalculation document between Mount Sinai and the Queens Health Care Network was finalized on June 29, 2015 for the June 30, 2014 year end.

Dr. Boufford asked if this is causing us a problem or it isn't, therefore it's happening fairly routinely? Is there anything we should be doing or is it okay? Mr. Martin responded that I guess this is in my purview also. The recalcs have been a problem here. We had identified one other affiliate where there had been a number of years where the recalcs weren't done on a timely basis. We have corrected that issue, so that all of the recalcs for 2014 have been done. With the new affiliation contracts that we are putting in place, we are actually embedding a time frame for when the recalcs need to be done. We are actually trying to streamline the recalc process because it is a little onerous. We are quite aware of this being an issue and I think we are taking the appropriate steps.

Ms. Youssef asked what the time frame is. To which Mr. Martin responded that he believes its six months. I believe that's fair to the affiliate and to us for the recalc to be completed.

Mr. Youssef stated that the reason it's an issue is because it's been cited. Mr. Telano said that it's been cited previously in this audit and also in the city comptroller's as I mentioned before. They also cited it with the Lincoln affiliation.

Ms. Youssef added that because they've cited it, obviously the Corporation wants to correct it because it shouldn't happen. But if I could ask Ms. Zurack, to explain the process, the steps here.

Ms. Zurack said that pursuant to the contract the affiliate is supposed to prepare a draft recalc and submit it to the facility affiliation officer, which would be Ms. Stager in the Queens Network for example. Once the hospital concurs, it gets sent simultaneously to the Office of Professional Affairs (OPSA) and to finance. Then ultimately OPSA and finance check it. If there are mistakes they tell the hospital person. They go back to the affiliate and fix it, and when everyone agrees the numbers are correct, Mr. Martin and I sign it along with the Executive Director of the hospital and the recalc is done. It can result in money owed one way or another and change the payment amount.

Ms. Youssef asked is it necessary that it goes to OPSA. Ms. Zurack responded absolutely because of the separation of function. So, the truth is, I, as the corporate treasure for example, I would never sign something that Mr. Martin has not signed first; because you need that separation of function. Otherwise, I could be paying for something that he has not checked and that would not be correct. I think that the delay is, we have each affiliate and even in the same affiliate for each hospital they are doing their own worksheets and they are different, they are not standard. There is a level of detail that is required because of the way the budgets are set up. So, if you have overspending in one department and underspending in another that does not wash unless you do special paperwork to make it wash. In addition, some of the elements of the affiliation contract require data for the final settlement that actually could take longer than the six months we are putting in the contract. For example, this may be a bad example, I'm trying to fix this, some of the performance incentives you do not actually know how they performed until a certain period after the end of the contract year. Also, there are certain individual incentive payments for certain kinds of individual physicians that require a lot of data and sometimes those things kind of lag.

You want to have a process that is speedy. But also if you were audited by an outside party, you have to have this separation of function. You have to have everyone check it. And there are certain kinds of payment systems that require this data for all kinds of legal reasons that may require taking more time than the auditors may like. So, the solution really has to include making sure your contract terms are not so detailed that you're locked into a detailed recalc. So, if the contract terms says that Mount Sinai needs to show us by doctor every hour spent, then that's what they need to show us. There's no give on that. If the city Comptroller came in and we didn't check that we might not be cited for being late but cited for having it wrong. Which I think would be worse actually. So, I think while it may seem like skip a step or this that, it really means making the actual recalc standard across the Corporation. Not everyone doing their own form. Hopefully automated so that the data can just flow from a payroll system into a database as opposed to each person keying in. And hopefully not so detailed that you can't get the data for a very long period of time. For some of the contracts transitioning to that is a bit of a challenge but we are committed to doing that.

Ms. Youssouf said that one, is that we don't like to be cited, especially by an outside auditor for anything. That's why this is critical to change this. Secondly is that if in fact they owe us money, I don't know how often that happens, I don't mean this particular but any affiliate owes us money, if that ever happens, that in my mind means that we are providing basically a working capital line to them and we can't afford to do that for anybody frankly. So, that's why this does need to be fixed. And it sounds like you're in the process of putting all this together.

I would ask that you keep us informed, the committee, so we know when it sticks because this is not the only time this has risen obviously. Now you are working on it, I think it sounds like the appropriate fix.

Mr. Martin added that I guess the other thing I mentioned, instead of the back and forth between all of the different entities that need to be involved we are talking about doing it together so everybody sits down in a room and goes through the process. All of this back and forth we can just cut out some steps. We are committed to number one, first and foremost, protect the Corporation but also to get this done in a timely manner.

Ms. Youssouf asked that would anybody from the institution or anyone like to add something.

Ms. Borruso stated that I misspoke before of the 17, 7 we were notified after the employee had already separated from service. So we were not notified until after they had separated and five of them were still considered active employees. They were marked terminated but they were still active because they either came back as an HHC employee or switched from Elmhurst to Queens or Queens to Elmhurst.

Ms. Zurack: stated that typically this particular network does a really good job with the recalcs and has been as current as any of our networks have been. I don't know if this was a little slippage in this year but their track record has been very, very good as has been their affiliate in providing data. Sometimes you don't know the context when you see the audit. In terms of recalcs typically they have been current relative to the corporate average and so I think that we should take this in context.

Ms. Stager commented that one of the things, I know we were cited last year, we have put together the recalc process and had it paid within the fiscal year. What changed with this contract, and it contributed in this instance as well, is based off the additional language that went into the last contract. We were required to do an extensive amount of additional audit work. So once we get the recalc there is a lot of audit work on my part to validate the numbers that are showing up in the recalc that we did not in the past have to do as much of.

Ms. Youssouf asked if it was because there was a change in the contract language.

Ms. Zurack responded that my office insisted that they be a little stricter with their affiliate in terms of level of detail. So we upped the detail in the recalc. Because their detail used to be much less than the others. Their recalc went up to the other standard. I think they're still probably doing better than average but not doing as well as they used to do. And that's my point about time versus accuracy. There is a trade-off.

Ms. Youssouf stated that there is a trade-off but now that you know you have to do the detail -- I mean, this is not insurmountable. It should be able to be done all of these on time.

Mr. Telano continued with the agreement between the State University of New York and Kings County Hospital Center. He asked the representatives to approach the table and introduce themselves. They introduced themselves as follows: Michelle Emmons, Director; Leo Johnson, SUNY; Sheldon McLeod, COO; Dorene Lewis, Associate Director; Anthony Saul, Chief Financial Officer.

Mr. Telano said that the first issue is once again about the recalc. We don't need to discuss that any further.

Ms. Youssef stated that I'm assuming that all of the relevant parties are well aware you are working on a way to make it more cohesive all the way around.

Mr. Telano continued onto the other issue which was that two affiliate staffs were being paid without regularly submitting time sheets which would substantiate the times worked. One employee over a two-year period or even less did not submit their time sheet for 24 pay periods and the other employee did not submit their time sheet for seven pay periods.

Ms. Youssef asked could we have an explanation about why that occurred and what you're going to do to make sure it doesn't happen again.

Mr. Johnson responded that one of those employees is in the assimilation program. We physically don't see that employee at Downstate. That person actually works at Kings County. It's somewhat of a challenge to get a time sheet from that individual. The FT is 20-20, the salary is \$20,000. From my understanding the way the program works, the staff from Kings County goes to a facility in Manhattan and they train in some sort of assimilation program. That individual that is conducting a training, there's no schedule that you can tie him down to nine to five. It's sort of a challenge for us to get an accurate time sheet on that individual. Going forward we contacted the administrator and told him that we have to have time sheets for this individual. If not, we are going to remove him from the state payroll.

Mrs. Bolus asked if he gets his paycheck on time. Mr. Johnson answered that we could hold his paycheck.

Mrs. Bolus then stated that there's no problem with the paycheck. It's just putting in the paper to get the paycheck? You understand what I'm saying? If he has a method of getting a paycheck he has a method of getting us his time sheets.

Mr. Saul commented that this was a special program where we were working in conjunction with Jacobi. We had this one individual who was actually stationed at Kings and had rotating hours. We do have an assimilation center set up there, so physicians would come in to train there as well as at Jacobi. We have spoken jointly with Jacobi and with the program for that particular department to ensure that they submit the annexes to us timely so that we can incorporate it with the other annexes that we do receive from SUNY on a monthly basis.

Mr. Russo asked if this an HHC employee. To which Mr. Saul responded yes and Mr. Russo asked is he a union position.

Mr. Saul said it is a union position, this individual also has an appointment at Downstate. This actually allows us to facilitate this special program. It was really Downstate partnering with HHC and Kings to ensure this program.

Ms. Youssef said that this sounds like somebody else's responsibility. Mr. Saul said that it is our fault. It is our responsibility to change it.

Ms. Youssef commented that I think it is great somebody is working in assimilation and can do the special program. But I would urge you that that exists and that's wonderful, but as Ms. Bolus just said, if somebody is getting paid and nobody knows -- there's no record to show that he showed up, he's getting paid for what he did, it's really just not acceptable. I'm sure you can appreciate why because if it happens once people are afraid it happens more than once.

Mr. Martin added that that's exactly my concern. I need Mr. Saul to assure me that you are doing the adequate checks to make sure this isn't occurring elsewhere in your facility.

Mr. Saul said that we are.

Mrs. Bolus asked if he is getting paid just by us not by SUNY. To which Mr. Saul responded that for our portion it is a point two FTE. \$20,000 is the cap on what we pay. We do not look at the portion outside of our facility.

Mr. Russo asked if SUNY also paying him? Mr. Saul said that it is pass-through on our behalf.

Mrs. Bolus asked if he submits his pay vouchers to SUNY. Do they get it on time? Mr. Johnson responded that we have the normal state time sheets.

Mrs. Bolus then asked that he puts those in on time but ours he does not? To which Mr. Johnson answered right, yours he does not. Because yours has to be signed off on by a supervisor, and to lock in who's the responsible supervisor has been a challenge in the past.

Ms. Youssouf stated that to me is shocking that somebody does not know who their supervisor is for 24 months. Mr. Martin, we are believing that you are going to get a charge and whoever else is responsible to get your arms around this. I mean, this is something that could be incredibly problematic in many, many ways. We're paying someone and we have no record that they worked. I'm assuming everybody can appreciate that.

Ms. Zurack commented that the solution to the problem was that there was no one on-site at Kings to sign the time record because the activity was taking place at Jacobi. You have now made arrangements for Jacobi to sign the time records. The problem is solved for this individual, and you are going to make sure, Mr. Saul, that this is taken care of for the entire institution if there are any similar arrangements? Mr. Saul answered that that is right.

Ms. Youssouf thanked Ms. Zurack and thanked them for coming.

Mr. Telano continued and said that I just want to go through the rest of the briefing real quick. On page six is the audits in progress. You can see they are all affiliations. On page seven is just the status of our follow-up audits. I just wanted to note that our follow-up audit program is working. We have found since we implemented this a few years ago, 99 percent of the issues that were found originally were either partially resolved or resolved.

Ms. Youssouf said that the good news is that I know people hate to come to Audit Committee -- but that means the Office of Internal Audits is working because that's the point. You'd rather be here and having us say what's going on than having somebody from the outside, especially a regulatory authority, saying what's going on?

Mr. Telano commented that I would only bring someone back to the committee if we found that they did not take any action. So we have yet to bring anyone back.

Ms. Youssouf stated that this is all in saying that internal audit is your friend.

Mrs. Bolus said that on this sheet MetroPlus is behind six months. To which Telano acknowledged that we just have not gotten to the review yet. We are behind in some of our follow-ups. We have not done it. We will be doing it shortly. He then said that that concludes my presentation.

Ms. Youssouf then passed the presentation over to Compliance.

Mr. McNulty saluted everyone and said turn to section one paragraph one on page three of the corporate compliance report. This is a follow-up on an audit that took place by the Department of Health and Human Services Office of the Civil Rights in the first quarter of 2014. Since then we have responded with numerous documents to the Office of Civil Rights. The audit involved their review of Metropolitan's policies and procedures as it relates to limited English proficiency. And also the policies and procedures as it relates to the security and privacy of protected health 21 information. And actually when they look at the security and privacy of protected health information, because HHC is to cover any, they look at the entire Corporation. I want to provide the Audit Committee with an update. We have entered into a contract with a third-party vendor to provide a security risk analysis. The third-party vendor will provide infrastructure security and perimeter penetration assessment, application vulnerability assessment. They will also provide a risk analysis of all systems that house, store, process or transmit protected health information.

The timetable for the assessment to be performed by the vendor, they actually started this week, they performed their audit of central office. Of all facilities in central office, and today they are up at the North Bronx Health Care Network to perform a perimeter assessment. And they will be performing a risk analysis in Metropolitan sometime next week. We will have to report back to the Office of Civil Rights on a periodic basis.

On September 9th we received a letter from the Office of Civil Rights that they were closing this matter contingent on us following up with them on a periodic basis. They did have some recommendations with regard to our policies and procedures as it relates to limited English proficiency. We are going to meet internally to discuss those recommendations. We have a follow up phone call with the Office of Civil Rights at the end of the month to discuss those recommendations. We will brief the Audit Committee in October when we next convene to go through in detail what recommendation the Corporation will accept in regards to those recommendations.

Moving along to the privacy incidents and related reports. We received 22 complaints with respect to our HIPAA incident tracking system. Out of the 22 complaints, 11 were determined to be violations of the HIPAA operating procedures. Six were determined to be unsubstantiated. One was not a violation. And four were determined to be still under investigation. Out of the 11 violations, six were determined to be breaches of protected health information.

Please turn to the next page on page five, just briefly in paragraph three, you can see the definition of a breach, which is the impermissible use, access, acquisition and disclosure of protected health information that violates the privacy rule. Turn to page six. There are a couple of breaches I would like to go over with the committee. The first one occurred at Bellevue Hospital Center. There was a record that was released to the United States District Court. We received an order from a clerk of the court but not an order from the judge. So, Bellevue mistakenly thought that an order from the clerk of the court was the same as a court order but it's not. They released information back to the court. The patient complained to the Office of Civil Rights and the Office of Civil Rights contacted us. We instructed Bellevue to revise their policies and procedures with regard to that.

Ms. Youssouf stated that that's something I did not realize the difference, and I just want to be sure that perhaps all the facilities get reminded of that. That seems like a difference that not everybody would know.

Mr. Russo added that it is really a shame that our clerks who gets these things have to almost have a law degree. They're always encouraged to call our office if there is anything. That was such a nuanced difference. In terms of any harm or anything it was back to the court. It was a technical violation but that's really a close issue.

Mr. McNulty stated that we have policies and procedures in place that exist that make this clear. The other privacy offices throughout the facilities are aware of this and the Office of Civil Rights have on their website this distinction.

Ms. Zurack asked that if they had known what they should have done. Mr. McNulty responded that they should contact legal affairs, and legal affairs would need to quash the subpoena. Or probably just call the clerk and say to the clerk that can you please have a judge sign the court order. So then it would be an actual court order.

Mr. Russo said that the right procedure is to call us. To which Ms. Zurack said that I do not think they know that.

Mr. Wayne said that we can brief the facilities.

Ms. Youssouf said that I think that would be very helpful if you could schedule that. Mr. McNulty added that in this particular case it looked just like a court order.

Mr. McNulty continued and stated that there was another breach that I would like to briefly discuss. This occurred at Bellevue Hospital Center. This was a breach that occurred when the information was sent pertaining to protected health information to a case manager at a shelter. The shelter is not considered a health care provider under HIPAA regulations. Technically this is a breach of protected health information. So we will provide training and education with regard to the same.

If we can turn to page eight. The monitoring of excluded providers. We had one excluded provider out at Harlem Hospital. The individual worked in the OB-GYN department. He had privileges granted in January 2015. The affiliate PAGNY checked to ensure that he was not in fact excluded and they did a vendor check. However, the vendor did not pick up that he was excluded. Internally the medical staff office picked up that he was excluded but the individual that performed the check reported to their supervisor and the supervisor did not further escalate the situation. So the person was allowed to be brought on with regard to PAGNY. We learned about it in May or June at the same time as OMIG contacted us. It turns out that we're looking at \$85,000 that we have to give back. This was a unique situation as the provider was excluded in 1992. The provider had since had their license reinstated. The provider thought they were in fact off the exclusion list. In fact they were not on the exclusion list for Medicare just for Medicaid. In fact, once the provider wrote the Office of the Medicaid Inspector General within I would say in 10 or 14 days, they took the exclusion off. I believe he's back at Harlem Hospital Center. We performed a self-disclosure protocol to the Office of Medicaid Inspector General and we are awaiting direction with regard to the payment. We are hopeful that they will waive the payment in this particular case.

Ms. Youssouf said that what is important is that if you could just briefly say how you caught this. Because we have three checks.

Mr. McNulty said that we have a check that's performed by the affiliate. So the affiliate should not bring anyone under their contract that is excluded. Then the Medical Staff Office performs a check. Any time the individual has to be re-credentialed they have to do another check. Then there is a check that's performed at central office by my office. There's three checks. That redundancy normally works, but in this case the vendor didn't pick up the exclusion check. We did pick it up at Harlem but when it was escalated for whatever reason he was still brought on. By the time we picked it up at central office OMIG had picked it up at the same time. I think we have a good process in place.

Ms. Youssouf stated that that's what I was going to comment on because I believe we do have a good process. I think it's great. It's a shame it all happened but you knew when OMIG picked it up you were like yes, we were on it I think speaks well how you do this.

Mr. McNulty continued on to section four on page nine. I want to provide an update on the corporate-wide risk assessment. As I previously informed the Audit Committee, we have started our enterprise-wide risk assessment. We started this process in March as far as assessing all the different risks. Then in late July, in the first week of August, if you could turn to page ten, the middle bullet on page ten, bullet number two, we have met with all the compliance committees at the various networks. We met with 19 different compliance committees in a three week period. And since then we have three additional different compliance committees in central office and we met with executive leadership at each facility and discussed all the corporate risks which were unique to each facility. Each facility had a unique set of risks.

We had a discussion about the risk here at central office with the executive compliance work group co-chaired by Mr. Martin and myself. We went through the top 15 risks that were identified throughout the Corporation through our scoring process. The executive compliance work group will meet again in another week to look at the risks that we have identified internally. And then we will come up with a corporate compliance work plan for Dr. Raju's approval and then submission to the Audit Committee for the Audit Committee's determination as to risk tolerance and risk appetite.

We also will have Compliance Committee meetings with regard to DSRIP in the Accountable Care Organization. Actually the Accountable Care Organization Compliance Committee is meeting this afternoon and the World Trade Center Health Program Compliance Committee. We will be performing a risk assessment. So we look forward in October to providing the committee greater detail as to the different risks.

The Office of Corporate Compliance in the Corporation received a civil investigative demand from the United States Attorney's Office of the Southern District of New York with regard to information concerning HHC Health and Home Care. The Office of Legal Affairs sent out a litigation hold instructing all employees that may have pertinent information to preserve that information. This matter has been assigned to outside counsel, Katten, Muchin, Rosenman, Joe Willey for internal investigation and to respond to the CID. We should have more information once the investigation is concluded.

Audit Committee – October 8, 2015

As reported by Ms. Emily Youssouf

Mr. Julian John, Corporate Comptroller thanked KPMG, Jim Martell, Partner; Maria Tiso, Engagement Partner and Joe Bukzin, Engagement Senior Manager and their team for working closely with the Corporate Comptroller's office to get the financial statements completed in a timely manner and this was in spite of getting the pension report from the New York City Comptroller's office very late on Friday. It was due on Wednesday but despite that we were able to work through the reports and get the financials completed. Mr. John also thanked Chris Telano and his team for their supporting audit and the other areas within the finance partners because everyone sort of pulled together to get all of the necessary data. Mr. John also stated that he would like to take a second to thank James Linhart, Deputy Comptroller; Marshall Bondi and Joseph Dubroja for their help and their hard work during the course of the audit. They worked very hard and he really appreciates what they have done. We lost four people to retirement in March, and despite that the team pulled together to get the financials done.

Mr. John reported that KPMG has completed audit of the Corporation's financial statements for 2015 and will issue an unqualified opinion. In 2015 the Corporation adopted GASB Statement # 72, Fair Value Measurement and Application. This guidance requires entities to expand their fair-value disclosures by determining major categories of debt and equity securities within the fair-value hierarchy on the basis of the nature and the risk of the investment. The statement only requires additional disclosures and did not have an impact on the financial statements.

Mr. Bukzin said that this guidance was discussed during the planning procedures. There was enhanced disclosures primarily around investments. It does not deal with re-measuring the value of fixed assets. It was just disclosures around the government security obligations. You will see a couple of footnotes that have been incorporated into the financial statements this year.

Ms. Tiso commented that this GASB guidance came after the FASB, so the Financial Accounting Standards Board had already sent this guidance out for public and nonpublic entities already, so the chart had just come out for a couple entities.

Mr. John continued with Significant Financial Ratios Comparisons - the current ratio is financially indicated in the measure of the Corporation's ability to pay off its short-term liabilities with current assets, and it is determined by the ratio of current assets and current liabilities. Ideally we would like to have a ratio of one or better, but for the current year our ratio was .84, last year it was .87.

Days cash on hand - HHC ended the year with 35 days cash on hand. Last year, it ended the year at 19.5, and this year we had a much higher number because at the end of the year in the fourth quarter we received approximately \$600 million in UPL payments as well as \$100 million in DSRIP payments.

Net days revenue in patient receivables decreased from 71.91 in 2014 to 61.19 in 2015 that is primarily due to the efforts by the facilities in improving their collections.

Mr. John reported that Net position is the difference between the Corporation's assets and liabilities. Net assets decreased by \$395 million, net liabilities decreased by 314 million between 2014 and 2015. Accordingly, the Corporation's net deficit position grew by \$81 million. Mr. John then proceeded to provide highlights of the Fiscal Year 2015 financial statements, as follows:

Assets

- Current assets decreased by \$ 205 million.
- Cash and cash equivalents increased \$268 million primarily due to a receipt of \$600 million for two years of retroactive inpatient upper payment limit funds during the fourth quarter. \$319 million pertaining to State Fiscal Year '13 and \$280 million pertaining to State Fiscal Year '14.
- Grants receivable increased \$60 million due to a delay of payment of the Medicaid Administration grant.
- Patient accounts receivable, net decreased \$58 million due to an increase in collection effort and a decrease in the risk incentive pool payable between MetroPlus and HHC.
- Estimate third-party payor settlements decreased \$540 million due to receipt of \$1 billion of UPL payments.
- Due from the City of New York decreased \$40 million due to receipt of collective bargaining payments from the City.
- Capital assets, net decreased \$74 million due to major retirement of assets related to Goldwater. Buildings, leasehold improvements and equipment, net of accumulated depreciation decreased \$138 million, and that was netted against construction in progress increase of \$64 million.
- Other assets decreased \$13 million primarily due to a decrease in assets restricted as to use of \$11 million resulting from the use of the Construction Fund for various capital projects.
- Deferred out flows – Unamortized refunding costs which represents the amortization of loss on bond refunding. This was implemented after GASB 65, which we did last year. Decreased \$3 million from 2014.

Liabilities

Total liabilities, in 2015 decreased by \$314 million compared to 2014.

- Current liabilities decreased \$247 million. Decreases in estimated pools payable and estimated third-party payable, which were offset by increases in the amount due to the City of New York and current portion of pension.
- Estimated pools payable – decreased \$259 million primarily due to a decrease in the State's advance payments for Disproportionate Share or DSH Hospital and DSH Max funds of approximately \$354 million.
- Estimated third-party payor settlement payable - decreased \$32 million primarily due to a re-estimation of third-party anticipated take-backs both for Medicaid and Medicare rate change.
- Current portion of pension increased \$9 million as the Corporation recognized its annual pension costs and payments towards its liability as determined by the New York City Office of the Actuary.
- Other non-current liabilities and long-term liability – based on the advice of the auditors and the approval of OMB, we agreed to move \$300 million into these two categories.
- Due to the City of New York, increased \$36 million.
- Other noncurrent liabilities increased \$300 million was due to reclassification of our FY '15 debt service and malpractice practice payments due to the City of New York from current liabilities to long-term liabilities.
- Long-term debt, net of current portion, decreased \$58 million due to the payment of current debt obligations.
- Pension, net of current portion, increased \$289 million due to the Corporation's recognition of its annual pension costs and payments towards its liability as determined by the New York City Office of the Actuary.
- Post-employment benefits obligations other than pension or OPEB, net of current portion, decreased \$148 million as the Corporation recognized its annual OPEB credits and costs, again, as determined by the New York City Office of the Actuary.
- Deferred in flows decreased \$450 million due to changes in the net differences between projected and actual earnings on pension plan investments from 2014 to 2015. These balances are derived from the pension report issued by the New York City Office of the Actuary.

Income Statement

Operating loss, the difference between operating revenue and operating expenses, decreased by \$30 million with a loss difference of \$63 million in 2015 compared to \$93 million in 2014.

Operating Revenue

Operating revenue increased \$69 million primarily due to increases in net patient service revenue, grants revenue and other revenue offset by a decrease in the appropriations from the City of New York.

- Net patient service revenue, increased \$76 million due to the recognition of risk pool payments from MetroPlus, \$95 million, increases in DSH Max, \$43 million, and a decrease in UPL payments of \$84 million.
- Other revenue increased \$10 million primarily due to \$6 million increase and 340B program revenue.
- Grants revenue increased \$241 million primarily due to the recognition of \$137 million for IAAF payments and \$117 million of DSRIP grant revenue.
- Appropriations from the City of New York decreased \$259 million primarily due to the fact that in 2014 the City and HHC agreed that debt service and malpractice payments for 2013, \$150 million and \$122 million respectively, would not be paid, which resulted in the total amount of \$272 million being recorded as appropriations from the City of New York.

Ms. Youssef asked what year the debt service malpractice payments were for. Mr. John answered 2013, the 2014 debt service and malpractice payments are still due to the City as of 6/30/2015, and we subsequently made those payments in August of 2015.

Operating Expenses

Operating expenses increased \$39 million primarily due to increases in personal services, fringe benefits/employer payroll taxes, OTPS, pension and affiliation contracted services, and this was netted against decreases in OPEB and depreciation.

- Personal services - increased \$68 million primarily due to collective bargaining settlements and an increase in FTEs of approximately 795.
- Other than personal services - increased 39 million, and that is primarily due to increased cost of pharmaceuticals, \$28 million, and an increase in IT software maintenance expenditure of \$17 million.
- Fringe benefits and employer payroll taxes - increased \$50 million due to health benefit increases of \$27 million and increases in welfare benefits of \$17 million
- Pension - increased \$61 million as determined by the New York City Office of the Actuary.
- Affiliation contracted services - increased \$72 million due to market adjustments and enhanced services. Approximately \$30 million of that increase is for increased staffing and salary increases.
- Post - employment benefits other than pension, OPEB, decreased \$239 million as determined by the New York City Office of the Actuary and is predicated on assumptions for healthcare actuarial gain experience, cost trends updated to reflect recent past experience and future experience.
- Depreciation decreased \$11 million due to the loss on retirement of assets at Goldwater.
- Other changes in net assets - decreased \$207 million due to changes in the following components. Capital contributions funded by the City of New York decreased \$197 million due to fewer continuing major modernization projects.

Ms. Youssef asked how is that related to the decrease from the City Capital budget.

Ms. Zurack responded that it is really point in time because the amount that would have been contributed would have really been from projects two, three years ago coming online, so it was the taper off from that period that you are seeing. We had a very robust period of major modernization with Henry J. Carter and Harlem, so it is just tapering off, but because of what you are saying about the City contributions, it should go down in future years even further.

Mr. John continued with MetroPlus:

- Cash and cash equivalents - decreased by \$126 million primarily due to increases in the required statutory reserves and long-term investment activities.
- Premiums receivable increased \$64 million due to an additional IGT accrual of \$50 million.

- Accounts payable and accrued expenses - increased \$10 million due to increase in New York State accruals for incarcerated members, \$7 million, and premium over payment estimate of \$5 million.
- Premium revenue increased \$250 million, and that is because of growth. There was an increase in Medicaid members of 41 thousand.
- Other than personal services - increased \$216 million for medical expenses related to increased services and growth. Pharmacy costs increased \$123 million. Additionally, HHC risk expense increased by \$49 million.

Ms. Youssouf requested explanation of HHC risk expense in this context.

Ms. Zurack stated that HHC and MetroPlus have the relationship of insurer and provider, so HHC's contract with MetroPlus is a percent of premium contract for medical services, 86 percent of premium is for medical services, so MetroPlus has to set aside 86 percent of their premium for medical services, some of which are provided by HHC and some of which are provided by other providers, Coney Island network, or the network for MetroPlus is broader than HHC.

After claims are paid for specific services, if in fact those claims are lower than that number that was set aside, that 86 percent, that difference comes back to HHC as a risk payment because HHC took risks. If in fact it had gone over, HHC would have to pay the difference, so we have actually very successfully preserved premium revenue by having this kind of arrangement and benefitted because we are able to get reasonable money coming from MetroPlus to HHC, and one could argue because we have done this for so long that we are kind of in a position where value-based purchasing that is a little bit a head of the rest of the industry, and we have the same kind of arrangement with Health First, slightly different details but conceptually similar.

Mrs. Bolus asked to explain how HHC is paying for the incarcerated members? To which Ms. Zurack answered that once you are incarcerated, you are no longer on Medicaid. So if you had been a MetroPlus Medicaid member, the State might not have real time information on the incarceration date, so the State might pay. Let's say Wayne is a MetroPlus member and June 1st the State paid MetroPlus for his premium, and on June 5th he was incarcerated. MetroPlus owes, New York State, 25 days of the premium because they are not allowed to give Medicaid premiums for incarcerated members.

Ms Youssouf asked if MetroPlus sets aside a certain percentage as a reserve to cover this, or do they just pay it out of current income?

Ms. Zurack said that that is their normal – that is not the reserve. That is part of their normal sort of working capital issuance.

Ms. Youssouf then turned the meeting over to KPMG.

Ms. Tiso saluted everyone and introduced herself as Maria Tiso, the lead audit partner for the account, to her right Joseph Bukzin, who is the senior manager on the account. To her left, Jim Martell who is the Healthcare Resource Industry partner and to his left is Bennie Hadnott the partner from Watson Rice LLC.

Ms. Tiso stated that she will not go through all of the details of the presentation. That she is going to go through a lot of high-level information. Deliverables -- these are the deliverables that were reported to you during the audit planning meeting in June. We are here today to go through all the required communications and the final result of our audit. In November we will be coming back to the Committee to go through our management letter observations. We are just wrapping up the audit, so we are in the process of putting together our observations at the moment. We will be issuing various regulatory cost reports in 2016, and then also we will be doing an audit of the MetroPlus HHC Insurance Company and ACO, so those will be coming in December year end.

The description of management's responsibility, KPMG's responsibility and the Audit Committee's responsibility. Management's responsibility is making sure the internal controls are working effectively in order to prevent, detect and deter fraud and obviously making sure that the financial statements and all the disclosures in the financial statements are appropriate in accordance with generally accepted accounting principles. KPMG's responsibility is to render an opinion on the financial statements, and the Audit Committee's responsibility is one of oversight monitoring, and the Audit Committee does rely on management, the internal auditors and the external auditors as it relates to the financial statements.

Ms. Tiso said that KPMG intends to issue an unmodified opinion on the financial statements, which is the highest level of assurance, that the financial statements are free of material misstatement. Mr. Bukzin will go through some of the findings and the results of the audit.

Mr. Bukzin saluted everyone and said that they had one corrected adjustment during the course of the audit for approximately \$20 million. It resulted in some updated calculations for certain components of third-party reimbursement. It resulted in a reduction to the net patient service revenue. That has been recorded and reflected in the financial statements. The other item mentioned that Mr. John alluded to earlier was the classification due to the City for about \$300 million to long-term liabilities. The new accounting pronouncement described earlier at the bottom part of the page describes some of the significant accounting estimates where we devoted a significant amount of time during the audit. These balances are reasonably stated, and we do involve certain subject-matter

professionals such as reimbursement professionals, actuaries to assist us as part of reviewing the amounts that are listed in the line items in those financial statements.

Ms. Youssef stated that it says that you are still doing the valuation of the pension plan liability.

Ms. Tiso added that as of yesterday evening, they received a concluding memo from their pension actuary specialist stating that he has completed his review, so that area has been completed.

Mr. Bukzin wanted to highlight some of the significant accounting transactions during the year. The first one relates to the Interim Access Assurance Funds that were received of which \$136.9 million has been recorded within the financial statements. We spent a bit of time working through the DSRIP accounting treatment this year. There was approximately \$111 million that has been recorded as part of grant revenue. During that process we did consult with our national office since it was unique in terms of the transaction, and we wanted to make sure it was recorded proper and appropriately in an appropriate period, and it has been concluded that it is properly reflected as grant revenue. Towards the middle of the page, we spoke a bit about the UPL balances. We did want to provide some insight into what transpired from last year's balance to the current year balance. Last year's balance was approximately \$1.4 billion. Approximately a billion of that has been collected, and there is also an increase for 2015 UPL with in the receivables.

In terms of the electronic medical records system, there are disclosures around this within the fixed asset footnote, and in terms of certain balances, the capitalized costs related to this project are \$115 million as of the end of the fiscal year. In terms of expenses related to the project, it is approximately \$13.6 million recorded in the financial statements. On the bottom of the page, during 2015 the organization did receive grant funds for FEMA for approximately \$33 million. That has also been reflected as part of grant revenue.

To highlight a couple of subsequent event items -- The first is disclosing of financial statements. It describes the line of credit arrangement related to equipment financing. The Corporation drew down approximately \$10 million just after the fiscal year end, and note 15 of the financial statements describes the memorandum of understanding related to the correctional health services, and there is a budget for this for fiscal 2016 of approximately \$159.3 million, which is funded by the City of New York.

Ms. Tiso said that the last bullet on that page talks about liquidity considerations. When the audit plan was presented, this was an item that we look at every year as part of our audit plan, so some of the key performance indicators that we look at it relates to the Corporation when we work in capital, we looked at operating loss of income, we have looked at cash flow from operations, and then we look at the net position of the Corporation over all.

For Fiscal Year '15 there were two positive indicators. The first one was including MetroPlus and HHC. The Corporation over all had a loss of \$14 million last year but generated income from operations of \$44 million this year. Again, positive trends. The other positive indicator was the operating cash flow. The organization had about \$ 452 million of cash flow from operations. Again, another positive trend. The other thing was the working capital. It is relatively break even. It's been probably the first year over a couple of years that it's slightly below working capital. It is a working capital deficiency of about \$72 million, so it is something that the organization should look at going forward, but again, still we looked at liquidity. Everything looks fine at this point in time to issue an unmodified opinion.

Ms. Youssef asked that does any of that have to do with the payments that were delayed to HHC.

Ms. Zurack responded that essentially, this is really what in the next 12 months do we expect in terms of new assets versus liabilities, and the liabilities are largely consisting of money owed to the City. But there is other things in there as well, and that is now in the wrong direction, and that really speaks to a very challenging budget for Fiscal Year '16. In the next 12 months we think you are going to have more of a loss here because your current assets are not sufficient to pay your current liabilities, so it is a problem, and unless either HHC can figure out ways to do things more efficiently and create savings or generate additional revenue, that is going to be a problem in next year's budget, and when KPMG comes back next year for Fiscal Year '16, unless something is changed, I think you might not be able to be so optimistic at this point.

Ms. Tiso said exactly, so each year we have to evaluate both qualitative and quantitative aspects of liquidity, so we look at each year separately. Hopefully, things will move differently next year where your current assets will be in excess of your current liabilities.

Ms. Tiso continued with page nine -- these are some of the other required communications, just quality of accounting principles have been consistently applied, and they are disclosed in the financial statements. Mr. Bukzin talked about the management judgments and accounting estimates, and we concluded that they were reasonable, and yet as it relates to audit misstatements, there was one corrected audit adjustment that we saw went out before, and there were no material uncorrected financial statements to disclose to the Committee.

There were no unresolved disagreements. To the best of our knowledge management did not consult with other auditors to get a different opinion. We obviously as part of our audit do discuss issues. We had healthy discussions, but again, no difficulties encountered in performing the audit.

There will be three material written communications. One was the engagement letter that was signed by the committee, a management representation letter and a management letter, which we will be presenting in November. We discussed the significant and unusual transactions, and at this point as we look at the observations that will be included in the management letter, we do not note any significant deficiencies and material weaknesses at this point in time.

As part of our audit we do have various SAS 99 audit procedures, which we meet with key levels of senior management to talk about various transactions, if they are aware of any fraud. We believe that the Committee is aware of anything that was spoken to us at that in those meetings. There were no significant changes to the initial 2015 audit plan. If there were any scope changes, we obviously would have discussed it with you during this meeting, and noncompliance with laws and regulations, nothing that came to our attention, and litigation claims and assessments, nothing noted other than the normal course of business items.

Items that we need to complete in order to issue the final report -- We are finalized with the concurring partner review. We have received all of his comments, and his edits are actually included in the financial statements that you have, so we are pretty much done with his review. We talked about the GASB 68 pension review -- that was finalized yesterday evening. We are still doing some test work on consulting costs, and hopefully we will be wrapped up with that shortly. Then we have subsequent event procedures, down to date legal letter inquiries and any minutes that we have not inspected as of this point in time that are not drafted. We need to get management's rep letter, the final debt covenant calculations based on the final numbers. We were working on the final financial statements up until probably 8:00 yesterday evening, and then again management letter observations, which we are in the process of doing, and that completes our formal presentation.

Ms. Youssef asked if there were any questions.

Dr. Boufford congratulated the staff for a clean letter -- it is an amazingly complicated set of statements.

Ms. Youssef asked if the committee can get a little color on how HHC looks with their counterparts around the country.

Mr. Martell responded that if you take a step back and you try to compare HHC to what you would think would be comparable, the first thing is there is no real such animal that is comparable with HHC. We all know that HHC is a unique organization. HHC is a head of its game as Ms. Zurack said relating to a lot of the things they are doing. The risk sharing, the local systems are just getting involved. They have never done that and they are experiencing a significant amount of pain and suffering losses trying to create this insurance company, so as you go a long that route, I think the one issue that has been a positive for HHC is obviously getting into the game of risk sharing insurance-type business years ago.

Quite frankly, the liquidity issue is tough. More of the major academics are obviously doing better, not only from the operating care, but they also have a strong philanthropy, which assists. When you take a step back and just compare yourself to local things like that, it is difficult. Your mission has different goals, and that has to be taken into account. I have been involved almost 25 years off and on in, in some form or fashion. We have had discussion relating to liquidity that went back ten years, and then the Corporation comes back.

DSRIP will be a major issue matter going forward. Controlling that and identifying it and working with the PPSs, we are the lead in certain ones, will be clearly the next step in healthcare transformation in terms of how do you provide services to the environment. So the old bricks and mortars that we see, the 11 hospitals and all the buildings, may change, and it may be more of a population help, more into the ambulatory care clinics and things of that nature where perhaps those are where the investments are. So what we see today of HHC may not be the HHC you see in five or ten years. I don't know if I answered your question.

Ms. Youssef answered yes and sorry I asked it.

Ms. Zurack stated that she would like to disclose that HHC has had a slight marginal change in some of the City numbers since the version you have before you, so when the Committee is ready to vote to approve the statements, I would like to ask the Committee a caveat plus or minus one percent for minor changes that we have to do tonight and tomorrow.

Ms. Zurack asked for a vote. The committee voted unanimously to approve with plus and minus one percent.

Ms. Youssef then directed the meeting to Chris Telano for the audit update.

Mr. Telano thanked her and saluted everyone and said that the audits that he will discuss today are all about the PAGNY affiliation agreements. Before I start out, I just want to commend PAGNY on the efforts they have given since last year to resolve prior audit issues. Although progress has been made, there are still some areas that need to be addressed, and I will go through those areas shortly. As you can see on page four of the briefing the audits encompass seven different facilities, Lincoln, Harlem, Jacobi, North Central Bronx, Metropolitan, Coney Island and Kings County. The objectives of the audits were to evaluate the internal controls and processes pertaining to the affiliation agreement. Keep in mind that these audits included a review of both PAGNY and HHC operations as it relates to the affiliation agreement.

During the course of the audits at the seven PAGNY facilities, various issues were found at each site. Many of the issues noticed were similar to those of previous year audits. In addition some of our conclusions found while reviewing the subcontractor's activities were the same as those found by the New York City Comptroller's Office during their audit of the Lincoln affiliation. Specifically, the failure to submit the required time sheets or documentation to support payments and the lack of current service agreements.

For example, at Lincoln we found on 9 of the 35 invoices that we reviewed, totaling \$436,000, did not have time sheets or other appropriate documentation. Payments were made for 4 of 35 invoices we reviewed, totaling \$396,150 for services provided without a contract in place or an expired contract at the time of service. We also noted that although PAGNY has established an annual contract compliance review process, we were only provided with 1 review of the 26 Lincoln subcontractors for agreements with automatic renewals. We also noted there were payments for \$187,500 each month that were being paid in advance of orthopedic services provided. We found two such checks during our review of 35 invoices.

At Harlem we found that PAGNY processed payments for providers under two of the nine subcontract reviewed for which they are not listed as a party on those agreements. One contract is between HHC/Harlem and New York Presbyterian, and the other contract is between HHC/Harlem and an employment agency, Solomon Paige.

Ms. Youssouf asked if it means that somebody got paid twice. To which Mr. Telano responded no.

Ms. Youssouf asked if he insured that Harlem did not pay as well. Mr. Telano answered yes, we did.

Mr. Telano continued and stated that at Jacobi and/or North Central Bronx we noted 4 of 37 invoices, totaling \$189,000 were approved and paid for services that were not supported by time sheets. Time sheets were also unavailable for department chairs for surgery and neurology that received an additional stipend under a subcontractor agreement. Also in Jacobi, the Montefiore Medical Center was paid \$33,000 a month to provide ultrasound and fetal surveillance services from June 2013 to May 2014 without a contract. In addition, the physicians from Montefiore did not submit time sheets as supporting documentation for payment. Payment was based on the physician schedules and invoices provided by Montefiore. As such we found PAGNY approved and paid eight invoices totaling \$278,000 for services provided under this agreement. We also noted that there was not an annual review of the subcontracts for agreements with automatic renewals. We were not provided any documentation.

At Metropolitan 2 of 30 payments that we reviewed totaling \$22,000 were paid to vendors without time sheets to validate the receipt of the services. Five of the 30 payments we reviewed, totaling over \$11,000, were dispersed to EPIC Staffing Agency without a subcontractor agreement. We also asked for an annual contract compliance review, and we were provided three out of the nine. Lastly, regarding Metropolitan, one of the nine subcontractors reviewed received monthly advance payments totaling \$568,000 for services received subsequent to the payments.

In Coney Island 3 of 30 check requests reviewed, totaling \$246,000, were approved and paid without 8 time sheets being signed by the department head attesting to services that were paid.

The affiliation contract also states that gastroenterologist services at Kings County Hospital Center should be conducted by employees or contract services providers. However, we did not find individuals on the PAGNY payroll register who performed this service. Instead the gastroenterologist physician providers were paid \$239,000 through PAGNY's account payable system as a vendor without a subcontractor agreement.

When we reviewed the subcontractor files, we noted there was documentation missing related to criminal background checks, and we also noted expired medical clearances at Lincoln and Harlem. We noted time keeping errors at Jacobi, Harlem and Metropolitan. At Jacobi it was noted that time sheets had hours for holiday, vacation and sick days processed in error as regular time worked. At Harlem and Metropolitan we found time sheets in which the hours recorded did not agree to the amount paid. There were also some issues in which HHC and PAGNY bore some responsibility, and those issues are related to system access still for terminated employees, those systems being our medical records system, QuadraMed, and our email system, Group wise. And lastly at the time of the completion of our audits, the annual recalc documents for all PAGNY facilities were not completed for Fiscal Year 2014.

Mr. Martin asked if the services were provided. Mr. Telano responded yes.

Mr. Martin then said that this was really a failure of time keeping or documenting recordkeeping, so clearly this is something HHC and PAGNY will work together to make sure is done. I just really want the Board to know that the services were provided, and that is very important. Again, I think the recalcs, have been completed through 2014, so all of the recalcs for all of our affiliates happened and have been completed, have been signed off on. I believe at the time the audit was done they were not, but they are all current now. We continue to have a problem with system access, and I think that is something I guess we share responsibility on. I do not know whether it is the failure of the affiliate to notify us timely or it is the failure of HHC to remove the respective individual from the system, but as you know, we did put a process in place where IT is supposed to be handling this, so I will revisit this again and really try to make sure that we are much more compliant in the future. It should be noted, I think Mr. Telano said this at the very beginning, there has been significant improvement over the past year. I think the audit a year ago was really very, very harsh, and there has been significant improvement. The issues that were brought up are something that we will work together with PAGNY.

Dr. Boufford asked that I am interested in what is the management structure for PAGNY at the individual institutions is everything done centrally, or are there actually officers on site managing the affiliation contract with each hospital or at two hospitals or whatever?

Mr. Martin answered that there is a PAGNY administrator at site at each one of the hospitals.

Dr. Boufford asked if you have any patterns around the competency of those individuals, or do you think it's just an infrastructure issue as described, the systems are poor and they have not been focusing on it?

Mr. Telano responded that he thinks they are just improving their processes, from the very beginning they were poor, and they are just improving year by year, and there was some movement, some transition among the affiliation offices before or during the course of our audit, which resulted possibly in some of these comments.

Dr. Boufford asked if there is some formal training of their folks. And that that would be worth finding. Mr. Telano responded that he did not know.

Mr. Martin asked if she means training that PAGNY gives to the administrators onsite. Dr. Boufford answered yes, to help fulfill the affiliation contract obligations to the Corporation.

Mr. Martin stated that he assumes that they do, but will follow up with that and bring it back.

Dr. Boufford stated that we have had this conversation. I do not know that it's fully accepted, but arguably if you look at them as your physician practice embedded in HHC, I think arguably there could be a different relationship around their competence in terms of accounting and accountability to the Corporation than with some of the other affiliates.

Mr. Martin stated that he agrees and he thinks one of the things that we have attempted to do, particularly in the most recent past, is really have a much more collaborative of us working together much more closely. We realize that PAGNY is a really valued partner for us and that we need to really work together very closely to ensure success, so whatever we need to do we are committed to do in the Corporation.

Ms. Youssouf stated that I would just say that, again, for everybody to remember, please that although it does not always seem like it, Internal Audits is your friend because Internal Audits will find these things and help you correct them prior to it really getting out of hand or causing any major financial issues, so it is important for everybody to always continuously cooperate with Internal Audits and heed to their advice.

Mr. Martin added that I want to echo that, I think one of the things that was heartening to me was hearing that 95 percent of the recommendations have been complied with, so over the course of the Internal Audit during their investigation, our facilities have taken it seriously and have implemented 95 percent of those recommendations. I think that shows a good partnership.

Mrs. Bolus stated that for the record PAGNY is here, so we do know they complied and came to this meeting. I want to make sure it's on the record they are here.

Dr. Marcos stated that my name is Luis Marcos. I am the CEO of PAGNY and I am happy to be here with you. I thank the Committee. We have been talking the past month and so on to try to improve the situation at PAGNY, and I appreciate very much the help from the administration, Mr. Martin, and the executive directors and Chief Financial Officer that are here. I thank Mr. Telano, I think he is doing the best he can. I think he could do better, but that is my personal opinion. What I would like to say, and I appreciate the statements made that we are doing better, we still need to improve. I want to also say that we disagree with some of the findings. I am glad that Mr. Martin asked the question have we paid for things that we did not receive, services, and the answer is no. So when you hear all these numbers, paid for this, paid for that, double pay or whatever, keep in mind that PAGNY has not, to my knowledge, over paid or taken money or do something illegal, right? I think that has to be taken into account when numbers are given out without the full explanation.

Having said that I think that we need to improve. I am not an auditor. I am simply a shrink by training, and I think that we need to improve the process. For example, as it has been mentioned, many of the findings at PAGNY but also the hospital, and it takes many players to be able to solve some of these issues. There are other issues where PAGNY, frankly, has no control over it. For example, if a physician leaves Coney Island at 5 and starts working at Bellevue at 5 p.m., there is no way for PAGNY to know if other hospitals within HHC or others have our own physicians working there as well, so there are many examples of that kind.

Finally, I do not want to take your time. Just to say that in the past eight months or nine months PAGNY has underwent 15 audits. When you think of PAGNY, we have about ten employees per facility, ten employees, and that counts me, so we are not really an affiliate that has resources beyond. We went through 15 audits, so we would like to suggest, respectfully, that those be taken into account when we schedule audits, and audits take months, and sometimes it takes from three to five months for PAGNY to receive the final report, so if we can all work together so that we can continue the improvement with your support, Madam Chair and the Committee and HHC, I think that you can all then be proud of what PAGNY did. Thank you for your patience.

Ms. Youssouf thanked him and asked if there are any other questions?

Mr. Telano stated that one of the goals of Internal Audits is to ensure that we find issues before a government agency finds the issues, and at the audit done of the Lincoln affiliation by the City Comptroller's Office, they found numerous invoices, I believe \$1.3 million worth that lacked supporting documents. They also found 5 out of 30 vendors without current contracts, so we cited the same things to give warning that if the Comptroller's Office comes back, these are the type of issues that are going to be cited by them, so that's the reason we note them also. The Comptroller's Office did not state that there were no services provided, but they could not be sure because there was a lack of documentation, and that was the concern.

Ms. Youssouf said that I appreciate that and I also would like you to know, Mr. Telano, you have the full confidence of this Committee, so thank you. We move on to Mr. McNulty for the Compliance update.

Mr. McNulty saluted everyone and said to turn to page three of the Corporate Compliance report. My name is Wayne McNulty, Senior Assistant Vice President, Senior Corporate Compliance Officer. I will start with the compliance of the Deficit Reduction Act of 2005. On an annual basis, HHC is required to disseminate to all its contractors, employees and work force members a summary of its policies and procedures designed to prevent and detect fraud, waste and abuse. We are also required to ensure that all employee handbooks have information regarding the Deficit Reduction Act.

At the end of September, we disseminated to our entire work force and to over 1400 contractors and vendors a summary of the Deficit Reduction Act. We also summarized our policies and procedures, namely our corporate compliance plan, our principles for conduct, our operating procedure for compliance programs and also our compliance plan in general and our guide to compliance, and those are set off on pages three to five of the report with some detail.

The monitoring of excluded providers -- we have no reports of excluded providers to report since the last time the Audit Committee convened in September. The Office of Corporate Compliance is presently awaiting results being performed by our vendor of the September review.

I am going to provide an update of the calendar year 2015 risk assessment process. As previously reported from the period of mid-July to the period of September, we had 25 compliance risk meetings at the various facilities and at Central Office.

I just want to update the Committee on three compliance committee meetings that we had since the last time the Committee convened. We had a OneCity Health / DSRIP Compliance Program Committee, which was held at Central Office. We also had a compliance committee meeting for the HHC Accountable Care Organization. Both OneCity Health and Accountable Care Organization are wholly owned subsidiaries of HHC.

We also had a compliance committee meeting for the World Trade Center Health program. We have to have a follow-up meeting with regard to the World Trade Center Health program, and then we have to have just one more executive compliance committee meeting and we will be finished with the risk-assessment process and we will have a Corporate compliance work plan to present to the Board in executive session the next time the Audit Committee convenes.

If there are no questions with regard to the risk-assessment process, I will move on to section four, compliance training. We are required at HHC because we participate in the Medicaid program under the compliance regulations to provide training and education on compliance issues to all effective employees and persons associated with HHC, and that compliance training must reach the governing body of HHC. We have four different modules of training, which is out lined in paragraph two. We have a training for Group 11 employees and other designated employees. We have training for all the physicians throughout the Corporation. We have training for all the healthcare professionals, and we define healthcare professionals as individuals licensed under Title 8 of the Education Law, so occupational therapists, nurses, respiratory therapists. We also have training for the Board of Directors. The training for the Board of Directors is the only training that is not live yet. It is right now under review. We are hoping that we will have a version for Ms. Youssouf to look at early next week, and after she reviews the same along with Dr. Raju, we will then have that ready for the Board of Directors to take a look at and complete their compliance training.

Moving along, please turn to page nine, I just want to provide an update of the results of the compliance training. If you look at page nine, the current status, paragraph one, in July of this year, the physician module, we have 56 percent completion. The healthcare professional module we had 69 percent. We had not implemented the general workforce module at that time. As of October 1st, we have 63 percent of completion on the physician module, we have the healthcare professional 76 percent completion, and the general work force just started beginning of September, so we do not have those numbers. I will be working with the executive directors, senior vice presidents, chief operating officers and the chief medical officers of each facility to bring up the numbers with respect to the healthcare professionals and the physician modules over the next couple of weeks. Moving along to section five of page nine, I just want to provide an update on the delivery system reform incentive payments compliance program. As previously reported to the Committee in June, the federal government recently agreed to allow the State of New York to reinvest nearly half of its savings generated through the Medicaid Redesign of reforms. The majority of funds use d by the State for reinvestment have been allocated for DSRIP activities.

On December 18th the Board of Directors approved by resolution the repurposing of the HHC subsidiary Assistance Corporation to function in the capacity of a centralized service organization for the purpose of providing technical assistance to HHC, who has been designated by the State as a PPS lead in the DSRIP program. Office of the Medicaid Inspector General has issued guidance with regard to the required compliance program elements for DSRIP. If you turn to page 11, you will see that there are eight elements. I presented these eight elements in June, but what I want to update the Board on is there are two elements that have changed.

OMIG issued guidance originally on April of 2015 about the eight elements, and on September 1, 2015, retracted their initial April guidance. There were two changes. Change one was with element number 6 on page 12. Initially they wanted the PPS to perform a risk assessment on the distribution of the use of DSRIP funds. Now they would like the PPS to perform a routine identification of risks, which we have done with the risk-assessment process and formed the DSRIP compliance committee. Element seven there is a particular change. They wanted before for the lead PPS, which is HHC, to look at the misuse of DSRIP funds. That meant the misuse within the PPS system. Through lobbying through the greater New York, OMIG has come back with some revision to that guidance, and now they want the PPS lead to specifically look at its own willful misuse of DSRIP funds or false statements made by PPS providers with respect to obtain DSRIP funds. It is a slight change, but it should make it easier for us to comply with those particular elements.

I just want to briefly go over some corporate governance requirements under the Public Authorities Accountability Act of 2005 and the Reformation Act of 2009, which is collectively referred to as PAAA. Both HHC and One City Health, because it is a wholly owned public benefit corporation, it has to establish a governance committee, it has to establish an audit committee, it has to be made up of a majority of independent members. The Office of Corporate Compliance, the Office of Legal Affairs, the One City Health leadership and the Office of Medical Professional Affairs are working together jointly to make sure that all PAAA requirements will be met, and I will report back to the Audit Committee in December as far as our progress on that.

As stated before, we established a DSRIP compliance committee. The compliance committee has key leadership from Finance, IT, Legal and Medical and Professional Affairs and Labor. The DSRIP compliance committee met on October 1, 2015, and we assessed, scored and prioritized different DSRIP related risks, and we will be developing a DSRIP compliance plan for the year. I should say a DSRIP compliance work plan for the year, and we will report that in December when we report our final work plan for the Corporation. With respect to compliance staffing for DSRIP purposes, the Vacancy Control Board approved the posting of a position for DSRIP for senior compliance personnel, and we should be posting that position sometime next week.

Under HHC ACO Compliance Activities Update -- We previously reported in June to the Audit Committee with regard to the HHC ACO compliance activities and the number of participants. I just also wanted to report that in both 2013 and 2014 ACO met its quality reporting standards and achieved a seven percent reduction in Medicare expenditures for its population. You can see the different quality performance measures that we have to meet. I would like to discuss the ACO compliance plan. ACO has to develop a compliance plan, and they have five elements. These five elements are somewhat different than the eight elements that are required under New York law because this is a federal law that governs the ACO. In summary these elements are designation of a compliance officer, the implementation of risk identification process, employee training, law-enforcement reporting and a mechanism for employees to report compliance issues. We have all of those elements in place, and we have completed the risk assessment process and we are developing the ACO compliance work plan over the next couple of weeks.

The makeup of the ACO compliance committee meeting -- We have representation from ACO, Medical and Professional Affairs and Compliance and also the Office of the General Counsel.

As previously indicated on September 17, we had the ACO compliance committee meeting and identified several ACO compliance risks, which will be incorporated into the corporate compliance work plans. Just to remind the Audit Committee, the HHC ACO recently submitted a renewal application to extend its participation in the Medicaid shared status program from 2016 to 2018. CMS will issue its decision on application later this year, and I will update the Audit Committee in December with regard to any other ACO compliance activities. We need to review the compliance plan for ACO. As required under law, we have to periodically review, and if necessary make amendments within the next month or two.

Then Mr. McNulty stated that if there were no questions that that will conclude my report.

Equal Employment Opportunity Committee – October 13, 2015

As reported Ms. Anna Kril

Assistant Vice President's Report

Manasses C. Williams, Assistant Vice President, Affirmative Action/EEO briefed the Committee on the 22th Annual Competitive Edge Conference which was held on July 21, 2015 at the Bank of New York Mellon located on 101 Barclay Street, New York, NY.

2015 Conditionally Approved Contractors Update

Sharon Foxx, Assistant Director, Affirmative Action/EEO reported on five conditionally approved contractors, Sungard Availability Services, LP which had one Female underutilization in Professionals Job Group 3 which was the same as last year and two new ones for Minorities in Job Group 3 and for Females in Sales Job Group 5. Cablevision Lightpath, Inc., which had three underutilizations, one for Minorities and Females in Managers Job Group 1B which was the same as 2014 and one new underutilization for Females in Managers Job Group 1A, the underutilization for Minorities in Managers Job Group 1C registered in 2014 was eliminated this year. Microsoft Corporation had three underutilizations for Females in Professionals Job Groups 1, 2 and 6 and a new underutilization of Minorities in Professionals Job Group 3. Finally, Stericycle Inc., another new contractor had three underutilizations, one for Minorities in Managers Job Group 1E, in their Northbrook, Illinois facility and two for Females in Operators Job Group 7 and Laborers Job Group 8 in their New York, New York facility.

2015 Corporate Affirmative Action Plan Update

Gail Proto, Senior Director, Affirmative Action/EEO stated that the Corporation's level of representation of minorities and women have remained at a high level of 82.8% minorities and 68.4% women. There were 44 job groups analyzed this year, the same as last year. The total number of job groups with an underutilization has increased from 14 in 2014 to 16 in 2015 with one additional underutilization each for Hispanics and Asians. She further stated that there were 21 underutilizations in 2015, two more than 2014.

Finance Committee – October 13, 2015

As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Marlene Zurack informed the Committee that the report would include only an update of HHC's cash flow which as of that day, 10/13/2015, the cash on hand was at 12 days; however, there are two large UPL payments outstanding that are scheduled for receipt the end of October 2015. One has been approved and is in the State's payment cycle and the other is at the approval process phase by CMS. In January 2016 there are some large payments expected and if all goes according to the scheduled plan, with the receipt of those payments, HHC will be able to maintain that level of cash on hand.

Ms. Youssouf asked for clarification of the 12 days of cash on hand through the end of the fiscal year with the receipt of those large payments. Ms. Zurack explained that the cash on hand will increase and the 12 days would be the minimum.

Key Indicators/Cash Receipts & Disbursements Reports

Mr. Fred Covino brought to the attention of the Committee that data for the reporting period represented a small sample size and as such there was a lot of variability which is inherent in the first quarter of the fiscal year.

Ms. Krista Olson stated that the FY 16 utilization through August 2015, the downward trend continued. Billed ambulatory care visits were down by 6.2% compared to 2.5% at year-end FY 15. This is due to a couple of factors; 25% of the visits across HHC are due to a change in the HIV billing whereby counseling is no longer billable; while it occurred during the course of last year it is more dramatic due to a comparison that is reflective of a fully implemented year. Elmhurst is experiencing a lag in closed visits that should be resolve by next month.

Committee member, Emily Youssouf asked for an explanation of various negative variances, particularly Jacobi.

Ms. Olson stated that there was a lag in the visits but there was an across the board decrease due to the HIV factor. Discharges were down by 1.9% consist with the decline during last year. At the North Bronx, Jacobi is down but NCB is up due to the shift in the labor and delivery reopening. The decline at Woodhull and Coney Island is due to a large drop in one day stays in conjunction with the variability at the beginning of the year. Nursing home days were down by .8% compared to last year but is a significant improvement over last year's trends. The LOS, a comparison to the corporate-wide average is more vulnerable to variations as noted on the report. Bellevue and Coney Island are showing very large variation. The CMI is up by 1% over last year.

Mr. Covino, continuing with the reporting stated that the reporting reflected a new format in the reporting of the FTEs as part of the global headcount that includes temps, hourly, and overtime converted to FTEs. The FY 16 current target for FY 16 currently at 48,892 global FTEs which reflects a 482 increase in FTEs compared to the prior year end level. The increase is primarily in FTEs with a slight increase in overtime offset by a slight reduction in allowance lines. The major increases by title included, 154 tech/spec, 37 art therapist; 28 lab techs; 15 pharmacy techs; 13 social workers; 11 behavioral health techs; 98 aids and orderlies all in patient care techs; 83 environmental positions; 72 residents; 62 clericals. Currently against the target FTEs are up by 1,675 against the year-end target of

47,217. The increase by network included; North Bronx over by 53 FTEs; Northern Manhattan/Generations Plus, over by 686; South Manhattan over by 229; Central Brooklyn over by 247; Staten Island/Brooklyn over by 381; and Queens over by 48.

Mr. Page asked if there is a specific focus on those areas where there are declines in workload and whether there is a qualitative sense of where HHC is going given that the patient population is trending downward but the staffing is increasing.

Mr. Covino stated that there is a focus on reducing the number of temps as part of the Corporation's initiative.

Ms. Youssouf asked for clarification of that focus in relation to the global FTEs as previously reported included the temps. Mr. Covino stated that the global FTE included the temps as part of the total headcount.

Ms. Zurack interjected that the assumption that went into the development of the global FTE target was the movement away from a process base control at central office to a leadership base control at the network. In terms of the global target, the network or local leaderships were informed that the reduction could be achieved through various categories, overtime, attrition and allowances. How that gets achieved must be determined by the facilities. Currently data on benchmarking for comparison purposes is being provided to the hospitals. However, that data shows that the efforts have gone in the wrong direction.

Ms. Youssouf stated that last year the headcount was trending downward and asked if there has been any major changes that triggered that large increase and the increases previously reported by Mr. Covino did not total the 1,675 increase stated in his reporting.

Mr. Covino stated that there has not been any specific change. The 1,700 is what has to be reduced to meet the target compared to what has increased year-to-date.

Committee member, Mark Page added that those numbers against the base did not provide any major details of the problem relative to where the increase has occurred.

Mr. Covino stated that based on the percentage of the total target the Networks' targeted reductions are more attainable.

Ms. Zurack stated that the target includes all staffing, affiliation, allowances, overtime converted to FTEs, and is workload driven. The local leadership must determine how to reduce expenses or increase the number of patients and increase their market share in order for them to achieve their target.

Ms. Youssouf asked for clarification of the Network's efforts in increase the number of patients and what that would involve. As part of the workload there is an established ratio of how many employees per workload which should be standard across the Corporation.

Ms. Zurack stated that it was included as part of the budget methodology whereby a ratio of staffing to workload was established by corporate finance.

Ms. Youssouf asked whether it was uniform. Ms. Zurack stated that it is within the acute care hospitals but different within the long term care facilities and the D&TCs within a sector it is uniform.

Dr. Raju stated that as Mr. Covino indicated early, it is too early in the year to make any reliable assumptions. However, in response to earlier questions raised by Mr. Page and Ms. Youssouf, it is important to have the senior leadership in attendance at these meetings given the latitude that allows the local leadership in making decision about how those targets will be achieved. Going forward the local leaderships will present to the Committee their plan for meeting those targets.

Committee member, Josephine Bolus asked when would the ambulatory care be separated from the hospitals and will Gotham have the same as the hospitals.

Dr. Raju stated that effective January 2016 that separation would occur and asked Ms. Zurack to address the Gotham question as it relates to the budget methodology developed by finance.

Ms. Zurack stated that the methodology treated Gotham in one particular way and the ambulatory care at the hospitals in a different way. It was separated by sector. Corporate finance consulted a number of trade associations on how to measure workload and it was more technically based.

Mr. Covino continuing with the reporting stated that receipts were \$108 million better than budget while disbursements were \$35 million over budget and would be more detailed in the reporting. Cash disbursements and receipts compared to the prior year, inpatient receipts were up by \$37.4 million due to an increase in Medicaid fee-for-service, up by \$30 million which included \$14 million

of Meaningful Use funding; Medicaid managed care was also up by \$14.5 million. Outpatient was up by \$56.8 million of which \$48.4 million was for Medicaid managed care due to the MetroPlus risk pool payment that was received in July 2015. All other receipts were up by \$209 million due to an increase in City payments that were up by \$195 million; \$173 million due to tax levy advances for collective bargaining funding and prior year intracity payments. The pools were also up by \$109 million due to the timing of FY 15 first SLIPA payment that was prepaid offset by a reduction in DSH which was down by \$100 million compared to last year. However, in September 2015, HHC received \$201 million in DSH and as previously reported by Ms. Zurack, \$600 million in UPL payments are expected in October 2015. City payments were up by \$309 million that included payments for the prior FY 14 for medical malpractice, debt service and health insurance payments to the City. Affiliation expenses were up by \$14.5 million due to new contracts which included the collective bargaining increases. Bond debt was flat.

Mr. Page asked what drives the issuance of the Medicaid risk pool payment and why was it received at that time.

Mr. Covino stated that based on the utilization within the risk contracts, whereby whatever HHC does not receive as premiums after a small administrative fee from MetroPlus it is the saving on the care.

Mr. Page stated that the question related to the scheduling of those payments relative to whether the payments were scheduled monthly, quarterly, etc.

Ms. Zurack in response to Mr. Page's question stated that it is six months after the end of the fiscal year when MetroPlus is in a position to have enough IBNR worked off to better calculate the number.

Mr. Covino stated that to-date HHC has received the funding earlier due to HHC's cash position therefore this is not a true surplus. The actual estimate for the risk is around what it was for last year. This was just an early payment to HHC's due to the cash flow problem.

Ms. Youssef asked if the City payments of \$309 million was the major factor driving the reporting period that had the most impact on the actual. Mr. Covino responded in the affirmative.

Dr. Raju added that those payments were not a negative impact as Ms. Zurack explained last year those payments were delayed as planned and scheduled for payment this FY 16. Dr. Raju asked Ms. Zurack for further clarification.

Ms. Zurack added that the \$309 million refers to the FY 14 malpractice and debt service payments which HHC finance based on the pending UPL payments in FY for calendar Year 14 which was recently received in September 2015. Essentially, it is a year and nine months late. One of the UPL payments that was expected was for CY 11. The State and Federal governments were behind in those payments that ultimately impacted HHC's cash flow which HHC managed by delaying those City payments. Therefore, the FY 14 payments were made in August 2015, FY 16. The significance of those delays is that in order for HHC to catchup with the City for those payments HHC must receive those UPL payments from the State and Federal governments.

Ms. Youssef asked what would be the normal payment. Ms. Zurack stated that an annualized number including EMS would be approximately \$475 million constituting three major components, EMS, medical malpractice and debt service with slight fluctuations in each.

Ms. Youssef asked if HHC has any other outstanding payments other than those previously noted.

Ms. Zurack stated that there is an FY 15 payment of \$479 million outstanding.

Mr. Page asked what the projected outstanding amount is for the current FY 16.

Ms. Zurack stated that HHC expects to pay the FY 16 in FY 17. Therefore it will always be a running amount. Mr. Page asked if that amount would be \$475 million and whether that amount would be consist with HHC's plan.

Ms. Zurack responded in the affirmative adding that except for EMS given that those receipts are not HHC. If HHC makes its plan it would be \$300 million assuming that HHC gets caught up on EMS.

Mr. Covino continuing with the reporting stated that the comparison of the budget to the actual, inpatient receipts were up by \$5.3 million due to the Medicaid-fee-for-service that included an increase in the Meaningful Use funds of \$14 million. Outpatient receipts against the budget were down by \$2.8 million due to a reduction in the Medicare actual. All other receipts were up by \$8.3 million due to prior year intracity receipts. Miscellaneous receipts were up by \$4.4 million due to excess faculty practice receipts from PAGNY as well as the receipt of the 340B funds received in excess of the budget. Expenses, personal services (PS) and fringe benefits were on budget or slightly over budget due to the increase in FTEs. OTPS was \$29 million over budget due to an increase in the contracting

of professional services of \$8 million; purchased services of \$7 million; pharmaceutical and medical surgical supplies up by \$5 million in payments and bond debt was on budget.

Mr. Page asked if those OTPS services were connected to HHC labor force and the amount of services required.

Mr. Covino stated that it is a totally different requirements in terms of the budget variance which is not due to those temp services.

Ms. Zurack added that it is in the number.

Mr. Covino stated that it is in the number but it is not one of the driver of that increase versus the budget. It is consistent with prior year spending.

Ms. Youssef asked if HHC was affected by the recent news article pertaining to the closing of an ACO in NYS.

Dr. Wilson in response stated that it was not an ACO but rather Health Republic, an insurance plan.

Ms. Youssef asked if any of HHC patients were insured by that plan.

Ms. Zurack stated that a large number of HHC patients are covered by that plan.

Dr. Raju added that the issue is being address by HHC in that MetroPlus will enroll some of those members.

Ms. Zurack stated similarly HHC is looking into some of its other partners from HHC to pick up as many member as possible as well.

Information Item

Ms. Zurack introduced Ms. Laura Free and Mr. Robert Melican to the Committee stating that Mr. Melican was hired to manage the financial portion of the ICD-10 conversion under Ms. Free who is in charge of HHC Managed Care division where Mr. Melican resides.

Ms. Free stated that Mr. Melican has been leading the charge for the ICD-10 and working on HHC's readiness since 2012. The presentation on the Committee's agenda was intended to provide the Committee with an overview of the steps and actions taken by finance as part of that process.

Mr. Melican stated that HHC has overcome the first hurdle and is transmitting bills to payers from both fiscal systems and as of Friday, October 9, 2015, 1,700 claims which is an accomplishment were submitted. In terms of the Committee understanding ICD-10, what it is and its importance to HHC and the necessary steps taken to meet the requirements of the ICD-10, the entire US moved to a new coding scheme ICD-10 international coding of diseases on October 1, 2015. What has remained constant is that the ICD-10 is the building block for HHC's reimbursement based on the DRGs. The last time the US switched was in 1979. The reason for the change is that the language in 1979 did not fit the current medical terminology greater specificity was needed for today's research. This has translated into a change in the codes from 17,000 to 140,000 due to that specificity, in terms of encounter versus subsequent encounter and how an injury occurred. For example, one code in ICD-9, a broken leg, turns into 26 codes in ICD-10 due to the expansion of the cause, such as why it occurred, where it occurred, whether it was an initial or subsequent encounters noted a lot more documentation is required by the physicians. In terms of how HHC prepared for the change in the ICD-10 coding, there were targeted groups, HIM (health information management), coders; DRG validators and clinicians documentation improvement specialists that required training. There was a need to upgrade all of the software to accommodate all of the new coding from five to seven and educating the physicians on how to meet the new specificity. This was led by the executive steering committee chaired by Ms. Zurack and Sal Guido, Interim CIO, comprised of all of the major divisions, finance, managed care and each facility was represented.

Mrs. Bolus asked how far back HHC would have to go to correct the coding. Ms. Zurack stated that from October 1, 2015; however, there was a need to do some concurrent coding for some period of time.

Mrs. Bolus asked if that would pose any problems for HHC. Ms. Zurack stated that Mr. Melican would address that issue in the presentation.

Mr. Melican stated that the first piece was how to educate the staff involved in the process. All 200 plus coders were put through an introductory training class. Originally, ICD-10 was scheduled to begin in 2014 but was delayed to 2015. There were onsite webinars twice a month, onsite training seminars every other month. The coders were tested and a process of dual coding cases which Ms. Zurack prefaced or whereby cases were coded in ICD-10 and the computers would back-code them to 2009 in order to give the coders practice as part of the coding efforts.

Ms. Youssouf asked who does the coding. Mr. Melican stated that coding is done by the coders in the HIM department by reading the medical record and abstracting the procedures and diagnosis into a code set through the use of a software from 3M which enables them to get to a code faster by forming a pathway to get to a code.

Ms. Youssouf asked if it is something that through the EMR implementation will be done automatically. Ms. Zurack stated that it would not.

Mr. Melican stated that there will always be a certified medical record coder reading that medical record.

Mr. Page asked if the medial record was adequate to enable the coder to create the code.

Mr. Melican stated that it is and that is the challenge in the ICD-10 to put in place.

Ms. Zurack added that this is a highly regulated field in that the coders are certified. Coders can only code what physicians' document in the record and only physicians can document. Therefore, the coders reviewing the medical records identify inconsistencies must inform the physicians. The physician has to update the medical record.

Ms. Youssouf asked how often that occurs. Ms. Zurack stated that it occurs constantly.

Mr. Page asked what the time lag is from when the physician has to update the chart from the initial encounter with the patient.

Ms. Zurack stated that based on the information in the chart it is not a question of memory but rather looking at the chart and making the correct note. The case is there and some information may be missing or lacking. There are a number of indicators or factors that come into play that the coders are required to review and question.

Ms. Youssouf asked who certifies the coders. Ms. Zurack stated that it is HIMA.

Dr. Wilson clarified that it is the American Health Information Management Association (AHIMA).

Mr. Rosen asked if there is a crosswalk for converting the old ICD-9 to the new 10. Ms. Zurack stated that there is a crosswalk.

Mr. Melican stated that there is a software that can do that conversion.

Ms. Zurack stated that the other thing is the elementary piece, HHC has certified or super coders or DRG coders who review the coding after the fact and find things that the coders failed to catch. There are also clinician documentation specialist who are nurses who review the medical records on an ongoing basis who work with the physicians on identifying issues in the charts. It is not only retrospective but in real time as well.

Dr. Raju in response to Ms. Youssouf's questions stated that the outpatient is coded by the physicians. There is a major difference. It is easier to code and the coders are already trained to code charts, but the residents and physicians are a major challenge and a huge amount of work is needed to get them trained on how to do that level of specificity in the charts.

Mr. Melican stated that the IT component was focused on changing the systems and the handoff of codes one to another and to ensure continual payments. There were tests conducted with some of the major payers, Medicaid, MetroPlus and Medicare. The managed care rates were renegotiated to go to the new ICD-10 compliant grouping, converted payers encounter forms to be compliant. The physicians and the QuadraMed system which was completely updated to accommodate the new code set which was changing the problem with physicians selecting the diagnoses or the problem with the patient's encounter that in terms backup into a code. The physician does not code but selecting the proper diagnoses that links to a code in the QuadraMed system.

Ms. Youssouf asked if the system questions the selection made by the physician through a prompt.

Mr. Melican stated that the physician evolves to that definition through the input into the various medical services. For example, the broken leg the physician would enter orthopedics, the system would ask what bone was broken and that would prompt to the list whereby the physician would then select the code which is where the physicians' education would begin.

Ms. Zurack stated that there are two types of codes done by the physicians, one is the diagnosis code and the procedure code. What Mr. Melican was describing was the procedure code process. The doctors do know the diagnose codes and pick them from a dropdown menu.

Ms. Youssouf asked if that selection was out of the 176,000 codes. Ms. Zurack stated that there is a piece that cues the physician to the most common codes.

Ms. Katz stated that what was done in QuadraMed based on different services; based on the physicians documentation in the charts those common codes are based on the most common diagnose seen in that service; therefore, it is not out of the 176,000 codes but rather the subset of those codes. Over time the patients' problems were grouped and behind that those problems were codes and what was done for ICD-10, all of the problems' that were the patients diagnoses, the ICD-9 codes were converted to the 10.

Mr. Melican stated that on-site for the go-live, there were consultants in attendance at each facility from White Glove and the Enterprise service desk was used as a point of contact if any issues arose the physicians were instructed to contact the Enterprise service desk and assistance would be provided or the HIM state were on call as well. The physicians' education piece included a lot of on-site in person education that was the best approach on how to document to the ICD-10 level of specificity that resulted in over 120 sessions at each facility on primarily nine specialties with the greatest amount of changes from the ICD-9 to 10. Concentrating on those areas where the greatest difficulty would be. There were tip cards issued to the CMOs to HIM staff and on HHC website all of the pertinent information was made available.

Mr. Rosen asked if all of the current medical record must be recoded.

Ms. Katz stated that it is not the medical record. There is a problem list seen in a particular service such as medicine and each patient had in their records a list of diagnoses in the chart behind the screens. Those written diagnoses had a code attached to them that were in ICD-9 prior to October 1, 2015. Using common files and software those ICD-9 codes were converted to ICD-10 codes where possible. In some instances the 09 code was equal to more than one 10. Therefore, it was not a one for one match. In those instances a coder or physician would need to choose the appropriate code.

Ms. Zurack clarified that the IT contractor in conjunction with the staff did that piece. This is for outpatient where the physician does the coding.

Ms. Youssouf asked how the ICD-10 interacts with the electronic medical record, EPIC given that codes are required.

Ms. Zurack stated that when HHC moves from an electronic medical record to a state of the art electronic health record, it should result in more specificity of what is in the medical records which should improve coding.

Ms. Youssouf asked if in the new electronic medical records system there will be a code associated with the diagnoses.

Ms. Zurack stated it was difficult to answer that question given that the process will include the archiving of the old record until HHC has been on the new record for a while. The new record is an enterprise-wide record. If it is known that a patient has had a chronic condition at one of HHC facilities within the system each facility would know about that condition that should improve treatment and coding but that is only after the Corporation is a whole system and fully up and running on the new EPIC system. Only going forward, overtime it should improve the information available to the physician and the coders. On the outpatient side for Medicaid and Medicare documentation drives coding and coding drives reimbursements but the differences are not as extreme as the inpatient.

Ms. Bolus asked how many diagnoses could a patient have as part of the new ICD-10.

Mr. Melican stated that it could go up to 50 for one person but that would be rare given that it rarely goes above 25.

Ms. Zurack stated that the payers start at 25. There are multiple diagnose for comorbidity conditions. The choices are more but not necessarily more codes. However, the reimbursement is driven by the patient having multiple conditions at the time of the visit. On the outpatient side, there are two codes. Typically but there have been some efforts to get the physicians to do four to five complaints by the patients at the time of the visit.

Dr. Raju stated that if a patients comes in with a broken leg but has other conditions such as diabetics, hypertension, sometimes the physician only documents the broken leg and the hypertension but all of the conditions should be chosen. The problem is that physicians view the treatment as an episodic care only the primary diagnoses is addressed but other conditions exist and should be documented in the chart. This is the major issue with the physicians that is being addressed through the training as part of the ICD-10.

Ms. Zurack stated that as a way of conveying this issue as Mr. Melican indicated, the hospitals have used tip cards that basically state, "Be as specific as possible about the diagnosis." "Be very comprehensive for conditions that are systematic" which makes a significant

difference in HHC's reimbursement, managed care premiums, inpatient cases, etc. There has been reinforcement within the HIM departments relative to the coders and validators.

Dr. Raju stated that the major problem is that there needs to be a major change in the mindset of the physicians that would address the lack of documentation in the charts which is a major task and educational effort going forward.

Ms. Youssouf asked if it is expected that the coding changes in the ICD-10 will be at some point audited by the federal government.

Ms. Zurack stated that the validation on the part of the validators who address the compliance aspect of the coding and software that identifies inconsistencies in documentation and coding and compliance as well. The key is for the documentation to reflect only what was actually done and only code the revenue earned which is emphasized repeatedly as part of the process training.

Ms. Youssouf asked if that software was approved by the federal government or the required authorized regulators.

Mr. Melican stated that the software used is 3M on the inpatient side and QuadraMed on the outpatient side. The 3M software is the largest provider in the country and is fully compliant.

Ms. Zurack stated that 3M got the state contract for the state grouper and therefore it is a requirement for use by the hospitals.

Mr. Rosen asked how long ICD-9 was in existence. Mr. Melican stated that it has been since 1979 to October 2015.

Mr. Rosen asked if the hospitals would be required to use all of the codes in documenting and what is the logic behind the creation of that huge volume of codes.

Dr. Wilson stated that the ICD-10 is an international classification of diseases. It was not established for billing but rather for the purpose of describing illnesses and to epidemiological mapping around the world and is being upgraded due to the inadequacy in describing illnesses and treatment, diagnoses and procedural codes. In the USA, it has been taken as a description for billing purposes but that's not the primary reason for its design. There is a large number of codes inside these codes that may not materially make a big difference to coding. There are other codes that make a huge difference to coding and it depends on which payor better goes through it. The process is that a patient has an interaction a documentation of that interaction occurs in the medical records already a drop in information. Then that information in the medical record is received and translated into codes, a further drop of information and from that point billing is done. In each of those steps there is a reduction. The problem with under coding which is a bigger problem of compliance risk of over coding. Under coding means that HHC will not get the appropriate level of reimbursement but it also means that patients are being described as not being as sick. Therefore, in the epidemiology world where there are CMIs, HHC patients appear less sick than other patients. This whole process as it relates to doing it correctly, if not done the way it should be, HHC will bill less resulting in less revenue. At the current time there are some weak points in this process which this training program and team have done by addressing some of those weak points but some of those weak points consist of whether the physician are documenting the interaction fully and secondly, the question of whether physicians should be doing coding. Although there are fewer codes there still five million visits compared to 220,000 inpatient discharges. Therefore, in terms of volume there is a major difference. HHC has to get over the hump and then rethink how HHC is doing all of these processes. This is a major challenge and a lot of preparation has gone into this process.

Mrs. Bolus asked for clarification of reduction stated in Dr. Wilson's overview.

Dr. Wilson stated that all of the information is not being captured that is stated as part of the visit and all that is stated in the records does translate all that was stated in the visit and within the record into a code.

Ms. Zurack stated that the ICD-10 has been around for a long time approximately twenty years.

Dr. Wilson added that in 1997-98 was the first public use of ICD-10.

Ms. Zurack stated that it has been used in other countries for a long time but do not have the type of reimbursement system as HHC. It is not as complicated and has been used for more precise diagnostics but now being used to drive more precise payments.

Mrs. Bolus asked whether it was more time consuming for the physicians or the coders. Ms. Zurack stated that it is more for the coders.

Dr. Wilson added that for physicians this month there has been a big issue with the ICD-10 training, Meaningful Use, and E-prescribing all of which increase the amount of time the physicians and to address that issue the schedules have been staggered to allow time to do that, otherwise the patients would be waiting an extremely long time which would not be very patient sensitive. This is a major impact on physicians and what is required of them.

Mr. Melican stated that the future plan include as Dr. Wilson indicated concentrating on improving the physicians documentation and having the coders capture as much as possible as accurately as possible that documentation in the inpatient system; optimizing the system by reviewing the changes and ensuring that the systems are as streamlined as possible and easy for the HIM staff to use and understand where the weaknesses are. There will be a fifth pass of the processes in the coming months through a value stream process to concentrate on the progress and evaluate where HHC stand in the ICD-10 process.

Mr. Rosen stated that it would appear that many of those codes will not be used and asked whether some effort would be made to review that in the future so as to easy the role of the physicians.

Mr. Melican stated that a lot of those codes will never be used. However, HHC has a tool that can used to run its coding through an Advisory Board tool called Compass that allows HHC to compare how it is doing to peer hospitals.

Ms. Youssouf stated that the overall presentation of the process was very impressive in terms of the volume of work involved and how this system works with the electronic health medical record which is of concern in terms of how these systems are being managed.

Dr. Raju stated and asked for confirmation on whether this system would interface with the EPIC system when it goes live. Mr. Melican responded in the affirmative.

Ms. Zurack stated that on the inpatient side it would not.

Dr. Raju clarifying the question and response stated that the ICD-10 coding software will interface with the EPIC system to which Ms. Zurack agreed.

Mrs. Bolus asked that provider be used as a point of reference as oppose to physician.

Dr. Raju stated that the ICD-10 is a huge problem across the country and finance has done a lot of work in pulling this together.

Mr. Melican stated that it was a team effort on behalf of the staff that worked on the project.

Mr. Page asked if when the physician does the initial write up it would be in a language that made sense at that level to avoid repeated translations which is extremely time consuming.

Ms. Zurack stated that what has been observed after reviewing this process, in the future the electronic health record it is important that as the providers are navigating through the screens which are driven by what the providers are doing it is not free text but it drives logically and intuitively so as to avoid having to do the extra work. This is part of the IT vendor to get a system that will do that which will enable better coding better reimbursement and documentation. The presentation was concluded.

Medical & Professional Affairs / Information Technology Committee

October 8, 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.

Hurricane Joaquin

Last week HHC activated its coastal storm preparations in response to the threat posed by this hurricane. Fortunately the hurricane changed course to avoid New York City, but did significant damage elsewhere. Our preparations demonstrated the great team work at HHC, and also how much progress we have made since Hurricane Sandy. Systematic debriefing will be undertaken so that we continue to learn, particularly for those facilities in zones 1 & 2 for possible evacuation. Those sites are Bellevue, Coler, Metropolitan, Coney Island and our office space on Water St.

Accountable Care Organization (ACO)

In September, the ACO released the newest version of its Population Management Dashboard to our 18 facility-based ACO Clinical Teams. This tool continues to evolve to optimize the value of Medicare financial utilization data, and joining it together with clinical, demographic, and social service information to guide teams to our highest risk patients and connecting them to the most valuable supportive interventions to keep them healthy.

Building upon the ACO's innovative use of data to drive high value patient-centered care, the ACO has also completed initial data validation with clinical and IT colleagues for a new Business Intelligence (BI) dashboard release. This BI dashboard is focused on an initial subset of clinical quality measures, and will be the first phase of development of a comprehensive Ambulatory Care Dashboard for HHC's total primary care population. The new tool was recently opened for clinician feedback.

As part of maintaining a rigorous compliance plan, the ACO recently completed a proactive risk assessment exercise with the Office of Corporate Compliance.

Office of Behavioral Health

The Office of Behavioral Health hosted a half-day conference on K-2 (Synthetic Cannabinoids) for Medical and Psychiatric emergency services staff from each of our facilities. The conference goal was to provide education, information and data on K-2. The conference also focused on establishing a standardized approach to management and treatment of patients presenting with K-2 use. Weekly data is collected from all facilities, adult, pediatric, and psychiatric and compared with the data collected by DOHMH. A representative work group from the facilities has been established to formalize these processes.

The Office of Behavioral Health is coordinating a work group related to the management of violence. This involves the Councils of Emergency Medicine and Psychiatry as well as other identified staff from facilities. The goal is to review the current state of resources, assessment and management of violence, review other best practices, and establish additional tools and interventions for the management of violence in HHC.

Behavioral Health Transformation activities are moving forward. There is ongoing work on both Access and High Utilizer projects. The Office is working with other M&PA divisions – Ambulatory Care, Population Health, ACO – to ensure alignment. OBH is working with One City Health on the DSRIP projects such as integration of Primary Care and Behavioral Health. The office is also working with facilities in readiness for Managed Care through a gap analysis.

Office of Patient Centered Care

The New York City Health and Hospitals Corporation 2015 Nursing Excellence Awards Ceremony honor nurses who exhibit excellence in six award categories:

- Home, Community and Ambulatory Care Services,
- Professional Management,
- Volunteerism and Service,
- Clinical Nursing for Inpatient Services,
- Education and Mentorship,
- Advancing and Leading the Profession

Award recipients are a remarkable group of individuals who serve as staff nurses, educators, leaders, innovators, collaborators, coaches, mentors and advocates. The six HHC nurses who will be awarded for their outstanding achievements are: Robert Smeltz, NP - Bellevue Hospital Center, Eileen Achacoso, BSN, MA - Central Office (EITS), Tiffany Reid, CLC, MS, PNP - Harlem Hospital Center, Susan Gullo, RN - North Central Bronx Hospital, Bindu Rai, RN - Elmhurst Hospital Center and Marie E. Torell-Alverio, RN,MSN,BC,WCC - Coney Island

Event Details:

HHC's 2015 Nursing Excellence Award Ceremony
 Tuesday, October 27, 2015 from 2:00 PM to 4:00 PM
 New York Law School
 185 West Broadway, 2nd Floor
 New York, New York 10013

Office of Ambulatory Care Transformation

Access to Primary Care: we continue to sustain and build on improvements. At an HHC average level, appointment access for new patients is improved to ~18 days in adult medicine and ~7 days in pediatrics on average (vs. 55 days and 14 days at baseline), though there is significant variation across sites.

IMSAL

HHC's Simulation Center expanded access to Queens based healthcare teams with the opening of the IMSAL Elmhurst Simulation Center. This is the first satellite center in the devolving structure of IMSAL. The center has staff who have been trained by IMSAL Central in simulation administration, simulation technical operations and simulation educational and debriefing expertise. The center will offer clinicians the access to train in a risk-free setting to perfect teamwork and communications skills and improve clinical techniques and procedures without having to spend hours each day in travel time. Using electronically programmed mannequins in real-life, orchestrated scenarios, HHC clinicians practice airway management, central line placement, pediatric and adult codes, postpartum hemorrhage teamwork/skills, and labor and delivery emergency management for shoulder dystocia. Simulation rooms replicate operating, intensive care, and emergency rooms, as well as patient exam rooms.

Are the IMSAL HHC Satellite Simulation Center going to be mobile, will they be taken from hospital to hospital or centralized in each hospital or borough? No, they will be staying in each hospital it's the people, not the equipment that will move around. Simulation training has devolved to satellite clinics from centralized program at Jacobi. The satellite simulation centers will stay at the site, the staff will move around. The objective is to reduce travel by staff to go to training and bring the training closer to staff. The protocols will be standardized centrally, the Leads may move around and assist local teachers at each site. *This is a good idea, older staff is leaving they have the experience and the younger staff needs more training and experience.* There should be a knowledge and skill transfer. Some of the mobility will be video conferencing. We have to make sure new staff have more experience need additional strategies for more training of knowledge and skills transfer.

A question on DSRIP- How are things progressing, budgets and I am curious on how we are working with our partners and is everything going smoothly? On time with all reporting requirements to the State. On time in expected financial receipts from the State. We are progressing well in our discussion with our 200 partners. We are in the contracting phase of the agreement issuing contract to particular partners for particular bodies of work. Contract Phase Agreement with the master contract will look like a lot of consultation. The expectation is that the contract will commence within the next 4 to 6 weeks. The partners' next concern will be that they received the budget they expected and amount they want to be paid. The point of potential tension over the next 3 to 4 months is the impact on jobs. The State has created a level of uncertainty as to what happens to jobs as a result of DSRIP. If DSRIP may lead to decrease in the number of beds what will happen to staff. Tension is ahead of identifying the problem, the tension it's not helpful. We can't solve the problem at this time. We are struggling to make demand ie: the Behavioral Health issue and emergency department visits are huge and not going down. We can't solve the problem right now. Demand is huge and is not going down. Wanted a sense of where the potential tension would be.

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 September 1, 2015 was 472,251. Breakdown of plan enrollment by line of business is as follows:

Medicaid	417,698
Child Health Plus	112,194
MetroPlus Gold	3,609
Partnership in Care (HIV/SNP)	4,645
Medicare	8,451
MLTC	874
QHP	24,116
SHOP	479
FIDA	185

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.

Since my last report to this committee, New York State of Health has approved the Qualified Health Plan rates we submitted. MetroPlus is the least expensive plan among our competitors. We are hoping for a significant enrollment due to our competitive rates. The Open Enrollment Period (OEP) begins in November. For our Silver product, our rate decreased by 4%, while the competitors' increased between 6% and 9%. For the Platinum product, our rate for 2016 decreased by 2%, while the competitors raised their rates by 5% - 10%. We reduced our Bronze and Gold metal tier rates by 7% and 2%, respectively, while the other plans' increased between 5% and 8%.

MetroPlus has received conditional approval for the new line of business, the Essential Plan, which is starting on November 1st. The Essential Plan is either free or \$20/month and it will cover eligible population that is between 138% and 200% of the Federal Poverty Level. We are looking to work closely with the HHC facilities to train all the HCIs. Some facilities are already scheduled for such training. Furthermore, MetroPlus and HHC are joining efforts in sending a mailing to the HHC self-pay population informing them how they can enroll in the Essential Plan.

MetroPlus Gold Open Enrollment opens on October 1st. We are excited about the expansion of the program to all NYC employees (CUNY employees, libraries, cultural organizations and some charter schools). MetroPlus, in conjunction with HHC, has developed a full marketing campaign and roll-out. We are also trying to increase the awareness in the HHC facilities; there will be a one sheet flyer with paychecks on October 9th, HHC wide, in addition to an email from Dr. Raju.

We have been preparing diligently for the upcoming Open Enrollment Period both operationally and strategically. We have developed aggressive marketing campaigns that now include TV advertising in addition to previously used venues such as subway, buses, etc. We continue to focus our efforts on both new member enrollment and retention of existing members.

I would also like to inform this committee that MetroPlus applied for and has been approved to participate in the Value Based Purchasing Quality Improvement Program (VBPQIP) as the lead for HHC's OneCity Health. We will establish governance oversight via a VBPQIP committee which will include leadership from MetroPlus Medical Management and Finance, OneCity Health, HHC Finance, Corporate Planning, and Medical and Professional Affairs, as well as representatives from HealthFirst and Emblem. The governance committee will ensure the PPS receives the data it requires to create quality improvement processes in collaboration with the facilities. There will be a key link between this committee and the facilities/participating entities forming the PPS. The program is scheduled to commence in April 2016.

Over the past several months, MetroPlus has been successfully working to achieve ICD-10 readiness for the October 1st implementation date. We are hopeful that our providers are also prepared. I will be submitting updates to the committee in the upcoming months.

As of the date of this report, we are undergoing the Article 44 audit (a full licensing audit conducted by the NYS DOH with representatives from both Albany and NYC offices). I will present the findings at this Committee's next meeting.

Do we have dental as part of MetroPlus? No, it is not standard we do have an option for it; it is the same dental plan the city uses Healthplex. *What other plans are part of shop (small business)?* MetroPlus has a very small percentage of shop. *What are the other two plans?* One is Emblem, I can remember the other plans. *Is there anything on the Staten Island issue?* Yes, we may be able to have MetroPlus Gold is good but there probably not until next year.

Sal Guido, Acting Senior Vice President/Corporate CIO Enterprise Information Technology Services reported on the following initiatives: 20 Requirement Contracts Awarded to provide IT Consultants, Spending Authority for non-Epic IT Consultant up to \$43 million, Benefits Associated IT Consultant Requirements Contracts and Work Order Assignment Process

Action Item:

Machelle Allen, MD Deputy Chief Medical Officer, Health Care Improvement presented the resolution to the committee on the trauma centers.

Approving the application for verification by the American College of Surgeons of Harlem Hospital Center ("Harlem Hospital Center") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation"), or his designee, to execute any and all documents necessary to verify trauma Center designation for Harlem Hospital Center through the American College of Surgeons, Committee on Trauma.

Approving the application for verification by the American College of Surgeons of Jacobi Medical Center ("Jacobi Medical Center") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation"), or his designee, to execute any and all documents necessary to verify trauma Center designation for Jacobi Medical Center through the American College of Surgeons, Committee on Trauma.

Approving the application for verification by the American College of Surgeons of Kings County Hospital Center ("Kings County Hospital Center") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation"), or his designee, to execute any and all documents necessary to verify trauma Center designation for Kings County Hospital Center through the American College of Surgeons, Committee on Trauma.

Approving the application for verification by the American College of Surgeons of Lincoln Medical & Mental Health Center ("Lincoln Medical & Mental Health Center") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation"), or his designee, to execute any and all documents necessary to verify trauma Center designation for Lincoln Medical and Mental Health Center through the American College of Surgeons, Committee on Trauma.

Approving the application for verification by the American College of Surgeons of Bellevue Hospital Center ("Bellevue Hospital Center") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation"), or his designee, to execute any and all documents necessary to verify trauma Center designation for Bellevue Hospital Center through the American College of Surgeons, Committee on Trauma.

Approving the application for verification by the American College of Surgeons of Elmhurst Hospital Center ("Elmhurst Hospital Center") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation"), or his designee, to execute any and all documents necessary to verify trauma Center designation for Elmhurst Hospital Center through the American College of Surgeons, Committee on Trauma.

Trauma center designation for Harlem, Jacobi, Kings County, Lincoln, Bellevue and Elmhurst was approved for consideration by the full board.

Does the leadership feels it's worth the investment? Does it fulfill a community service even though there is low volume? We believe as the public system it is part of our roll to provide trauma centers in the community. They are the determining body. If the American College of Surgeons believe this is not enough than the service cannot be provided. There is a real cost. Does the trauma center designation have a revenue implication? Yes. Does trauma center designation going to have an impact on the services to the community? No, we remain steadfast to our mission.

Sal Guido, Acting Senior Vice President/Corporate CIO and Brenda Schultz, Assistant Vice President Enterprise Information Technology Services presented the committee the following.

Authorizing the New York City Health and Hospitals Corporation ("the Corporation") to enter into a Cisco Enterprise License Agreement ("ELA") through a Third Party Contract as part of the LAN Migration/Network Infrastructure refresh project in an amount not to exceed \$11,410,000 for a five year period.

Approved for consideration by the full board

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to use the 20 requirement contracts that were awarded for a two year term with three one-year options to renew to purchase health information related professional IT consultant services as needed to meet non-Epic EMR related IT consulting needs for an amount not to exceed \$43 million for the initial two year term.

Approved for consideration by the full board

Information Item:

Alfred Garafalo, Interim Chief Medical Informatics Officer, Enterprise Information Technology Services presented the committee the on ICD 10 implementation: Six months of work in the following area CIS ICD10 Preparation - CIS Communication Strategy (Weekly Foreign Systems Updates, Quadramed Communication, Communication Plan, and Support Materials) – Thirty Six hour snapshot (Enterprise Service Desk Tickets, Unmatched Codes, Monitoring, White Glove Support Staff, and Command Center Updates) Manual updates no problems as of October 1. I would like to underscore that the e integrated teamwork in getting the job done was excellent. This is a model for how this type of work should be done. ICD 10 went off without a hitch. We won't see the results on billing until we have a look at revenues.

Strategic Planning Committee – October 13, 2015 **As reported by Josephine Bolus, RN**

Federal Update

Ms. Brown reported on the following:

Two-Midnight Rule Update

Ms. Brown reported that, on September 21, 2015, a federal judge rejected CMS' argument that it met the legal requirements for rule making when it cut the hospitals inpatient payments by .2% in conjunction with its Two-Midnight Rule policy. She informed the Committee that the reduction was included in the FY 2014 IPPS rule, which took effect on October 1, 2013. Moreover, CMS was ordered by the court to provide further justification, which would provide hospitals with an opportunity to comment on CMS' actions. Ms. Brown added that, if CMS cannot robustly justify its .2% cut, the court could order that withheld funds be retroactively restored to hospitals starting from October 1, 2013.

Ms. Brown informed the Committee that Dr. Raju, who is a Board Member of the American Hospital Association (AHA), along with herself and her staff have been very much involved with discussions with AHA, the Greater New York Hospital Association (GNYHA), the Healthcare Association of New York State (HANYs) and the American Essential Hospitals (AEH) concerning this issue.

Dr. Raju acknowledged that Ms. Brown has been very instrumental to this success. He explained that the Two-Midnight Rule helps the hospitals to keep the patients for more than two days, which is the opposite intention of the Two-Midnight policy. Moreover, 80% of patients' costs are incurred in the first day when all tests are done before a diagnosis is reached; thus, the rule is trying to replace 80% of the inpatient rate with a very minuscule outpatient rate. Dr. Raju noted that the Two-Midnight Rule is a cost saving measure, which is going to create a different mindset for the patient.

340B Drug Discount Program Update

Ms. Brown reminded the Committee that the 340 Drug Discount Program Mega Rule was promulgated by CMS at the end of August. She informed the Committee that the 340B Drug Discount Program guidance is still in play. Ms. Brown reminded the Committee that the 340B Program was specifically designed for safety net hospitals and federally qualified health centers (FQHCs). She explained that the definition of safety net hospitals has grown from just public and governmental hospitals to include children's hospitals and critical access hospitals in rural areas, etc. She added that, because of the high cost of certain drugs, there have been a greater uptake on the part of providers who meet the definition to participate in 340B program. This new guidance is HRSA's attempt to tighten up the rules on how and when the 340B Drug Discount Program can be used. As such, the new guidance:

- Changes the definition of patients tied to "billable" outpatient service
- Changes the definition of covered inpatient drugs
- Excludes discharge drugs from 340B program
- Excludes the use of 340B for observation and ED visits that lead to inpatient stays
- Excludes infusion only services
- Excludes pharmaceuticals in bundled Medicaid payments (which could cost HHC \$5-10 million/year)

Ms. Brown commented that there has been a great deal of advocacy particularly from the American Essentials Hospitals on pushing back on the greater stringency that HRSA has been inclined to make regarding the 340B program. The new guidance is not as bad as it could have been since there was language months ago that could have been even more restrictive.

Dr. Raju highlighted that the public hospitals would be affected more than the others. The fight is against one of the most powerful lobbying groups in the country. Dr. Raju stated that, if the program goes away, the services that require some of the most expensive medications such as HIV, chemotherapy, anti-psychotic and HepC would be tremendously affected. Moreover, Dr. Raju added that the fact that HHC would not be able to provide discharge medications to patients so that they do not have to go to a pharmacy in order to follow-up with their care, especially if it is snowing outside, is problematic. Dr. Raju stated that more advocacy efforts are needed around this issue, while keeping in mind that the fight will be against Big Pharma, one of the most powerful lobbying groups in the country. Dr. Raju commented that patients will be affected by this new guidance.

Re-authorization of Zadroga Act

As reported at previous Committee meetings, Ms. Brown stated that the James L. Zadroga 9/11 Health and Compensation Act for injured and ill 9/11 survivors and responders is set to expire in 2016. Ms. Brown added that, as challenging as that timeframe is, some recent media reports miss-stated or simply got wrong important facts that was disconcerting to both patients and staff. She clarified that first and foremost, HHC's World Trade Center Environmental Health Center is fully funded and budgeted through December 31, 2016. Notwithstanding, it is true that, as of October 1, 2015, the clock started ticking to require congressional reauthorization of the Zadroga Act. Ms. Brown informed the Committee that Senate and the House, Republicans and Democrats alike has assured that reauthorization for the health program would occur by early to mid-2016, if not sooner.

Ms. Brown stated that support grew significantly after September 16th when dozens of responders, survivors and their advocates, including staff and patients of HHC's WTC Health Program, visited the offices of over half of all Congress Members. As of October 13th, a total of 58 Senators and nearly 200 House Representatives have signed on in support of re-authorization. It is anticipated that those numbers will steadily grow. HHC joins the City of New York in thanking the key legislative leaders, New York Senators Gillibrand and Schumer and Congresspersons Nadler, Maloney and King, for continuing their push for a permanent re-authorization of the bill. In the meantime, the program is fully functioning and proceeding in the usual, expected and necessary ways.

Mr. Robert Nolan, Board Member, asked if the health component of the Zadroga Act has already expired. Ms. Brown responded that the health component of the Act did not expire. She stressed that it is authorized through December 31, 2016. She explained that the National Institute for Occupational Health Services (NIOSH), the federal agency responsible for the entire Zadroga program has to begin program phase out activities so that by December 31st they would not have any obligations such as contractual issues, etc.

Ms. Brown commented that purposefully the proponents of permanent reauthorization wanted to peak people's interest and wanted folks to get excited about the possibility that if the Act expired that many people would no longer have the level of support that pays for their very expensive and extensive healthcare needs. Ms. Brown reassured Mr. Nolan that the reauthorization of the Zadroga Act has gained the support of legislators throughout the country because there are many responders who came from middle of America to New York who have been affected in terms of their health conditions. It appears that there is a groundswell of Congressional support from both aisles and that there will be a permanent reauthorization.

Council Awards \$300,000 to HHC and NYLAG

Ms. Brown informed the Committee that the City Budget and negotiations with the Council usually takes place over the summer and concludes by the end June in order to meet a July 1st effective date. Ms. Brown reported that this year there were some programmatic and policy issues that the Council wanted to spend more time on before making a final determination particularly in the area of funding community based organizations and funding efforts related to immigrants. Ms. Brown informed the Committee that, HHC had put forward a couple of projects to be funded and was also solicited by the Council to put forward programs, particularly to serve immigrants patients. She reported that one of these programs is essentially an enhancement of an existing partnership HHC had with the New York Legal Assistance Group (NYLAG). She informed the Committee that NYLAG, which started at Elmhurst Hospital, now has a presence in several of HHC facilities. Ms. Brown clarified that NYLAG does not represent patients in malpractice cases but does help patients resolve critical issues that would enhance their lives around housing, citizenship, qualifying for support services, custody, employment issues, etc. Ms. Brown noted that there are many concerns that patients and their family members present. In particular, there are patients who are immigrants who have questions concerning their eligibility for certain services. These individuals need help with clarifying what their status is because there are many people who think that their status is such that they are not eligible. In fact, with some work on the part of attorneys who have a particular expertise and who can focus on issues, we find that many patients can enjoy some benefits that can help both them and HHC, in terms of reimbursement for their healthcare services. These attorneys can also help patients to retain their eligibility for financial support beyond emergency Medicaid for their healthcare services.

Ms. Brown reported that HHC had put together a proposal with NYLAG and submitted it to the City Council. The proposal entails a request for additional funds for 2.2 FTE staff attorneys and 1.5 FTE paralegals to augment the legal staff that are already in the facilities. This team would be mobile and would specifically focus on patients who are undocumented to see if they could garner any type of resources for those patients. Ms. Brown stated that HHC took this approach. She provided one such example that had a very positive outcome for a patient and HHC.

Ms. Brown read the following case:

"In the early hours of October 7, 2012, Mr. "P" was found at the bottom of a staircase at the entrance of a subway, apparently beaten badly with severe injuries. Mr. "P" was taken to Wyckoff Medical Center, the nearest emergency room, where he was medically stabilized but he was then transferred to Kings County. He suffered from broken ribs, a fractured sternum, numerous broken vertebrae and subsequent paralysis and paraplegia. After his acute needs were addressed, Mr. "P" required long term rehabilitative services. HHC's long term care facilities had no available bed at that time so Mr. "P" stayed at Kings County. Mr. "P", by the way, is an immigrant. Because Mr. "P" was undocumented, from Honduras, he was unable to receive rehabilitative care that would have been available by a non-public facility. Instead, he remained a long term and, what we call an "alternate level of care patient" at Kings. He was referred to Legal Health staff to determine whether there was any immigration remedies that could allow him to be eligible for Medicaid. After a comprehensive intake, Legal Health filed a deferred action application with the United States Citizenship and Immigration Services Office for discretionary relief. In doing so, Legal Health, and after many, many months, was able to establish Mr. P's eligibility for regular non-Medicaid. After multiple tests to process Mr. "P"'s Medicaid application, and a fair hearing in front of an administrative law judge, Legal Health and Medicaid settled the matter and Mr. "P" was approved after many, many months, meanwhile he is still in hospital bed. Mr. "P" has been transferred because he now has Medicaid to the Far Rockaway Rehabilitation facility (HHC's beds were all filled), where he is receiving physical therapy and is able to interact with others in a more appropriate setting. There are many Mr. "Ps" in HHC. There are many Mr. "Ps" in both our acute hospitals and our long term care facilities. So, in addition to providing the direct benefits to Mr. "P" Legal Health Services have enabled HHC to recover Medicaid dollars for the services we provided him. In his case, and two others, all at Kings County Hospital, alone we recover more than \$300,000 in Medicaid revenue."

Ms. Brown concluded her remarks by stating that Council funds would be used to expand legal services for immigrants who get their healthcare at HHC facilities. Attorneys will work to obtain assistance on immigration matters, healthcare access, public benefits and housing. Patients, like Mr. "P" would benefit from expanded services that they may not have otherwise qualified for. It is hopeful that the \$300,000 Council award will help thousands of Mr. "Ps" and provide HHC with additional revenue opportunities.

INFORMATION ITEM

Presentation: Gotham Health FQHC Update - Walid Michelen, Chief Executive Officer & Chief Medical Officer Gotham Health

Ms. Brown introduced Walid Michelen, MD, Chief Executive Officer and Chief Medical Officer of Gotham Health. As Gotham Health is a new entity within the HHC family, Ms. Brown stated that it was an opportune time to provide the Committee with some background information around Gotham Health to enhance the Committee's understanding of this very important effort undertaken by HHC to strengthen the viability of the ambulatory care services network.

Dr. Michelen greeted Committee members and invited guests. He stated that his presentation would cover the following topics:

- Definition of a Federally Qualified Health Center (FQHC)
- Why HHC sought FQHC Look-Alike designation for its six D&TCs
- HHC's strategy to obtain designation
 - Public Entity and Co-Applicant Model
- What is Gotham Health?
- How does Gotham Health align with Vision 20-20?

Dr. Michelen began his presentation by providing the Committee with an overview of what is a federally qualified health center (FQHC). He stated that there was a movement that started by Jack Geiger in New York to develop health centers to address the needs of the poor and uninsured across the country. Dr. Michelen stated that the Federal Government had established a health center under Section 330 of the federal Public Health Services Act, overseen/regulated by the Department of Health and Human Services' (DHHS) Health Resources Administration's (HRSA) Bureau of Primary Health Care. This health center is required to serve a medically underserved area (MUA) or medically underserved population designated by DHHS. It is mandated to provide care to anyone seeking health care (with emphasis on those with incomes below the poverty level) and is required to be a charitable, tax-exempt non-profit organization. In addition, the health center is to be eligible to receive "wrap-around payments" (i.e., difference between FQHC Medicaid FFS rates and Medicaid HMO payments) and higher than state Medicaid FFS rates, eligible for Section 330 grants for serving

special populations or providing targeted programs, eligible for participation in federal malpractice program. Dr. Michelen stated that, as a FQHC Look-Alike, HHC enjoys most of these benefits, except for certain Section 330 grants and the federal malpractice program.

Ms. Brown clarified that HHC had strategically sought the FQHC Look-Alike designation because the application process was more streamlined and designation could have been achieved more quickly. Dr. Michelen added that as healthcare is moving toward more primary care, becoming a FQHC Look-Alike aligns HHC with that national mission.

Dr. Michelen shared with the Committee the driving forces for HHC to seek FQHC Look-Alike designation for its six Diagnostic & Treatment Centers (D&TCs) as listed below:

- To ensure the viability of vital primary care, dental and behavioral health services in 40 service delivery sites
 - 130,000 patients served in FY'13
- To access new revenues through higher FQHC payment rates and federal grants
 - Estimated \$25 - \$30 million in additional patient revenues to offset losses of \$70 million in FY'13
 - Opportunities for 330 grants
- To increase access to primary care for low-income New Yorkers over the long term

Ms. Brown added that in 2013, HHC was engaged in the strategy of reducing its structural deficit through "the Road Ahead". Becoming a FQHC Look-Alike was one of the many strategies that were contemplated to avoid closing some of the smaller clinics in order to address HHC's operating deficit as it was done in the past. Ms. Brown noted that these clinics are never going to be self-sustaining. Therefore, because the Federal Government supports ambulatory care and HHC is the single largest public healthcare provider in the country, FQHC Look-Alike status would enable these smaller clinics to become more viable and have a sustainable source of funding.

Dr. Michelen continued his presentation and added that in the past, public hospitals were not allowed to seek FQHC Look-Alike designation. However, the Federal Government has changed the rules. First, it was recognized that given the federal requirements around governance, capital assets and financial controls that a public entity could not meet those requirements. Therefore, it allows a public entity to co-sponsor an FQHC with a co-applicant, which could be a community controlled board with half of its members being patients of the health centers. See timeline below:

- In 1997, the federal government issued its first guidance related to granting FQHC designation to public entity health centers
- A more recent, more expansive guidance concerning the public entity FQHC model was issued in 2014
 - Guidance(s) explicitly recognized that it would be impossible for public entities to meet all FQHC governance requirements (e.g., community controlled Board) as public entities are subject to laws and regulations regarding personnel, capital assets and financial controls
- New public entity FQHC model
 - Allows a public entity to co-sponsor an FQHC with a Co-Applicant that has a community-controlled Board
 - This arrangement allows the public-entity (HHC) to maintain its statutory arrangements regarding personnel and financial controls and to comply with requirements of bond covenants regarding capital investments

Dr. Michelen reported that half of the Gotham Board members are patients from the health centers. Together with HHC, that board submitted an application to HRSA to obtain FQHC Look-Alike designation. The application process is described below:

- Public Entity (HHC) and Co-Applicant (Gotham Health FQHC, Inc.) apply together for FQHC Look-Alike status
- Both parties sign a Co-Applicant Agreement that sets forth respective responsibilities and duties
 - Co-Applicant retains final approval of HRSA (federal agency) mandated policy and programmatic aspects of health center operations
 - Public Entity retains ownership of properties, continues employment of staff, maintains responsibility over fiscal and personnel policies, and is responsible for day to day operations of the center sites
- The Co-Applicant forms a community-controlled Board
 - At least 51% must use the D&TCs as their principal source of primary care
- A Liaison Committee is formed with representatives from the Public Entity and Co-Applicant to work through issues that arise

Ms. Brown added that she and George Proctor are the two corporate officers who serve on the Liaison Committee along with the Board's Chairperson and Vice Chairperson. She added that the responsibilities for each party is outlined in the Co-Applicant agreement signed by the Gotham FQHC, Inc. Board and by HHC. She noted that the agreement was reviewed and had to be approved by the Federal Government.

Dr. Michelen defines Gotham Health FQHC, Inc. as the Co-Applicant Board with which HHC (Public Entity) applied to HRSA and NYS for designation of the six diagnostic and treatment centers (D&TCs) as FQHC Look-Alikes. It is a New York not-for-profit corporation governed by a Board that meets the composition requirements of Section 330 of the Public Health Services Act. At the request of Mr. Rosen, Ms. Brown clarified that 51% of the Board members must use the D&TCs as their principal source of primary care.

Dr. Michelen shared with the Committee the names of the current Gotham Board Members as listed below:

NAME	TITLE
Dr. Dolores McCray	Chairperson
Ms. Elissa Macklin	Vice Chairperson
Ms. Antoinette Brown	Treasurer
Ms. Vivian Bright	Secretary
Mr. Paul Covington	Board Member
Mr. Moises Perez	Board Member
Ms. Michelle Morazán	Board Member
Ms. Denitra Johnson	Board Member
Mr. Herman Smith	Board Member
Ms. Ana Lee	Board Member

Dr. Michelen stressed that the members do not function as community advisory board members, but as board members who make decisions on significant policy and financial decisions.

Dr. Michelen presented the members of Gotham Executive Team as the following:

NAME	TITLE
Dr. Walid Michelen	Chief Executive Officer / Chief Medical Officer
Ms. Anita Lee	Chief Operating Officer
Ms. Karen Dudek	Chief Nursing Officer
Mr. Ollie Worthy	Director of Finance
Mr. Ching Min Yuan	Director of IT
John Rabbia	Director of Quality and Population Management

Dr. Michelen reported that HHC received FQHC-LA designation February 1, 2015 (it took nearly 3 years!). He explained that Gotham Health is the "umbrella" name of the FQHC-LA designated sites and their satellites. There are a total of six sites including Segundo Belvis, Morrisania, East New York, Cumberland, Gouverneur, Renaissance and 34 satellite locations including school-based health centers. Mr. Rosen asked if outpatient clinics are also included. Ms. Brown responded that it includes all outpatient clinics that are not inside an HHC hospital. She reminded the Committee that all the extension clinics or satellites of the D&TCs are part of Gotham Health. Ms. Brown stressed that Gotham Health FQHC, Inc. is the tax-exempt entity that was the co-applicant. However, Gotham Health is the name HHC is using to help people who work in those sites to form as a team. She noted that they are still part of the HHC family and also part of Gotham Health. Dr. Michelen added that, since Gotham Health is still part of HHC, it follows all HHC policies and procedures. Gotham Health employees are hired and paid by HHC and fall under HHC personnel policies and all operations continue to be run by HHC.

Dr. Michelen reported that Gotham Health sites are located in the Bronx, Manhattan and Brooklyn. At the present time, there are no sites in Queens and Staten Island.

Dr. Michelen described where we are headed. He stated that:

- Cumberland is now a Federally Qualified Health Center because it received a HRSA New Access Point Grant

- Grant is for \$650,000 per year grant to provide greater access to public housing residents
- Care management and community outreach services to several NYCHA developments in North Brooklyn
- HHC and Gotham Health FQHC, Inc., will seek approval to integrate all community primary care sites under Gotham umbrella in the near term (e.g., Vanderbilt D&TC on Staten Island)

Dr. Michelen reported that in April or May of 2015, Cumberland, one of HHC's D&TCs became a federally qualified health center. As such, Cumberland's designation for Gotham Health & HHC means that:

- We can apply for other FQHC-LAL sites to become a fully designated FQHC
- We can apply for more federal grants, including grants for renovations and construction
- We must increase Board representation (e.g., tenants of the NYCHA housing developments who are also patients of Cumberland)

Gotham Health and The 2020 Vision

Dr. Michelen stated that, because HHC is transitioning to a health care system that promotes health and wellness and manages the health of its patient populations primarily through an ambulatory care delivery system, Gotham Health is one of the main vehicles by which we will achieve that transformation. Dr. Michelen also stated that Gotham Health is aligned with Dr. Raju's 2020 vision of improving the patient experience, increase its market share and manage the population in the following ways.

Improve the Patient Experience

Dr. Michelen stated that Gotham Health will work to improve patient experience by:

- Improving Press Ganey score from 84% to 93%
- Improving staff engagement
- Transitioning from a provider-centered to a Patient-Centered Medical Home
- Decreasing average flow time from 60 to 45 and 30 minutes
- Adding select specialties

Dr. Michelen explained that Press Ganey is an organization that HHC hired in order to determine the level of patient satisfaction registered by each patient. Every two weeks, Press Ganey receives a list of patients who received inpatient and outpatient services at the health centers. Press Ganey sends them an extended questionnaire (available in different languages) to be filled out and returned to them with their input about their patient experience. The questionnaire includes just the overall experience as well as other specific details about the waiting time, nurse treatment and the clinical efforts. Press Ganey scores are used to compare our performance against the national, state and at the New York City levels. Dr. Michelen added that, in the future, CMS would either award or penalize hospitals and health centers based on their performance. He added that these scores are very important from a revenue perspective.

Increase Market Share:

Dr. Michelen reported that Gotham Health plans to increase its market share by:

- Continuously assessing each service area's needs to determine gaps and plan for additional services
- Adding 60,000 new MetroPlus members by 2020
- Implementing an aggressive marketing campaign
- Expanding Women's Health and select specialty services

Manage the Population

Dr. Michelen stated that we are already taking risks with DSRIP, MetroPlus and HealthFirst. He reported that, considering the indicators provided by HRSA, Gotham Health performs much better than the state and national averages for FQHCs. He noted, however, that there is a need to continue to improve our performance in QARR and other HMO incentive programs.

Dr. Michelen reported that Gotham Health needs to expand its community engagement by:

- Expanding its community partnerships
 - Including One City Health partners
- Becoming more integrated into communities' infrastructures (e.g., open our doors to community meetings, hosting CBOs', Chambers' of Commerce, faith-based organizations', and local educational organizations' activities, etc.)

Mrs. Bolus stated that at Cumberland it was suggested to post all related information/events taking place at the facility within the NYCHA developments. Dr. Michelen agreed with this idea.

Ms. Brown added that Dr. Michelen's presentation shows a visual of some of HHC's six Diagnostic and Treatment Centers that are part of the Gotham Health.

Mr. Rosen thanked Dr. Michelen for his presentation and confirmed with Ms. Brown that all his questions were answered.

Mrs. Bolus announced that Cumberland plans to have an open house in the near future to focus on bringing residents. With the help of their grant, they plan to buy some items and do a raffle to attract new residents. Dr. Michelen informed the Committee that Gotham Health held a focus group that included the participation of residents of the NYCHA developments. They have shared some great ideas on how to reach out to potential patients in the community.

Mrs. Bolus stated that Cumberland's community is also changing with the advent of newly built condominiums whose residents do not use our services. Dr. Michelen reassured Mrs. Bolus that, "if we do it right", they too will be able to use our services.

Dr. Michelen concluded his presentation by sharing with the Committee Gotham Health's commitment. It reads that "Gotham Health is committed to providing a caring, value-added outpatient experience that anticipates patient and community needs and exceeds expectations through a highly engaged patient-centered workforce."

SUBSIDIARY BOARDS REPORTS

HHC Assistance Corporation – OneCity Health (CSO) – October 6, 2015

As reported by Dr. Ram Raju

Below please find a summary of our October 6, 2015 OneCity Health Services (CSO) Board meeting:

- OneCity Health has submitted and received final approval from the Independent Assessor of its State Implementation Plan and its first DSRIP quarterly report; it is also on-schedule to submit its second Quarterly Report prior to the October 31, 2015 deadline.
- OneCity Health continues to working with closely with partners to define interest and participation in each DSRIP project, as well as to identify the mutual obligations in ensuring performance objectives are met.
- The Board of OneCity Health Services (HHC Assistance Corporation) adopted the HHC FY2016 + FY2017 budget estimate of \$36M. OneCity Health Services will provide an updated budget on quarterly basis and seek adoption of an updated budget on an annual basis. All DSRIP expenditures are ultimately subject to approval by the OneCity Health Executive Committee and HHC as fiduciary.

MetroPlus Health Plan, Inc. – October 13, 2015

As reported by Mr. Bernard Rosen

Chairperson's Remarks

Chair Rosen welcomed everyone to the MetroPlus Board of Directors meeting of October 13th, 2015. Mr. Rosen stated that the meeting would start with the Executive Director's report presented by Dr. Saperstein followed by the Medical Director's report presented by Dr. Dunn. Mr. Rosen stated that there would be three resolutions for approval and a presentation by McKinsey & Co. regarding MetroPlus growth.

Executive Director's Report

Total plan enrollment as of September 1, 2015 was 472,251. Breakdown of plan enrollment by line of business is as follows:

Medicaid	417,698
Child Health Plus	112,194
MetroPlus Gold	3,609
Partnership in Care (HIV/SNP)	4,645
Medicare	8,451

MLTC	874
QHP	24,116
SHOP	479
FIDA	185

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.

Since my last report to this committee, New York State of Health has approved the Qualified Health Plan rates we submitted. MetroPlus is the least expensive plan among our competitors. We are hoping for a significant enrollment due to our competitive rates. The Open Enrollment Period (OEP) begins in November. For our Silver product, our rate decreased by 4%, while the competitors' increased between 6% and 9%. For the Platinum product, our rate for 2016 decreased by 2%, while the competitors raised their rates by 5% - 10%. We reduced our Bronze and Gold metal tier rates by 7% and 2%, respectively, while the other plans' increased between 5% and 8%. Appendix A, attached to this report, includes a comprehensive summary of how the MetroPlus Exchange rates compare to the other NYC plans' for all metal tiers.

MetroPlus has received conditional approval for the new line of business, the Essential Plan, which is starting on November 1st. The Essential Plan is either free or \$20/month and it will cover eligible population that is between 138% and 200% of the Federal Poverty Level. We are looking to work closely with the HHC facilities to train all the HCIs. Some facilities are already scheduled for such training. Furthermore, MetroPlus and HHC are joining efforts in sending a mailing to the HHC self-pay population informing them how they can enroll in the Essential Plan.

MetroPlus Gold Open Enrollment opens on October 1st. We are excited about the expansion of the program to all NYC employees (CUNY employees, libraries, cultural organizations and some charter schools). MetroPlus, in conjunction with HHC, has developed a full marketing campaign and roll-out. We are also trying to increase the awareness in the HHC facilities; there will be a one sheet flyer with paychecks on October 9th, HHC wide, in addition to an email from Dr. Raju.

We have been preparing diligently for the upcoming Open Enrollment Period both operationally and strategically. We have developed aggressive marketing campaigns that now include TV advertising in addition to previously used venues such as subway, buses, etc. We continue to focus our efforts on both new member enrollment and retention of existing members.

I would also like to inform this committee that MetroPlus applied for and has been approved to participate in the Value Based Purchasing Quality Improvement Program (VBPQIP) as the lead for HHC's OneCity Health. We will establish governance oversight via a VBPQIP committee which will include leadership from MetroPlus Medical Management and Finance, OneCity Health, HHC Finance, Corporate Planning, and Medical and Professional Affairs, as well as representatives from HealthFirst and Emblem. The governance committee will ensure the PPS receives the data it requires to create quality improvement processes in collaboration with the facilities. There will be a key link between this committee and the facilities/participating entities forming the PPS. The program is scheduled to commence in April 2016.

Over the past several months, MetroPlus has been successfully working to achieve ICD-10 readiness for the October 1st implementation date. We are hopeful that our providers are also prepared. I will be submitting updates to the committee in the upcoming months.

As of the date of this report, we are undergoing the Article 44 audit (a full licensing audit conducted by the NYS DOH with representatives from both Albany and NYC offices). I will present the findings at this Committee's next meeting.

Dr. Saperstein reviewed Appendix A with the Board. Appendix A summarized how MetroPlus' Exchange rates compared with other New York City plans.

Dr. Saperstein reported that the Plan's Article 44 audit was completed the week before the meeting. There was nineteen auditors on site at MetroPlus. Overall the Plan did very well, there were just a couple of minor issues, mostly on letters sent to members.

Medical Director's Report

As part of MetroPlus Health Plan continuing efforts to provide health education and valuable information to our members, we completed the following mailings:

QM Mailings

- *Smoking Cessation Postcard* – As part of the Smoking Performance Improvement Project, a postcard was developed and mailed to a group of MetroPlus members identified as smokers. The postcard provided them with the NYS Smoker’s Quit line, smoking cessation covered benefits and links for free downloadable materials.
- *Medicare Birthday Card (July/August)* – These monthly birthday cards remind our Medicare members to contact their PCP to schedule their Annual Wellness Visit.
- *Public Health Reporting Requirement* – Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code. The providers are also required to report toddlers at-risk for developmental delay or disabilities, and suspected cases of child abuse. The provider receives a report, based on claim data, including the list of patients identified as having a suspected or confirmed communicable disease. Copies of the following reporting forms are included:
 - Universal Reporting Form
 - Early Intervention Program Referral Form
 - NYS Office of Children and Family Services (Report of Suspected Child Abuse or Maltreatment)
- *Medicare/Medicaid Medication Adherence Non Compliance Report* – As part of the NYS PIP, a medication adherence report was created including those patients who had at least a 60 day supply of any hypertension, hyperlipidemia, HIV, asthma, and oral diabetic medications in the last 4 months but has not filled a new prescription in the last 30 days. Providers are encouraged to follow up and discuss with their patients about medication adherence.
- *Postpartum Care* – A reminder letter and an incentive postpartum check-up form are mailed to a group of pregnant women, to encourage them to have their postpartum visit within 3-8 weeks after delivery. If they go to their postpartum visit and complete the postpartum form they get an incentive of \$25.00 Baby R Us gift certificate.
- *Initial Preventive and Annual Wellness Exam* – In an effort to educate all of our Medicare providers about “Care for Older Adults” the following tools (quick reference guides) are mailed to them to help them better assess older patients for functional abilities, depression, polypharmacy, family medical history, social history, advance care planning, and education counseling and referrals:
 - Initial Preventive Physical Examination
 - Annual Wellness Visit
 - Age Friendly Primary Care
- *Adolescent Immunization Registry* – NYCDOHMH requires providers to report all adolescent immunization tests. To assist our network provider to comply with this mandate and facilitate the appropriate follow up with our members, MetroPlus mails a reminder report/list to our network providers once a year.

QM Activities – The QM department is participating in the following projects:

- **HEDIS:** QM is finalizing the official results for HEDIS by site. Elmhurst has once again topped the performance charts with Renaissance coming in last. The top areas to focus for 2016 is asthma medication ratio and weight assessment. To this end, we have shared with Case Management a list of members we recommend they target. The final population set is still being negotiated. For weight assessment, we have begun to collect medical records for adolescent well child and well child 15 months to audit and provide feedback to the provider. For member outreach, Network Relations and QM temps are outreaching on breast cancer screening, adolescent well child and diabetes retinal eye exam. We have also been working with Merck to see what tools, programs and webinars might be useful internally with our staff and for the provider network.
- **Facility Visits:** QM is visiting all HHC facilities and going over their 2014 HEDIS scores with all relevant staff up including past charting performance. At the non-HHC sites, QM has provided more detailed education on measure specifications and coding guidelines.
- **Stars Program:** QM has put together the workplan and will be initiating activities over the remainder of the year. Doctors on Call has received a list of targeted members and will begin to complete those visits. Other projects involve improving our communication efforts (How we motivate the member, the staff and the providers). Some of these projects include reviewing our language in the newsletters and our portal, introducing a training program for staff, and re-looking at materials to enhance provider education.
- **Reporting:** Connect Portal is set to be released to the provider sites. This is the tool where providers can see their monthly quality measure rates. The goal for the next release in Q4 is to have a link to the application on the provider portal. In addition, we are generating new report designs for UM, HEDIS and appeals. We continue to work on eligibility criteria for

Case Management programming. Also, we are interested in redesigning the provider incentive program and include a new member incentive program.

Performance Improvement Projects (PIPs):

QM has several on-going PIPs: Medicaid MIPCD, Medicare QIP, MLTC, and two separate NYS Smoking PIPs.

- *Medicaid/HIV MIPCD Part 1:* We reached the target enrollment for the hypertension and Medicaid portion of the project. However, for the pre-diabetic program, we need 12 additional members to agree to participate in order to reach the NYSDOH goal. Several barriers to enrollment were identified and communicated to the NYSDOH. The interventions for diabetes and hypertension are completed by the member's provider. MetroPlus sends monthly data feeds to the state. For pre-diabetes, the intervention is a 16-week class created by Merck. MetroPlus QM staff now run's three separate classes. Results of these classes are sent weekly to NYSDOH.
- *Medicaid/HIV MIPCD Part 2:* QM reported its findings to the NYSDOH for the program specifically targeting diabetes. The goal was to improve HEDIS scores and reduce admissions. For Medicaid, the study did not see statistically significant changes for the HEDIS program, but there were reductions in the number of admissions.
- *NYS DOH Smoking:* A total of 17 pregnant smokers and 670 HIV smokers have been identified for outreach from the Case Management staff. QM has outreached to their PCPs to discuss engaging the member in smoking cessation strategies. Also, outreach to top PCP sites (by volume) have been educated on the NYS Quitline and other materials.
- *NYS DOH Smoking Part 2:* NYS is running their own study. For this, QM must be provide monthly data feeds.
- *Medicare CCIP and QIP:* The Medicare Chronic Care Improvement Project (CCIP) and Quality Improvement Project (QIP) both address the goal of improving member adherence to diabetes, hypertension and hyperlipidemic medications in order to reduce the burden of CAD and preventable admissions for chronic diseases among our members. The CCIP is a five year project and the QIP is a three year project. Interventions for these projects involve the use of a reminder medication refill program, provider specific medication adherence and gaps in care reports, case management services that follow members who are non-compliant with medication refills. The project uses CMS star measures-adherence to diabetes, hypertension and statins- to track our progress.

MLTC Advanced Directive:

The goal is to increase the number of advanced directives discussions with a provider and increase the number of completed advanced directives. Four hundred and one outreach calls were made. The interim report was submitted to the state.

Dr. Dunn reported that the State has recently started an end to AIDS campaign and MetroPlus was awarded a three millions dollar grant for three years to fight the AIDS epidemic. The goals is to identify folks who are undiagnosed and get them into treatment and to get people who have HIV and work with them to improve their adherence to antiviral medications. Also, if someone is at high risk behavior the goal is to make sure they get prophylaxis to prevent getting the AIDS virus. Dr. Jenkins asked if the terms of the grant and the performance measurements are known yet. Dr. Dunn replied no, that the State will wait until after the first year to release what their goals will be.

Action Items

The three resolutions were introduced by Mr. Dan Still, Chair of the MetroPlus Finance Committee.

Authorizing the submission of a resolution to the Board of Directors of the New York City Health and Hospitals Corporation ("HHC") to authorize the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to increase the spending authority for the contract with Milton Samuels Advertising Agency, Inc. ("MSA"), dated February 14, 2011, and to allocate additional funds for advertising for the fulfillment of the contract, for an amount not to exceed \$4,075,000 for the term which expires on February 13, 2016.

Mr. Rosen stated that this resolution was presented at the MetroPlus Finance Committee, held earlier in the day, and it was discussed at length. This resolution will be presented at the HHC Board held later in the month. Mr. Rosen stated that the need for more advertisement dollars comes from MetroPlus' plan to significantly grow its membership.

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

Authorizing the Executive Director of MetroPlus Health Plan, Inc. (the "Plan" or "MetroPlus") to negotiate and execute a contract with AMAC D/B/A Tunstall Americas ("Tunstall"), to provide twenty-four hour health plan medical answering services for a term of three years with two options to renew for a one year term, each solely exercisable by MetroPlus Health Plan, Inc., for an amount not to exceed \$1,370,000 total for the five year term of the contract.

Mr. Rosen stated that this resolution was also approved at the MetroPlus Finance Committee earlier in the day and that this firm is very reputable and does a great deal of work with HHC. Dr. Jenkins asked if MetroPlus was happy with their work. Dr. Saperstein stated that this is a new contract and we do not have any experience as of yet. Dr. Jenkins asked if there were going to be terms put in the contract that allow the Plan to oversee and insist upon performance improvements in the case that they are not performing up to what the Plan expects. Mrs. Gail Smith, MetroPlus' Chief Customer Officer, replied yes, but that what Tunstall is doing for MetroPlus is different than what they currently do for HHC. Dr. Saperstein stated that this is a resolution to negotiate a contract with Tunstall and if there are any suggestions that any Board member may have it would be greatly appreciated.

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

Authorizing the submission of a resolution to the Board of Directors of the New York City Health and Hospitals Corporation authorizing the Executive Director of MetroPlus Health Plan, Inc. to negotiate and execute a contract with Greenberg Traurig, LLC to provide legal services for a term of three (3) years with two (2) options to renew for a one (1) year term each solely exercisable by MetroPlus at hourly payment rates which shall be the following: \$350 per hour for services performed by partners; \$325 per hour for services performed by associates with more than six (6) years of experience; \$300 per hour for associates with three (3) to six (6) years of experience; \$250 per hour for services performed by associates with fewer than three (3) years of experience; and \$150 per hour for services performed by a paraprofessional.

Mr. Rosen stated that this resolution was also approved at the MetroPlus Finance Committee earlier in the day and if approved it will go to the HHC Board of Directors later this month.

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

Information Item

Mr. Rosen advised the Board of Directors that McKinsey & Co. would be presenting a review of MetroPlus' growth projections and requirements. Mr. Manish Chopra and Ms. Manisha Machado-Pereira from McKinsey and Company introduced themselves to the Board of Directors. Mr. Chopra stated that there are three key areas that would be discussed: key takeaways on market landscape, reviewing growth projections and discussion of the requirements for success.

Mr. Chopra stated that the overall market that the Plan operates in is relatively flat. Most of any future growth will come from either Medicare Advantage or Exchange lives. Medicaid has been the line of business that has driven the Plan's growth through 2015 but it is projected to be nearly flat through year 2020.

Mr. Chopra stated that holding onto members has created more of a challenge for the Plan than new member acquisition. There are four potential growth scenarios that McKinsey presented: Status Quo, Base Case, Moderate Case and Aggressive Case. Mr. Chopra went through all the scenarios and explained the reasoning behind them. The probability of success for Status Quo is 100%, Base Case is 80%, Moderate Case is 60% and Aggressive Case is 40%. There was a chart presented that depicted MetroPlus' projected growth by quarter for all 4 scenarios.

The Status Quo scenario would be if the Plan were to do nothing different operationally and remain as it is now. The Base Case would require internal efforts leading to moderately enhanced retention of members. The Moderate Case would involve enhancing HHC's access and MetroPlus being the preferred MCO partner with HHC/OneCity. The Aggressive Case would require aggressive improvement in both retention and new member acquisition. Mr. Rosen inquired if he was correct in assuming that to get from Base to Moderate Case HHC would have to contribute. Mr. Chopra replied that yes, it is one of the main requirements for MetroPlus' success. There was a brief discussion regarding the market share number and the fact that MetroPlus will have to be better than all its competitors to improve its market share.

Mr. Still stated that McKinsey did recognize in its report that it is a mature market in Medicaid and that some of the traditional growth opportunities are difficult and at the same time the report acknowledges that the Plan has members leaving because of dissatisfaction and various reasons. Mr. Still stated that this is a major challenge to turn this around given the two constraints. Mr. Still concluded that what it amounts to is that the Plan needs to retain its memberships and get members from other plans to want to switch to MetroPlus.

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

RAMANATHAN RAJU, MD
HHC PRESIDENT AND CHIEF EXECUTIVE OFFICER
REPORT TO THE BOARD OF DIRECTORS
October 22, 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.

MetroPlus Gold – Now Available to All NYC Employees

MetroPlus Gold commercial health plan is now available to all employees of New York City plus other local entities such as CUNY, the MTA and Port Authority. The premium plan had previously only been available to our own employees. This agreement between HHC and the New York City Department of Labor Relations to add MetroPlus Gold as a health insurance option is an important step in our goal of reaching one million MetroPlus members by the year 2020.

MetroPlus Gold – with no co-pays for most in-network services in 27,000 locations — has long been available to our own employees. Now, nearly 800,000 additional New York City employees, non-Medicare eligible retirees, their spouses or qualified domestic partners and eligible dependents will be able to choose this option during October's "Open Enrollment."

MetroPlus representatives will participate in benefit fairs hosted by agencies throughout October. An advertising campaign will accompany the new MetroPlus Gold expansion, focusing on government-themed publications and websites.

Contract with PAGNY to Provide Patient Care Services for Correctional Health

On your agenda today is consideration of a contract with the Physician Affiliate Group of New York (PAGNY) to help provide patient care services in New York City correctional facilities.

The contract is for \$192.8 million for two years, and will employ approximately 900 direct patient care providers. The majority of these funds will be dedicated to competitive salaries and benefits, as well as costs associated with recruitment and staff retention. Through our partnership with PAGNY, we will be better able to attract and retain qualified medical and mental health professionals to care for our patients in correctional health.

PAGNY has deep ties to many of our hospitals and community health centers, and understands our essential mission. I strongly urge your support of this contract.

OneCity Health Update

The OneCity Health Centralized Services Organization (CSO) is on-track to submit its October 31 DSRIP quarterly report to NYS DOH. The report details our progress in reaching the in Delivery System Reform Incentive Payment program transformation commitments, as defined by NYS DOH mandated milestones across 23 projects.

We plan to formally initiate projects using a phased approach across our four OneCity Health hubs according to community need, our commitments to NYS DOH, and partner interest. We have identified three projects that will be initiated earliest and expect to operationalize them over the next several months: asthma home-based self-management; integration of palliative care into the Patient Centered Medical Home (PCMH); and Project 11. We are especially excited for the opportunity to involve multiple partners and Community Based Organizations (CBOs) across the city in Project 11, which involves the engagement of the city's uninsured and Medicaid non- and low-utilizers and linking them as needed to strong primary care teams.

Federal Update

At end of August the Health Resources and Services Administration published its long anticipated Mega Guidance for the 340B Drug Pricing Program. HHC hospitals, in Fiscal Year 2015, spent over \$71 million on 340B pharmaceuticals. HHC saves about \$40 million through participation in the program. The proposed definition would end the practice of 340B pricing for discharge medicines; for drugs used during Emergency Department or observation stays that lead to an inpatient admission; and would exclude some infusion drugs from 340B pricing. In essence, the proposed changes in the definition of patient eligibility for 340B drugs would severely limit 340B pricing to drugs ordered or prescribed only to patients who have outpatient billable events. These proposed changes could increase HHC's pharmaceutical costs by \$15-\$20 million per year. HHC is submitting a comment letter to HRSA advocating against these proposed changes.

HHC Bands Together to Make Some Noise! And End Breast Cancer

Last Sunday, I joined HHC staff members across New York City as they participated in the American Cancer Society's Making Strides Against Breast Cancer walk. I walked in Central Park, where our presence was impressive in both numbers -- about 900 staff members -- and volume. Our contingent took our theme for the year -- Let's Make Some Noise! -- to heart. This marks the thirteenth year that we have served as a flagship sponsor of the event to end breast cancer, and we have raised more than \$1.5 million over that time. I'd like to offer my heartfelt thanks to Dr. Martha Sullivan, Antonio Martin, Joe Schick, and all the Team Captains for banding together to make this year's Making Strides a team-building event that represents our NYC Health and Hospitals family and our close ties with our patients and communities. Join me in thanking all of our staff who participated in the Making Strides walks or made a donation to ACS to help win the fight against breast cancer.

Bellevue Doctor Elected President of American Pediatric Association

Dr. Benard Dreyer, Director of Pediatrics at NYC Health and Hospitals Bellevue, has been elected as the new national president of the American Academy of Pediatrics (AAP), an organization of 64,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists.

For more than 30 years, Dr. Dreyer has led the pediatric primary care program at Bellevue, including mental and oral health services for children.

He is passionate about improving the lives of children and continues to make significant contributions in pediatric research, especially in the area of children living in poverty.

I am proud that Dr. Dreyer is one of our own and congratulate him on his election as President of AAP.

October is Take Care New York Month

As we commemorate the twelfth anniversary of our Take Care New York campaign this October, we will once again remind patients, staff and the community to get preventive immunizations, health screenings, and to live the healthiest life possible. We will also continue our effort to curb obesity and increase fitness with our "Move to Improve" message to challenge New Yorkers to eat healthier and add more physical activity into their routine. Our facilities will offer flu shots and screenings for HIV, blood pressure, cancer, asthma, diabetes and other health conditions at over sixty events. We will augment our fitness message with a "Move to Improve" contest at our facilities to allow staff, patients and visitors to win guest-passes to Crunch fitness centers. We will aim to engage New Yorkers through social media and PSAs in local community newspapers to promote and increase traffic to our Take Care New York events.

Our health plan MetroPlus will be a key partner of the Take Care New York Campaign and have representatives available at the education and screening events. October is a prime enrollment period for MetroPlus and the TCNY campaign can be a helpful platform for them to maximize enrollments.

One Year Anniversary of New York City's Ebola Patient

Tomorrow, October 23rd, marks the one year anniversary of when Dr. Craig Spencer – New York City's only Ebola patient – entered Bellevue Hospital Center for care. On November 11, 2014, he left Bellevue cured of the disease. On this occasion we should look back on the remarkable performance of HHC throughout the Ebola crisis. HHC was the first health system in New York City to be prepared to receive an Ebola patient and played a great role in the City's response.

Our foresight and readiness helped calm and reassure the City at a time when many were worried that the virus might spread here uncontrolled. While all of our hospitals studied and trained to recognize and isolate potential Ebola patients, Bellevue prepared its staff and upgraded its facilities so that when the day came we were ready for action.

And since that time Bellevue has assumed a prominent role in the national fight against Ebola and other dangerous pathogens: the hospital was later named by HHS as one of 55 designated Ebola treatment centers nationally; in June it was named one of just nine national referral treatment centers for patients with Ebola or other severe, highly infectious diseases; and in July, along with Emory University and Nebraska Medical Center, Bellevue was named one of three medical research institutions to co-lead a new National Ebola Training and Education Center. I am pleased to report that Dr. Spencer visited the staff at Bellevue earlier this week for a reunion with those who cared for him.

"Caring Neighborhoods" to Bring Primary Care to Underserved Neighborhoods across the City

This week Mayor de Blasio announced the "Caring Neighborhoods" program, designed to increase access to primary care services in high-need areas through the City. HHC will play a prominent role in Caring Neighborhoods by creating five new community health centers and expanding capacity and services at six other existing ones. In addition, the New York City Economic Development Corporation will provide support to at least 30 private, non-profit health centers that are looking to expand into high-need neighborhoods.

The neighborhoods were determined through a City-commissioned analysis conducted by the Community Health Care Association of New York State (CHCANYS), with supplemental areas identified at the recommendation of the New York City Department of Health and Mental Hygiene (DOHMH). We estimate that the 11 HHC centers involved will be able to accommodate over 60,000 new patients each year as a result of Caring Neighborhoods. The City will provide \$12 million in capital support to HHC for the project. The expansion of primary care availability directly supports HHC's long-term financial goal of stabilizing its budget by expanding its patient base and improving patient retention through better access to care and improved patient experience at HHC facilities.

Guns Down, Life Up Collaboration with Cleveland, Ohio

The city of Cleveland is struggling with record homicide rates —indeed, one of the highest rates per capita for a major American city. Cleveland has suffered through more than 100 homicides so far this year for a population of only 400,000 people. New York City has seen more than 200 homicides with a population of 8 million people. Earlier this year, Cleveland City Councilman Zackary Reed visited New York to meet with The Fund for HHC's Guns Down, Life Up team and learn about our innovative strategies to address violence. The meeting led to an invitation for GDLU Senior Director Erik Cliette to serve as the keynote speaker at a Solutions for Violence in Our City summit in Cleveland on October 13.

Cliette addressed a crowd of more than 200 key community representatives from a variety of youth, law enforcement, education, faith based, healthcare, and art organizations. He outlined GDLU's comprehensive response to violence and injury prevention as a public health model for Clevelanders to follow. After the address, Cliette travelled to John Adams High School where he spoke to a body of students regarding the value of mentoring and graduating high school.

Going forward, the Guns Down, Life Up team will advise Cleveland's civic leaders on community violence reduction and will share the GDLU resource guide.

Program of the Month: Our Obesity Prevention Efforts

So many problems keep healthcare leaders like us up at night. Few however, pose as clear a danger to the public health as obesity.

Probably everyone in this room today is familiar with its grim impact as a leading cause of Heart Disease, Stroke, Type 2 Diabetes and certain types of Cancer.

Nobody understands the scope of this threat better than we do.

At the Health and Hospitals Corporation we are drawing on our deep roots in the community, and using the most advanced tools and methodologies available, to provide the preventive care that is so urgently needed.

It is these efforts that I'd like to highlight today as our Program of the Month:

All Health and Hospitals Corporation pediatric practices screen for obesity.

All pediatric practices record body-mass-index percentiles into EMRs for every patient.

And all counsel patients on four key healthy behaviors that impact weight, by using the 5-2-1-0 per day approach, which for those of you who may be unfamiliar, stands for: 5 fruits and vegetables, 2 hours maximum of screen time, 1 hour of physical activity and 0 sugary beverages EVERY DAY.

Each and every pediatric patient receives a "Fit Kid" cards to help them set goals for healthy diet and physical activity, and to better understand and keep track of nutrition, blood pressure and BMI.

We also have very active obesity prevention initiatives going on at particular facilities, among them are –

The Family/Teen Weight Management Program at North Central Bronx Hospital Center.

The Fit Kid & Fit Teen Coaching Program at Gouverneur, Kings County, and Lincoln Hospital Centers

The Fruit And Vegetable Prescription Program at Bellevue, Elmhurst, and Harlem Hospital Centers

The Starting Early program at Bellevue Hospital Center

The Healthy Lifestyles Program at Queens Hospital Center

The Pediatric and Adolescent Weight Loss Clinic and YMCA Program at Coney Island Hospital

I couldn't be prouder that our healthcare system has been at the forefront, and fully engaged for over a decade, in the battle with obesity, and I commit to you that we will continue to be aggressive until we prevail.

Please join me in welcoming Dr. Susan Kansagra, Assistant Vice President for Population Health, who oversees our obesity prevention efforts.

Individual of the Month:

Dr. Rand David, Directory of Ambulatory Care, Elmhurst Hospital

One of our practitioners leading the charge on chronic disease prevention is Dr. Rand David, the Director of Ambulatory Care at Elmhurst Hospital Center, who is our Person of the Month for October.

Dr. David has dedicated tireless efforts over several decades towards reducing our patients' risk of cardiovascular diseases, including obesity, as well as hypercholesterolemia, diabetes mellitus, hypertension, and cigarette smoking.

In this regard he has participated and led several City-wide Health and Hospitals Corporation task forces, producing clinical guidelines that have educated countless physicians, nurses, medical students and residents, as well as members of the many communities we serve.

Dr. David is not only committed to addressing health disparities and wellness. He's been a leader on healthcare transformation as well. He has captained efforts to develop new models for more efficient, and compassionate care delivery.

By working to level provider workloads at Elmhurst's ambulatory care services, while also reducing patient wait-times, Dr. David has championed the sort of innovation that will improve our patient experience and help us become a far more patient-centric organization in the future.

Join me in congratulating Dr. David for work well done.

HHC in the Media Highlights

Broadcast

Childhood Obesity Among Latino Community, News 12 Brooklyn, Kings County: Dr. Lee Waldman; Dr. Sheila Perez-Colon

New York Holds Summit on Synthetic Marijuana, Also Known As K2, WCBS, Jacobi
Jacobi

Bellevue Hospital's Long, Twisted Road to Resiliency, WNYC, Dr. Ram Raju, HHC President

FEMA Emails Say de Blasio Administration Sought to Quash Bad Press on Sandy Recovery, WNBC, Dr. Ram Raju, HHC President

New York Summit on Synthetic Marijuana, News12 Bronx, Jacobi
Ebola Survivor, Caregivers Unite One Year Later, WABC (AP), Bellevue: Dr. Nate Link, Chief Medical Officer; Dr. Laura Evans, Director of Critical Care; David McCollum

Print

Dr. Raju ... and Putin, Crain's Health Pulse, Dr. Ram Raju, HHC President

At IHT2 New York, CEO of Largest Public Health System Outlines Bold Vision for "Healthcare Nirvana", Healthcare Informatics, Dr. Ram Raju, HHC President

Panel examines challenges in moving from coverage to care, AHA News, Dr. Ram Raju, HHC President

CEO: What hospitals don't understand about the patients of the future, The Advisory Board Company, Dr. Ram Raju, HHC President

De Blasio to create new health centers, partially fulfilling campaign pledge, Politico New York, Dr. Ram Raju, HHC President

NYC Health and Hospitals Expands Its MetroPlus Health Plan to Public Employees in Effort to Reach 1, Million Members by 2020, Insurance news Net, Dr. Ram Raju, HHC President; Seth Diamond, Chief Operating Officer, MetroPlus

MetroPlus Gold is now available to all City Employees, The Chief Leader, Dr. Ram Raju, HHC President

MetroPlus option for city workers, Crain's Health Pulse, Dr. Ram Raju, HHC President

MetroPlus Gold expands offering to all city employees, Politico New York, Dr. Ram Raju, HHC President

Health insurer allies with NYC hospitals, Newsday, HHC, Bellevue, Elmhurst, Coney Island, Kings County, and NCBH

CareConnect reaches deal with HHC, Politico New York, Kings County, Bellevue, MetroPlus

Municipal IDs help prevent medical mishaps, provide access to care, Modern Healthcare

Ebola Survivor, Caregivers Unite One Year Later, The Wall Street Journal, Bellevue: Dr. Nate Link, Chief Medical Officer; Dr. Laura Evans, Director of Critical Care; David McCollum

Ebola Survivor Dr. Craig Spencer Returns to Visit the Hospital That Saved Him, New York Magazine, Bellevue: Dr. Nate Link, Chief Medical Officer; Dr. Laura Evans, Director of Critical Care

As healthcare landscape changes, city hospital authority charts new path, Gotham Gazette, Dr. Ram Raju, HHC President

Meet crises head-on with advance planning, Business Insurance, Dr. Ram Raju, HHC President; Bellevue

Present health plan for undocumented immigrants in New York, El Diario, Dr. Ram Raju, HHC President

HHC, ProHealth and Beacon Health chat about ACOs, Crain's Health Pulse, Dr. Dave Chokshi, Assistant Vice President

MetroPlus Health Plan Sponsors Mother-Love & Father-Love Awards Luncheon, Bronx Chronicle, MetroPlus

Lincoln Medical gets grant to study obesity, hypertension in inner city, Amsterdam News, Lincoln: Milton Nunez, Executive Director; Dr. Balavenkatesh Kanna, Dr. Maria Espejo

Health Insurance 101 Workshop, Open Enrollment 2015, Harlem World, Gouverneur

Master of Doctors, Brooklyn Daily, Coney Island: Dr. Terence Brady, Associate Chief Medical Officer; Dr. John Maese, Chief Medical Officer; Dr. Paul Gitman, Quality Management

Au Bon Pain revises hospital menu to meet NYC nutritional standards after complaints of unhealthy food, New York Daily News, Jacobi; Elmhurst; Coney Island; Bellevue

Take Care New York, NY Daily News, HHC, MetroPlus

Breast Cancer Awareness Events and Fundraisers, Bronx Times, NCBH

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an agreement with the Physician Affiliate Group of New York, P.C. ("PAGNY") for the furnishing of staff required to provide physical and behavioral health services to inmates ("Inmates") in the custody of the New York City Department of Correction ("DOC") and certain other individuals for two years, starting January 1, 2016 for an amount not to exceed \$192,843,453 with three, two-year renewal options exclusive to the Corporation;

AND

Further authorizing the President to make adjustments to the contract amounts consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in payments to PAGNY in any fiscal year that exceed twenty-five percent of the not-to-exceed amount specified in this resolution.

WHEREAS, the Corporation is responsible for the provision of health services to inmates ("Inmates") in the custody of the New York City Department of Correction ("DOC") and certain other individuals including children under two years of age housed on Rikers Island whose mother is an Inmate and certain DOC employees ("CHS Patients"); and

WHEREAS, the Corporation desires to ensure the provision of high quality patient care services to CHS Patients; and

WHEREAS, the Corporation requires the services of an organization willing and able to furnish the staff necessary to provide for high quality healthcare professional services with respect to the delivery of health care to CHS Patients; and

WHEREAS, PAGNY is willing to, and capable of, furnishing such staff; and

WHEREAS, PAGNY is a professional service corporation organized under the laws of New York, all of whose physicians are duly licensed to practice medicine in New York State; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, desires that PAGNY furnish the staff to provide healthcare services to CHS Patients and PAGNY is ready and willing to do so.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation") is hereby authorized to negotiate and execute an agreement with the Physician Affiliate Group of New York, P.C. ("PAGNY") for the furnishing of staff required to provide physical and behavioral health services to inmates in the custody of the New York City Department of Correction and certain other individuals for a period of two years, commencing January 1, 2016 for an amount not to exceed \$192,843,453 with three, two-year renewal options exclusive to the Corporation; and it is further

RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in payments to PAGNY in any fiscal year that exceed twenty-five percent of the not-to-exceed amount specified in this resolution.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an agreement with Correctional Dental Associates ("CDA") for the provision of dental health services to inmates ("Inmates") in the custody of the New York City Department of Correction ("DOC") for three years, starting January 1, 2016 for an amount not to exceed \$13,413,150;

AND

Further authorizing the President to make adjustments to the contract amounts consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in payments to CDA in any fiscal year that exceed twenty-five percent of the not-to-exceed amount specified in this resolution.

WHEREAS, the Corporation is responsible for the provision of health services including dental health services to inmates ("Inmates") in the custody of the New York City Department of Correction ("DOC"); and

WHEREAS, the Corporation desires to ensure the provision of high quality dental health services to Inmates; and

WHEREAS, the Corporation requires the services of an organization willing and able to provide high quality dental health services to Inmates; and

WHEREAS, CDA, has successfully provided dental health services to Inmates over the previous five years during which it has greatly increased dental services to Inmates and received high satisfaction reports; and

WHEREAS, CDA is willing to, and capable of, continuing to provide such services; and

WHEREAS, CDA is a professional service corporation organized under the laws of New York, all of whose dentists and other professionals are duly licensed to practice their particular dental functions in New York State; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, desires that CDA provide dental health services to Inmates and CDA is ready and willing to do so.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation ("the Corporation") is hereby authorized to negotiate and execute an agreement with Correctional Dental Associates ("CDA") for the provision of dental health services to inmates in the custody of the New York City Department of Correction for three years, starting January 1, 2016 for an amount not to exceed \$13,413,150; and it is further

RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in payments to CDA in any fiscal year that exceed twenty-five percent of the not-to-exceed amount specified in this resolution.

RESOLUTION

Approving the application for verification by the American College of Surgeons of Harlem Hospital Center (“Harlem Hospital Center”) as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”), or his designee, to execute any and all documents necessary to verify trauma Center designation for Harlem Hospital Center through the American College of Surgeons, Committee on Trauma.

WHEREAS, the Corporation has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, Harlem Hospital Center has been designated as a trauma center by the New York State Department of Health; and

WHEREAS, in 2015 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the Board of Directors of the New York City Health and Hospitals Corporation fully supports the continued provision of trauma services at Harlem Hospital Center; and

NOW, THEREFORE, be it

RESOLVED, that the Board of Directors of the New York City Health and Hospitals Corporation of the City of New York (the “Board”) approves the application for verification of Harlem Hospital Center as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the President of the Corporation, or his designee, to execute any and all documents necessary to verify Harlem Hospital Center, as a Trauma Center, by the American College of Surgeons.

RESOLUTION

Approving the application for verification by the American College of Surgeons of Jacobi Medical Center (“Jacobi Medical Center”) as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”), or his designee, to execute any and all documents necessary to verify trauma Center designation for Jacobi Medical Center through the American College of Surgeons, Committee on Trauma.

WHEREAS, the Corporation has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, Jacobi Medical Center has been designated as a trauma center by the New York State Department of Health; and

WHEREAS, in 2015 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the Board of Directors of the New York City Health and Hospitals Corporation fully supports the continued provision of trauma services at Jacobi Medical Center; and

NOW, THEREFORE, be it

RESOLVED, that the Board of Directors of the New York City Health and Hospitals Corporation of the City of New York (the “Board”) approves the application for verification of Jacobi Medical Center as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the President of the Corporation, or his designee, to execute any and all documents necessary to verify Jacobi Medical Center, as a Trauma Center, by the American College of Surgeons.

RESOLUTION

Approving the application for verification by the American College of Surgeons of Kings County Hospital Center (“Kings County Hospital Center”) as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”), or his designee, to execute any and all documents necessary to verify trauma Center designation for Kings County Hospital Center through the American College of Surgeons, Committee on Trauma.

WHEREAS, the Corporation has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, Kings County Hospital Center has been designated as a trauma center by the New York State Department of Health; and

WHEREAS, in 2015 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the Board of Directors of the New York City Health and Hospitals Corporation fully supports the continued provision of trauma services at Kings County Hospital Center; and

NOW, THEREFORE, be it

RESOLVED, that the Board of Directors of the New York City Health and Hospitals Corporation of the City of New York (the “Board”) approves the application for verification of Kings County Hospital Center as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the President of the Corporation, or his designee, to execute any and all documents necessary to verify Kings County Hospital Center, as a Trauma Center, by the American College of Surgeons.

RESOLUTION

Approving the application for verification by the American College of Surgeons of Lincoln Medical and Mental Health Center ("Lincoln Medical and Mental Health Center") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation"), or his designee, to execute any and all documents necessary to verify trauma Center designation for Lincoln Medical and Mental Health Center through the American College of Surgeons, Committee on Trauma.

WHEREAS, the Corporation has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, Lincoln Medical and Mental Health Center has been designated as a trauma center by the New York State Department of Health; and

WHEREAS, in 2015 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the Board of Directors of the New York City Health and Hospitals Corporation fully supports the continued provision of trauma services at Lincoln Medical and Mental Health Center; and

NOW, THEREFORE, be it

RESOLVED, that the Board of Directors of the New York City Health and Hospitals Corporation of the City of New York (the "Board") approves the application for verification of Lincoln Medical and Mental Health Center as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the President of the Corporation, or his designee, to execute any and all documents necessary to verify Lincoln Medical and Mental Health Center, as a Trauma Center, by the American College of Surgeons.

RESOLUTION

Approving the application for verification by the American College of Surgeons of Bellevue Hospital Center (“Bellevue Hospital Center”) as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”), or his designee, to execute any and all documents necessary to verify trauma Center designation for Bellevue Hospital Center through the American College of Surgeons, Committee on Trauma.

WHEREAS, the Corporation has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, Bellevue Hospital Center has been designated as a trauma center by the New York State Department of Health; and

WHEREAS, in 2015 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the Board of Directors of the New York City Health and Hospitals Corporation fully supports the continued provision of trauma services at Bellevue Hospital Center; and

NOW, THEREFORE, be it

RESOLVED, that the Board of Directors of the New York City Health and Hospitals Corporation of the City of New York (the “Board”) approves the application for verification of Bellevue Hospital Center as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the President of the Corporation, or his designee, to execute any and all documents necessary to verify Bellevue Hospital Center, as a Trauma Center, by the American College of Surgeons.

RESOLUTION

Approving the application for verification by the American College of Surgeons of Elmhurst Hospital Center (“Elmhurst Hospital Center”) as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”), or his designee, to execute any and all documents necessary to verify trauma Center designation for Elmhurst Hospital Center through the American College of Surgeons, Committee on Trauma.

WHEREAS, the Corporation has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, Elmhurst Hospital Center has been designated as a trauma center by the New York State Department of Health; and

WHEREAS, in 2015 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the Board of Directors of the New York City Health and Hospitals Corporation fully supports the continued provision of trauma services at Elmhurst Hospital Center; and

NOW, THEREFORE, be it

RESOLVED, that the Board of Directors of the New York City Health and Hospitals Corporation of the City of New York (the “Board”) approves the application for verification of Elmhurst Hospital Center as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the President of the Corporation, or his designee, to execute any and all documents necessary to verify Elmhurst Hospital Center, as a Trauma Center, by the American College of Surgeons.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”) to use the 20 requirement contracts that were awarded for a two year term with three one-year options to renew to purchase health information related professional IT consultant services as needed to meet **non-Epic EMR** related IT consulting needs for an amount not to exceed \$43 million for the initial two year term.

WHEREAS, HHC from time to time has the need for IT consulting services in order to obtain expertise, experience or knowledge that is either not available in the Corporation, is not required on a long term basis, or any other circumstances where consulting expertise may be needed; and

WHEREAS, the requirements contracts will offer the Corporation IT consultants with a wide range of expertise and knowledge in a timely and efficient manner to support major software implementations, training, and maintenance activities; and

WHEREAS, the pool of requirement contracts will help HHC ensure continuity of services, avoid disruptions, delays, or gaps in service to both internal and external end users that rely on these essential and critical systems; and

WHEREAS, the Corporation previously awarded these contracts for professional services for the Epic EMR program; and

WHEREAS, the utilization of these contracts will provide the Corporation with health information related professional services on an as-needed basis for implementation, advisory, support and/or training services for a wide array of technology consulting needs as required by the business in order to provide the necessary skillsets; and

WHEREAS, the overall responsibility for managing and monitoring the agreements shall be under the Senior Vice President/Corporate Chief Information Officer.

NOW, THEREFORE, be it;

RESOLVED THAT the President of the New York City Health and Hospitals Corporation (the “Corporation”) be and hereby is authorized to use the 20 requirement contracts that were awarded for a two year term with three one-year options to renew to purchase health information related professional IT consultant services as needed to meet **non-Epic EMR** related IT consulting needs for an amount not to exceed \$43 million for the initial two year term.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (“the Corporation”) to enter into a Cisco Enterprise License Agreement (“ELA”) through a Third Party Contract as part of the LAN Migration/Network Infrastructure refresh project in an amount not to exceed \$11,410,000 for a five year period.

WHEREAS, Enterprise Information Technology Services (“EITS”) in undergoing a Network Infrastructure refresh program to upgrade the Corporation’s network to improve system availability, speed, bandwidth and stability necessary to meet the growing demand and advances in healthcare delivery models and improve patient care; and

WHEREAS, as part of the overall program, EITS will be installing new network infrastructure equipment, installing an enterprise wireless network throughout the organization, and replacing the existing Private Branch Exchange (PBX) with an agile phone system Voiceover Internet Protocol with full Business Continuity throughout the HHC environment; and

WHEREAS, the Cisco Enterprise License Agreement (“ELA”) provides the operating software for the unified communication system - voiceover internet protocol (“VOIP”) devices-throughout the Corporation’s facilities and clinics; and

WHEREAS, the ELA permits unlimited deployment of licenses across the enterprise for a unified communication system at significant savings compared to the costs if such licenses were purchased on an individual device basis; and

WHEREAS, the Corporation will solicit proposals from authorized vendors who offer the Cisco software via Third Party contracts; and

WHEREAS, the award will be made to the vendor offering the lowest price; and

WHEREAS, the overall responsibility for managing and monitoring the agreement shall be under the Senior Vice President/Corporate Chief Information Officer.

NOW, THEREFORE, be
it

RESOLVED, THAT the President of the New York City Health and Hospitals Corporation (“the Corporation”) be and hereby is authorized to enter into a Cisco Enterprise License Agreement (“ELA”) through Third Party Contract(s) as part of the LAN migration/Network Infrastructure refresh project in an amount not to exceed \$11,410,000 for a five year period.

RESOLUTION

Authorizing the President to execute a **Memorandum of Understanding** between HHC and the **New York City Department of Investigation** ("DOI") to create an Office of the Inspector General for HHC under the authority and control of DOI to replace the existing office within HHC

WHEREAS, DOI is a mayoral agency of the City of New York under the New York City Charter, the Commissioner of which has the authority to make any study or investigation which may be in the best interest of the City , including but not limited to investigations of the affairs, functions, accounts, methods, personnel or efficiency of any agency; and

WHEREAS, mayoral agencies of the City of New York and other City-related authorities and entities have Inspectors General who are under the auspices and authority of DOI; and

WHEREAS, the Board of Directors is fully committed to the highest standards of ethical behavior in the conduct of the Corporation affairs; and

WHEREAS, currently HHC has an Office of the Inspector General which investigates matters of potential criminality, malfeasance, and misconduct and makes recommendations designed to prevent crime, fraud, and misconduct within the Corporation; and

WHEREAS, in an arrangement unique among New York City entities, the HHC Office of the Inspector General is not under the direct authority and control of DOI and instead reports to the President and Chair of the HHC Board with a dotted line to DOI; and

WHEREAS, authority and control by DOI will provide greater accountability and independence through supervision of investigations outside of HHC and thereby enhance the prevention of fraud, mismanagement and corruption;

NOW, THEREFORE, be it

RESOLVED that the President is hereby authorized to execute a **Memorandum of Understanding** between HHC and the **New York City Department of Investigation** to create an Office of the Inspector General for HHC under the authority and control of DOI to replace the existing office within HHC

RESOLUTION

Authorizing the Executive Director of MetroPlus Health Plan, Inc. to negotiate and execute a contract with Greenberg Traurig, LLC to provide legal services for a term of three years with two 1-year options to renew, each solely exercisable by MetroPlus, at hourly payment rates which shall be the following: \$350 per hour for services performed by partners; \$325 per hour for services performed by associates with more than six years of experience; \$300 per hour for associates with three to six years of experience; \$250 per hour for services performed by associates with fewer than three years of experience; and \$150 per hour for services performed by a paraprofessional.

WHEREAS, MetroPlus Health Plan, Inc. (“MetroPlus” or the “Plan”), a subsidiary corporation of the New York City Health and Hospitals Corporation (“HHC”), seeks specialized legal counsel experienced in serving health plans to supplement the assistance provided by the HHC Office of Legal Affairs; and

WHEREAS, it is crucial for the Plan to maintain a presence in Albany to advocate for issues related to Plan operations and maximization of revenue; and

WHEREAS, Greenberg Traurig is a law firm with extensive resources, an established record and reputation of excellence in healthcare and managed care laws and regulations, has provided highly effective counsel to the Plan, and has a thorough working knowledge of MetroPlus and its affairs; and

WHEREAS, Greenberg Traurig has a major presence in Albany and Washington DC, and is currently advocating on behalf of the Plan’s interests including implementation of programs authorized under the Affordable Care Act and NYS Medicaid reform initiatives; and

WHEREAS, an RFP for legal services was issued in compliance with the Corporation’s contracting policies and procedures and;

WHEREAS, Greenberg Traurig, is the vendor selected to provide these services;

WHEREAS, the rates negotiated with Greenberg Traurig are far below those charged by the firm to other clients; and

WHEREAS, the Board of Directors of MetroPlus has duly considered and approved the proposed contract between MetroPlus and Greenberg Traurig; and

WHEREAS, the Certificate of Incorporation of MetroPlus reserves to the HHC Board of Directors the sole power to approve selection of outside legal counsel for MetroPlus.

NOW, THEREFORE, be it

RESOLVED, that the Executive Director of MetroPlus is hereby authorized to negotiate and execute a contract with Greenberg Traurig to provide legal services for a term of three years with two 1-year options to renew, each solely exercisable by MetroPlus, at hourly payment rates which shall be the following: \$350 per hour for services performed by partners; \$325 per hour for services performed by associates with more than six years of experience; \$300 per hour for associates with three to six years of experience; \$250 per hour for services performed by associates with fewer than three years of experience; and \$150 per hour for services performed by a paraprofessional.

RESOLUTION

Authorizing the submission of a resolution to the Board of Directors of the New York City Health and Hospitals Corporation (“HHC”) to authorize the Executive Director of MetroPlus Health Plan, Inc. (“MetroPlus”) to increase the spending authority for the contract with Milton Samuels Advertising Agency, Inc. (“MSA”), dated February 14, 2011, and to allocate additional funds of \$1.2 million for advertising for the fulfillment of the contract, for an amount not to exceed \$4,075,000 for the term which expires on February 13, 2016.

WHEREAS, MetroPlus is certified under Section 4403(a) of the Public Health Law of the State of New York as a Health Maintenance Organization and has organized a plan for the provision of Prepaid Health Services to its members; and

WHEREAS, despite substantial enrollment in health insurance under the Affordable Care Act, it is estimated that over 400,000 New Yorkers remain uninsured and providing these New Yorkers with insurance is critical to the goals of ensuring health equality; and

WHEREAS, enhanced outreach and advertising are required to reach those, who despite substantial publicity over a two-year period, have not yet enrolled in health insurance; and

WHEREAS, the 2015 open enrollment cycle through the implementation of the Essential Plan and MetroPlus’ reduced price, there are new opportunities for low income New Yorkers to receive low price, quality health insurance; and

WHEREAS, additional advertising and marketing expenditures are needed to inform New Yorkers about these new opportunities; and

WHEREAS, MetroPlus anticipates being approved to do business in Staten Island and additional expenditures are needed to inform Staten Islanders about the availability of MetroPlus insurance and the services it offers; and

WHEREAS, in 2010, MSA was selected as the vendor, through an RFP process, to provide advertising and marketing services to MetroPlus; and

WHEREAS, MetroPlus’ existing contract with MSA for advertising services is for an amount not to exceed \$2.875 million per year and, due to the additional marketing needs described above, MetroPlus is requesting an additional \$1,200,000 to cover the final year of the contract which is February 14, 2015 to February 13, 2016; and

WHEREAS, MetroPlus’ procurement procedures require HHC Board of Directors approval for all contacts over three million dollars per year.

NOW THEREFORE, be it

RESOLVED, *that a resolution will be submitted to the New York City Health and Hospitals Corporation Board of Directors authorizing the Executive Director of MetroPlus Health Plan, Inc. (“MetroPlus”) is hereby authorized to increase the spending authority for the contract with Milton Samuels Advertising Agency, Inc. (“MSA”), dated February 14, 2011, and to allocate additional funds of \$1.2 million for advertising for the fulfillment of the contract, for an amount not to exceed \$4,075,000 for the term which expires on February 13, 2016.*

Providing
quality,
affordable care
to all New Yorkers



Bellevue • Belvis • Carter • Coler • Coney Island • Cumberland • East New York • Elmhurst • Gouverneur
Harlem • Health & Home Care • Jacobi • Kings County • Lincoln • Mariner's Harbor • McKinney • MetroPlus
Metropolitan • Morrisania • North Central Bronx • Queens • Renaissance • Sea View • Stapleton • Woodhull

Ambulatory Care Transformation *Toward the Triple Aim*

Division of Medical & Professional Affairs

November 17, 2015

NYC
HEALTH+
HOSPITALS

HHC by the numbers

- 1.4 million New Yorkers served;
~470,000 uninsured
- >200,000 discharges; 19,000 newborn deliveries
- 4.5 million outpatient visits (1.6 million primary care visits)
- Over 472,000 MetroPlus members
- 1.1 million emergency department visits; 47% of NYC's emergency department services
- ~48% of NYC's mental health inpatient admissions; 46% of alcohol/detox inpatient admissions
- Correctional health services
- Diverse patient population, with many new immigrants (many patients excluded from ACA coverage expansion)



Admissions ED Visits Clinic Visits

1.4 Million Patients

~225,000 Admissions

1 Million+ Emergency Room Visits

5 Million+ Clinic Visits

113 Languages

 = 50K

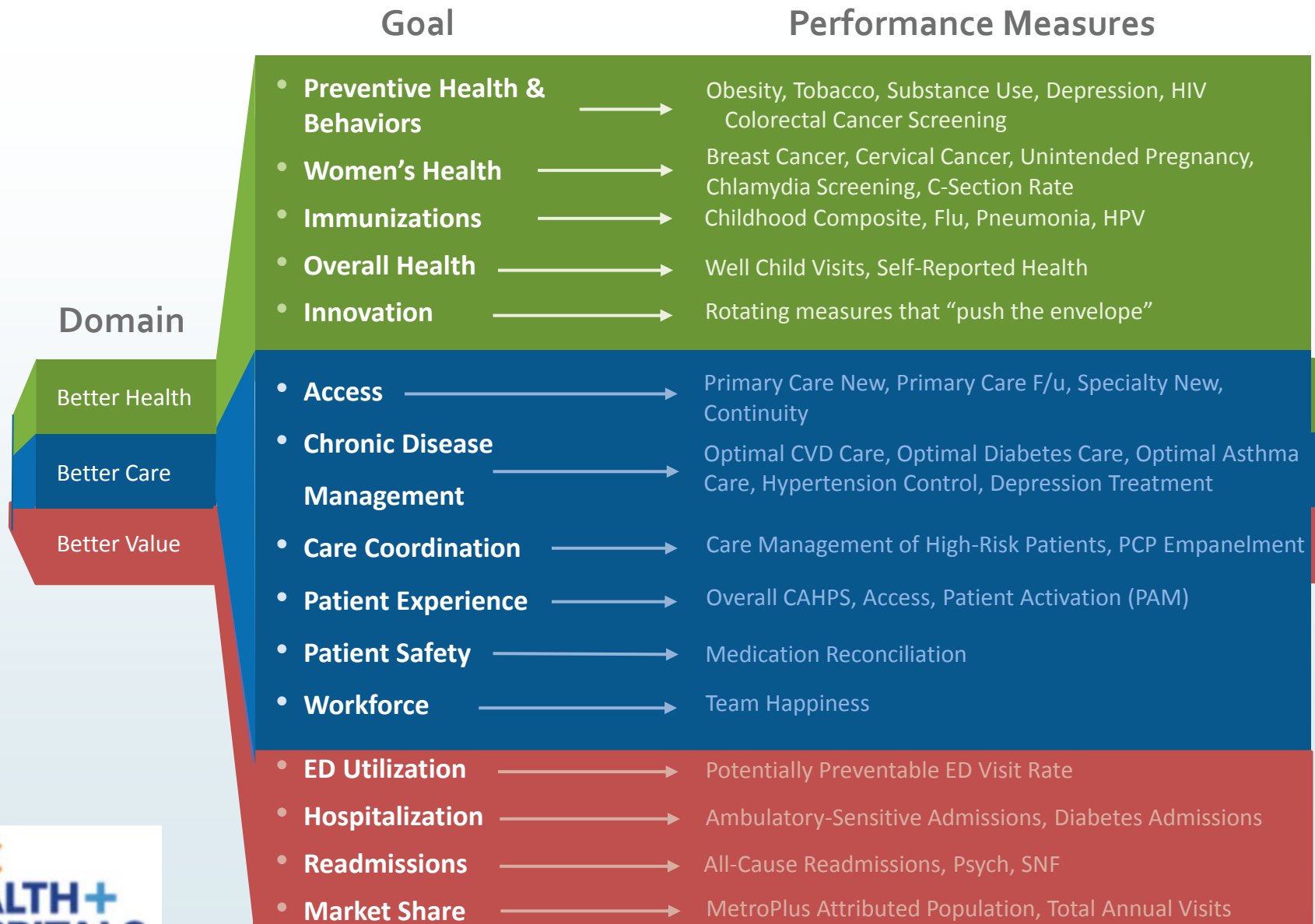
The Future State

- Overall goal is triple aim:
 - ✓ Better health
 - ✓ Better care
 - ✓ Lower cost
- Context:
 - ✓ Population Health
 - ✓ 'At risk' or 'value based' payment model
- Platform:
 - ✓ Ambulatory (rather than inpatient) driven system
 - ✓ Primary Care at the center
 - ✓ Care Management as a key driver
 - ✓ IT as essential component
- 2020 Vision & Goals

Our Initiatives

- *Patient Centered Medical Home* model to improve primary care – NCQA designation and significant funding from Hospital-Medical-Home project
- Improving care management through formation and state designation of *HHC Health Homes, refocusing HHC Home Care Agency and learning from a CMS (CMMI) innovation grant.*
- Formation of ACO – *Accountable Care Organization* as model for population health management
- Making the system work – *improving primary care access* and *integration of behavioral health* into primary care
- *Improving chronic disease management* and *preventive health care* with more timely performance information to providers
- Leveraging DSRIP – to strengthen the *IT platform* and build a new *Care Management* platform
- Preparing for new payment models, for example managed behavioral health and

Ambulatory Care Dashboard



Access to Primary Care

Objectives

- Timely access to primary care is critical for healthcare transformation

History of corporate-wide access efforts

- Kickoff and baseline data collection in late 2013
- All sites collecting data and conducting access improvement meetings by mid-2014
- Centralized tracking of metrics since September 2014

Standard corporate-wide metrics

- Wait times: Days to Third Next Available Appointment for New and Revisit patients
- Schedule utilization metrics: Fill rates, No-show rates
- In-clinic flow metrics: Cycle time of visit

Standard Improvement Methodologies

Schedule Optimization

- Schedule hygiene/scrubbing
- Reallocate schedule slots
- Simplify/automate overbooking

Improve No-Show Rates

- Deploy consistent appointment reminders and patient education

Manage Demand

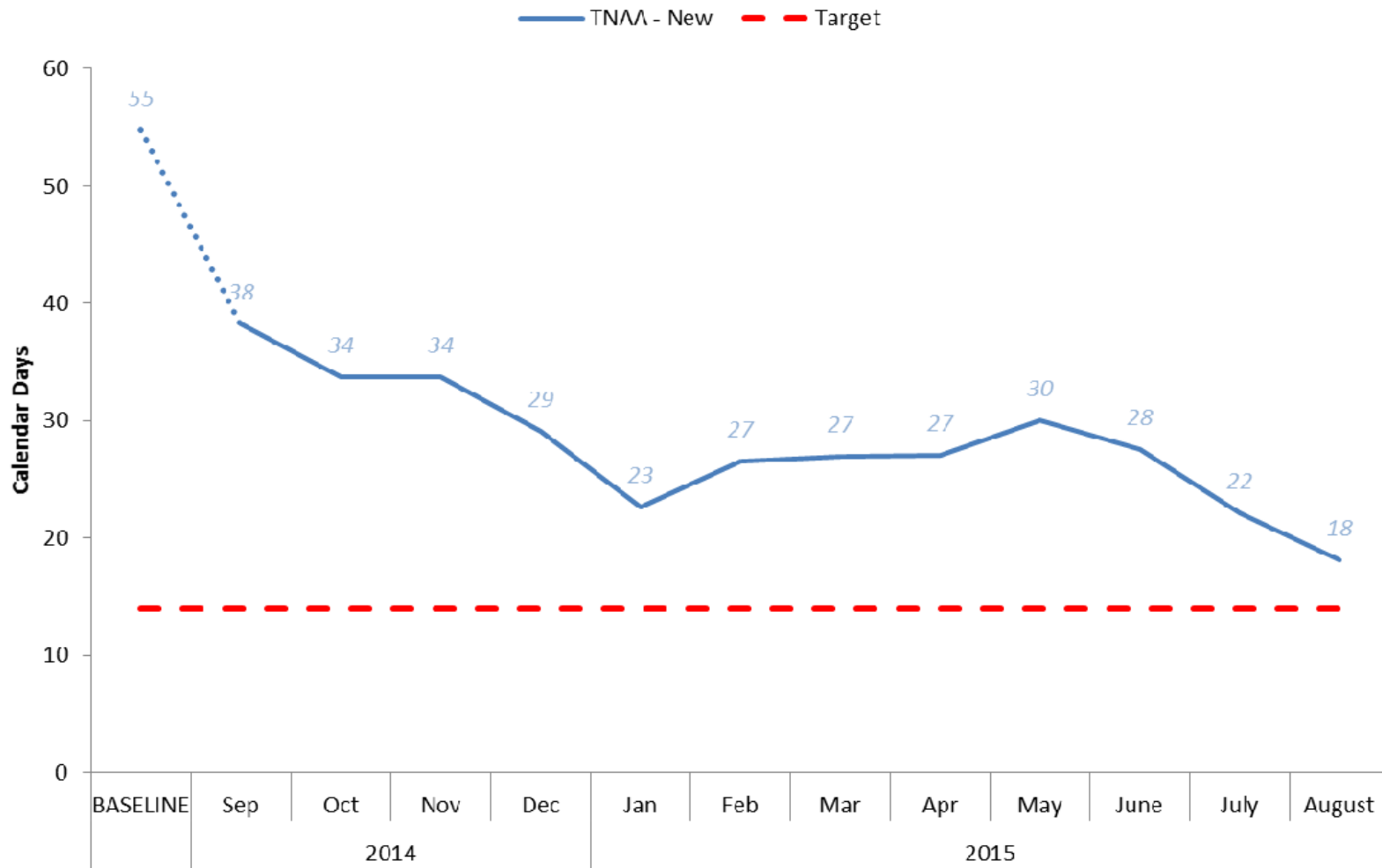
- Refine referral guidelines from ED
- Guide “walk-ins” to appointments while still addressing urgent needs

Increase Clinic Throughput

- Use “flow facilitator” to manage patient queue

Days to Third Next Available New Appointment

Adult Medicine, H+H average



Dates: Monthly averages since Sept 2014, when all 17 major sites were reporting. “Baseline” for each site occurred at different times between mid-2013 and mid-2014.

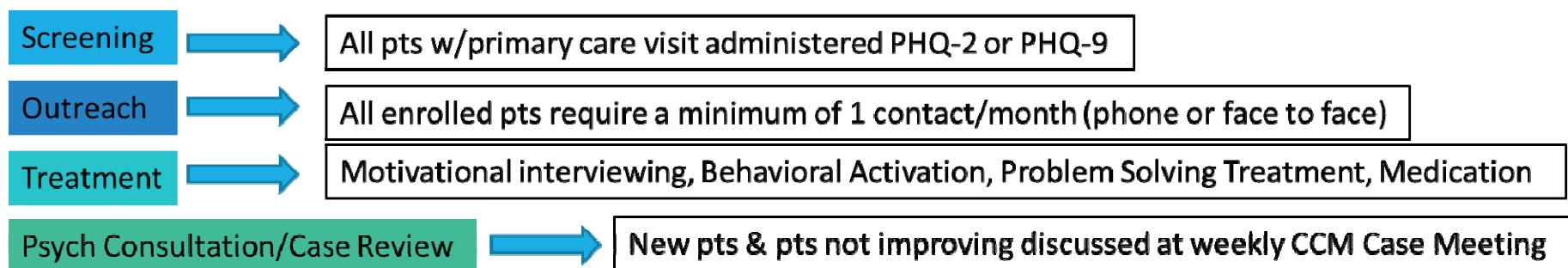
Definition: Calendar days to the third next available appointment for new patients; practice-level, not individual provider; excludes same-day appointments. Weighted by patient volume.

Method of Collection: Two options: (1) Manual lookup of the schedule or (2) MEDNEW availability pulled automatically from appointment scheduling system

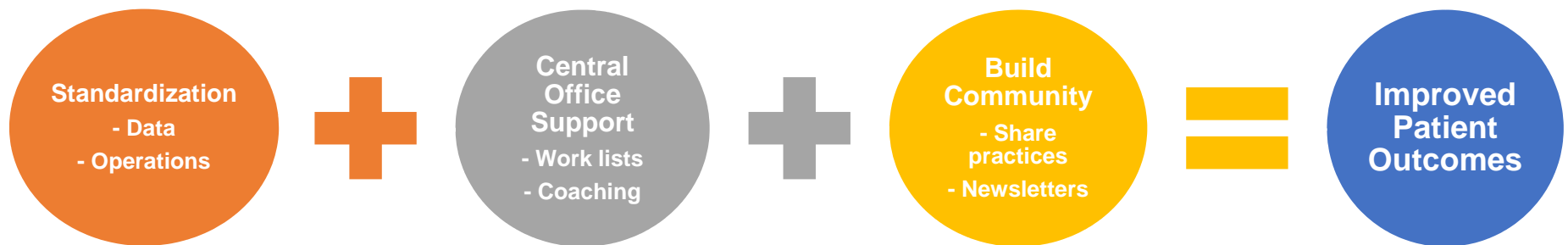
Sample Size: (1) Manual: sites are encouraged to provide the average of TNAA pulled 3-5 times per week (2) Automated: average of daily TNAA (data reflects TNAA as of midnight each day)

Collaborative Care for Depression

- **Collaborative Care** = Chronic Care Model + Collaborative Depression Care + Treat to Target Approach
- DSRIP – **Primary Care & Behavioral Health Integration**
- 17 HHC facilities participating in the program
- Originally funded under H-MH grant



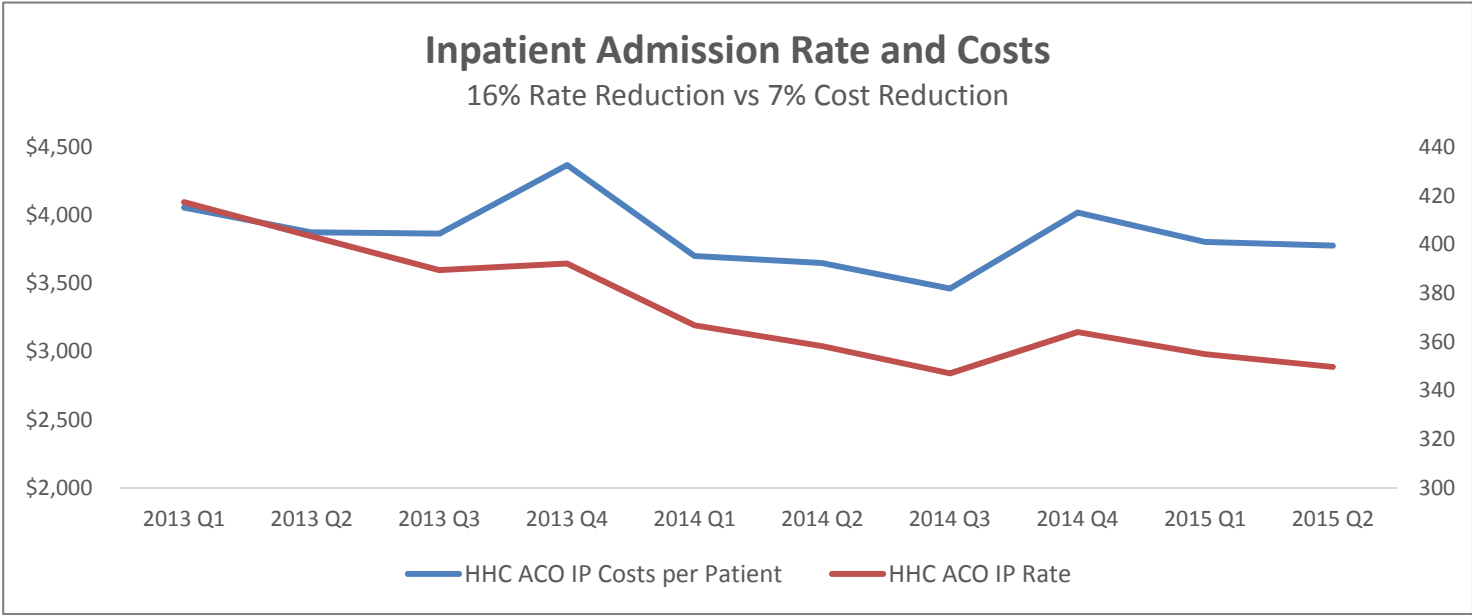
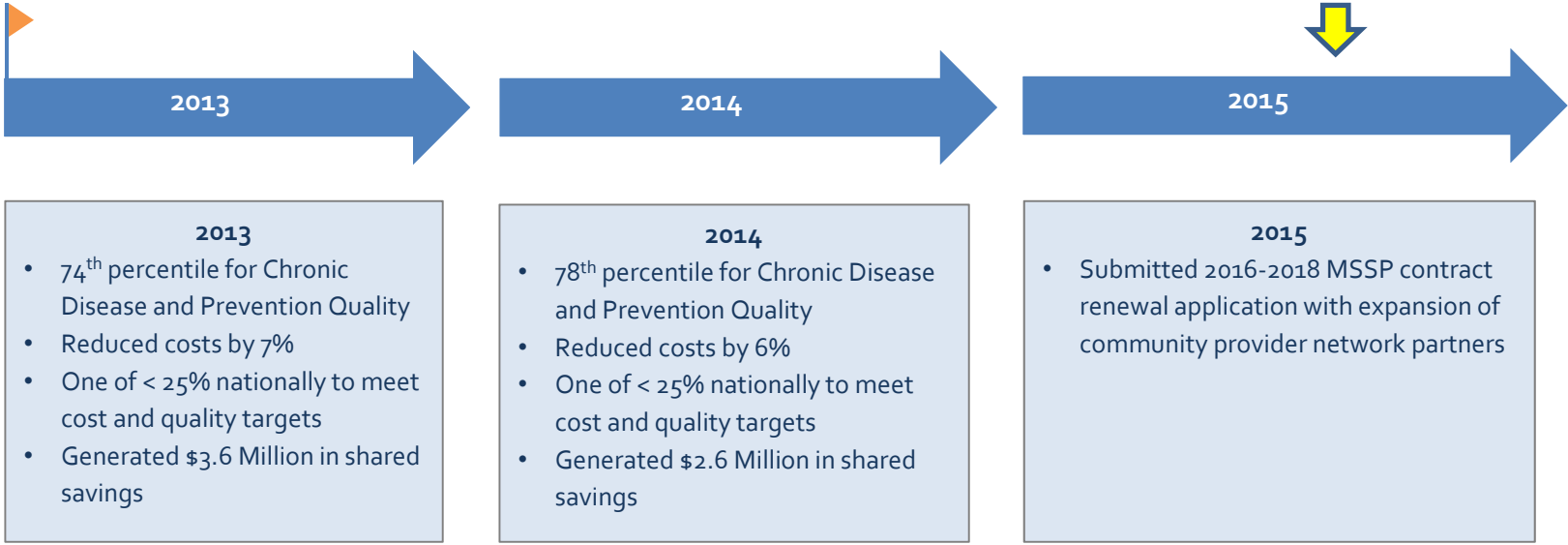
Collaborative Care for Depression Program



- Jan-Aug 2015: ~185,000 patients screened for depression in primary care (screening yield ~6%)
- HHC Average Screening Rate (2015): **88.5%** (Target $\geq 75\%$)
- HHC Average Improvement Rate (Q3/2015): **31.6%** (Target $\geq 50\%$)
- **827 patients** had a clinically significant improvement of PHQ-9 score in the last quarter

HHC Accountable Care Organization

HHC ACO
Launch



Utilization Risk Stratification

ED High Risk
155,971 ED Visits

ED & IP High Risk
30,904 ED Visits
&
15,292 IP Visits

Inpatient (IP) High Risk
5,477 IP Visits

Patients with
≥5 ED Visits
AND
< 4 IP Visits
(N = 18,665)

Patients
with ≥5
ED visits
AND ≥4
IP Visits
N=2,399

Patients with
≥4 IP Visits
AND
< 5 ED Visits
(N = 1,073)

5% of ED Patients had
5 or more ED Visits

3% of IP Patients had 4
or more IP Visits

Resolution

Authorizing the President of the NYC Health + Hospitals to enter into a contract with CareTech Solutions, Inc. (“CareTech”) for Epic Service Desk Support in an amount not to exceed \$14,694,651 (includes a 7.5% contingency of \$1,024,673) for the contract term of five years with two one-year options to renew, at the Corporation’s exclusive option.

WHEREAS, the end users of the Epic electronic medical record system (“Epic EMR”) at each of the Corporation’s facilities will require a single point of contact for Epic Pre and Post Go-live Service Desk Support to resolve requests and issues as they arise on a 24/7/365 basis as Epic EMR is rolled out to each facility; and

WHEREAS, the Corporation issued a Request for Proposals seeking an appropriately qualified vendor to provide Epic Service Desk Support for all Corporation facilities; and

WHEREAS, CareTech was selected as it was the highest ranked responsive and responsible proposer that demonstrated the experience and organizational capacity necessary to provide the services and its proposed pricing was consistent with industry rates for similar services; and

WHEREAS, CareTech will provide Epic Pre and Post Go-live Service Desk Support by credentialed or certified clinical experts with direct experience supporting Epic applications for each HHC facility as Epic is deployed in the facility on a 24/7/365 basis and will provide knowledge transfer and training to the HHC service desk; and

WHEREAS, the HHC service desk will continue to provide and maintain support for all other non-Epic related applications issues and requests, including the Quadramed EMR; and

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

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

NOW, THEREFORE, be it:

RESOLVED, THAT the President of NYC Health + Hospitals be and hereby is authorized to enter into a contract with CareTech Solutions, Inc. (“CareTech”) for Epic Service Desk Support in an amount not to exceed \$14,694,651 (includes a 7.5% contingency of \$1,024,673) for the contract term of 5 years with 2 one-year options to renew, at the Corporation’s exclusive option.

EXECUTIVE SUMMARY

The accompanying Resolution requests approval to enter into a contract with CareTech Solutions, Inc. ("CareTech") for Epic Service Desk Support in an amount not to exceed \$14,694,651 (includes a 7.5% contingency of \$1,024,673) for the contract term of 5 years with 2 one-year options to renew. The funding for this contract will be provided through the Epic EMR budget previously presented to the Board of Directors.

CareTech will provide Epic Pre and Post Go-live Service Desk Support by credentialed or certified clinical experts with direct experience supporting Epic applications for each HHC facility as Epic is deployed in the facility on a 24/7/365 basis. The Epic Service Desk will be a single point of contact for facility clinicians and other end users to resolve all Epic requests and issues. Since these requests and issues arise while the clinician or end user is actually in the Epic EMR system tending to a patient or patient record, it is imperative that the requests and issues are resolved as quickly as possible so as not to negatively impact productivity or patient care.

A Request for Proposals (RFP) was issued and advertised in the City Record and HHC received 8 responses. The 7 proposals that met the Minimum Qualification Requirements were evaluated and scored by a selection committee. Based on an initial scoring, the evaluation committee determined that a short list of the top 4 respondents would give oral presentations and demonstrations of their proposed solutions. The evaluation committee provided final scores of the short list after the oral presentations. Site visits were then conducted by HHC of the two (2) highest ranked vendors.

CareTech was selected as it was the highest ranked responsive and responsible proposer that demonstrated the experience and organizational capacity necessary to provide the services and their proposed pricing was consistent with industry rates for similar services.

Currently, HHC operates a service desk that supports all non-Epic related applications, including the Quadramed EMR. Due to the large scale of HHC's Epic implementation, for each Go-Live the Epic Service Desk will have trained staff that will specifically support Epic incidents/requests to offset the load on the current HHC Service Desk. The current HHC Service Desk will continue to provide and maintain support for all other non-Epic related issues/requests, including the Quadramed EMR.

Since the Epic EMR will be a phased roll-out across all facilities, the combination of the current HHC service desk and the Epic Service Desk will be necessary to ensure high quality service delivery. The objective is to transition the Epic EMR service desk support to the HHC service desk, as Epic is rolled out to more facilities and as the service desk staff is appropriately trained. CareTech will provide knowledge transfer and training for the HHC service desk.

A dedicated Epic Service Desk will optimize agent availability and direct calls to specialized trained agents to assist users with their needs. Existing HHC service desk customers will not be impacted by the increased call volume as a result of the Epic Go-Lives.

These Services will provide the following benefits:

- Improve patient care
- A knowledgeable clinical Support Team
- A Single point of contact for Epic issues or requests
- 24/7/365 Support

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: EPIC Enterprise Service Desk Support
Project Title & Number: EPIC Enterprise Service Desk Support
Project Location: HHC Corporate and Facilities
Requesting Dept.: Enterprise IT Services

Successful Respondent: CareTech
Contract Amount: \$14,694,651 (includes a 7.5% contingency of \$1,024,673)
Total Not to Exceed
Contract Term: Five (5) years with two (2) one-year options to renew

Number of Respondents: Eight (8)
(If Sole Source, explain in Background section)

Range of Proposals: \$11.0 M (Lowest to highest) \$31 M

Minority Business Enterprise Invited: Yes If no, please explain: _____

Funding Source: General Care Capital
 Grant: explain _____
 Other: explain EMR Operating Budget

Method of Payment: Lump Sum Per Diem Time and Rate
 Other: One-Time Implementation Fee, Monthly Recurring Service Desk and On-site Tech Support Fees

EEO Analysis: _____

Compliance with HHC's McBride Principles? Yes No X Pending

Vendex Clearance Yes No X Pending

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

CONTRACT FACT SHEET (continued)

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

The purpose of the contract is to support the transition to an Enterprise Epic EMR system at each facility for EPIC implementation Go-lives, and software upgrades.

CareTech will provide Epic Pre and Post Go-live Service Desk Support staffed by credentialed or certified clinical experts with direct experience supporting Epic applications for each HHC facility as Epic is deployed in the facility on a 24/7/365 basis. The Epic Service Desk will be a single point of contact for facility clinicians and other end users to resolve all Epic requests and issues. Since these requests and issues arise while the clinician or end user is actually in the Epic EMR system tending to a patient or patient record, it is imperative that the requests and issues are resolved as quickly as possible so as not to negatively impact productivity or patient care.

Currently, HHC operates a service desk that supports all non-Epic related applications, including the Quadramed EMR. Due to the large scale of HHC's Epic implementation, for each Go-Live the Epic Service Desk will have trained staff that will specifically support Epic incidents/requests to offset the load on the current HHC Service Desk. The current HHC Service Desk will continue to provide and maintain support for all other non-Epic related issues/requests, including the Quadramed EMR.

Since the Epic EMR will be a phased roll-out across all facilities, the combination of the current HHC service desk and the Epic Service Desk will be necessary to ensure high quality service delivery to patients at all HHC facilities. The objective is to transition the Epic EMR service desk support to the HHC service desk as Epic is rolled out to more facilities and as the service desk staff is appropriately trained.

Existing HHC service desk customers will not be impacted by the increased call volume as a result of the Epic Go-Lives.

These Services will provide the following benefits:

- Improve patient care
- A knowledgeable clinical Support Team
- A Single point of contact for Epic issues or requests
- 24/7/365 Support

The funding for this purchase will be provided from the EPIC EMR budget previously presented to the Board of Directors.

Contract Review Committee

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

The Request to issue a Request for Proposals was presented to the CRC for approval on June 18, 2014 and was approved by the CRC on July 14, 2014.

The request to award the contract was approved by CRC on 10/28/15.

Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC?

No

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

An ad was placed in the City record. Proposals were received from eight (8) vendors on the due date specified in the RFP. The proposals were reviewed for responsiveness and to determine whether the Minimum Qualification Requirements (MQR) were met.

Of the 8 vendors that responded to the RFP, one (1) vendor did not meet the MQR and was not considered by the evaluation committee.

The evaluation committee evaluated the seven (7) proposals that met the MQR based on the following criteria:

Past Performance	25%
Management Plan	20%
Cost	20%
Technical Qualifications	15%
Company Qualifications	10%
Understanding of Work	10%

Below are the initial scores:

Vendor	Total Score
Dell	78%
CareTech Solutions	76%
Enterprise Systems Software (ESD)	75%
Xerox	62%
LinkEHR	52%
Nordic & PDS	45%
TEKSystems	44%

Based on the initial scoring, the evaluation committee determined that a short list of the top 4 firms (CareTech, Dell, ESD and Xerox) would be asked to provide oral presentations and demonstrations of their proposed solutions.

The evaluation committee provided final scores after the presentations:

Vendor	Total Score
CareTech Solutions	78.2%
Dell	67.5%
Enterprise Systems Software (ESD)	50.6%
Xerox	60.8%

HHC conducted site visits of the 2 top ranked vendors, CareTech and Dell.

CareTech received the highest score based on its technical abilities, experience and cost therefore, CareTech was selected as offering HHC the best combination of technical approach and cost.

Attachment A – Evaluation Committee Members

Attachment B – Vendor Respondents/Vendors Considered

CONTRACT FACT SHEET (continued)

Scope of work and timetable:

The contract will commence on January 1, 2016 for a 5 year term with two (2) one-year options to renew. CareTech will provide operational Epic EMR application support, including but not limited to: on-site Command Centers at each Go-Live, on-going Service Desk Support Post Go-Live support, initial triaging, and level 1 support and ticket routing based on defined policies/procedures. A comprehensive, but not limited, sampling of work to be performed includes:

- Level 1 Support for each Go-live: Support for the Epic application for all interactions and tickets during Go-live and post Go-live which includes incident control, life cycle management of all service requests, and communicating with the clinician for all Epic related incidents and/or service requests.
- Knowledge transfer: Provide an up to date knowledge database for NYCHHC specific to the Epic implementation, to include knowledge articles, phone scripts, Epic application support materials. Additionally, the vendor must provide HHC with the knowledge (via the HHC Knowledge Management System) required to become fully familiar with the Epic support processes and procedures, as well as the relevant support materials. They will also be responsible for providing pertinent training materials to HHC in the event of an early transition of support to internal resources.
- Support for Epic upgrades: Maintain same level of support during and after any major Epic upgrade or any major upgrade to the environment.
- Continual Service Improvement: Continually align and re-align services to the changing business needs to increase service performance for the Epic customers based on the results of service reviews and process evaluations by HHC.
- Customer Survey – Maintain a comprehensive customer survey review process to ascertain performance against the critical success factors i.e., customer satisfaction

CONTRACT FACT SHEET (continued)

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

CareTech offered the lowest pricing of the top two finalists.

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

N/A

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

The current HHC Enterprise Service Desk will continue to support our legacy EMR application and will begin EPIC support training. The objective is to transition the Epic EMR service desk support being procured under the proposed contract to the HHC service desk, as Quadramed calls decline as Epic is rolled out to more facilities and as the service desk staff is appropriately trained.

CareTech will be providing Knowledge Transfer and Training to ensure and plan proper handoff to the HHC Enterprise Service Desk from the Epic Service Desk.

Currently, HHC operates a service desk that supports all non-Epic related applications, including the Quadramed EMR. Due to the large scale of HHC's Epic implementation, for each Go-Live the Epic Service Desk will have trained staff that will specifically support Epic incidents/requests to offset the load on the current HHC Service Desk. The current HHC Service Desk will continue to provide and maintain support for all other non-Epic related issues/requests, including the Quadramed EMR.

Since the Epic EMR will be a phased roll-out across all facilities, the combination of the current HHC service desk and the Epic Service Desk will be necessary to ensure high quality service delivery to patients at all HHC facilities. The objective is to transition the Epic EMR service desk support to the HHC service desk, as Quadramed calls decline as Epic is rolled out to more facilities and as the service desk staff is appropriately trained.

CONTRACT FACT SHEET (continued)

Will the contract produce artistic/creative/intellectual property?

No

Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

Not applicable.

Contract monitoring (include which Senior Vice President is responsible): Sal Guido Interim, Senior VP / Corporate CIO

This contract will be administered by *Sal Guido Interim*, Senior VP / Corporate CIO.

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

Received By E.E.O. _____
Date

Analysis Completed By E.E.O. _____
Date

Name

**ATTACHMENT A
EVALUATION COMMITTEE MEMBERS**

Jim Gomez – Interim AVP

Michael Keil - AVP

Eli Tarlow – NCIO – South Manhattan

Jeffrey Lutz – Sr Director – Infrastructure Services

Ruby Ditchfield-Agboh – NCIO – North Manhattan

Angel Zumaran – Director –Enterprise Service Desk/Workplace Services

ATTACHMENT B VENDORS

List of firms responding to solicitation:

1. LinkEHR
2. Nordic
3. TEKsystems
4. ESD
5. Xerox
6. CareTech
7. Dell
8. HCl – (Did not meet the Minimum Qualification Requirements)

List of Firms Considered

1. LinkEHR
2. Nordic
3. TEKsystems
4. ESD
5. Xerox
6. CareTech
7. Dell

EPIC SERVICE DESK SUPPORT CONTRACT CARETECH SOLUTIONS, INC.

BOARD OF DIRECTORS MEETING

November 17, 2015



The Request

Award Contract to CareTech Solutions Inc. for Epic Service Desk Support

- Contract Term 5 years + 2 one-year renewals
- \$14,694,651 (includes a 7.5% contingency of \$1,024,673) for 7 years
- Funding for this contract will be provided through the Epic EMR budget

CareTech will provide Epic Pre and Post Go Live Service Desk

- Staffed by credentialed or certified clinical experts with direct experience supporting Epic applications for each HHC facility as Epic is deployed across HHC
- 24/7/365 basis
- Provide a single point of contact for facility clinicians and other end users to resolve all Epic requests and issues
- Knowledge transfer and training for the HHC internal Enterprise Service Desk



Business Justification

Combination of the HHC internal Service Desk and CareTech will ensure high quality service delivery, maintain productivity and improve patient care at all HHC facilities:

- HHC internal Service Desk will continue to provide support for all non-Epic applications, including Quadramed
- CareTech Epic Service Desk support will offset the anticipated upsurge in call volume that will result from the Epic implementation, allowing the internal HHC Service Desk to continue supporting all HHC applications without a decline in service
- CareTech will provide knowledge transfer and training for the HHC service desk



Procurement Process

Solicitation

- Publicly Advertised Request for Proposals in City Record
- 8 proposals received
 - 1 proposal did not meet the Minimum Qualification Requirements

Evaluation

- 7 proposals were evaluated by evaluation committee based on the criteria identified in the RFP
- Based on initial scores a short list of the 4 top vendors gave oral presentations/demonstrations
- The committee re-scored after the oral presentations
- Conducted site visits of the top 2 vendors

Selection

- CareTech Solutions, Inc. was selected as it received the highest score and offered HHC the best combination of technical ability and price



Epic Implementation Budget

EMR Project - Six Year Implementation Budget								
[Expenditures include Invoices Paid or <u>In-Process</u>]								
	Item		Total Implementation Dollars (in millions)					
			Project to Date			FY2016		
			Total Budget FY13 to FY19	Expenditures (Paid or in Process) as of 9/30/2015	Balance FY13 to FY19	Budget FY16	Expenditures FY16 (Paid or in Process) as of 9/30/2015	Balance FY16
1	Epic Contract	Includes Software and Implementation and Training Services.	\$144	\$69	\$75	\$18	\$2	\$16
2	Third Party & Other Software	Includes Endoscopy, Fetal Monitoring Systems, ePrescribing, Patient Education.	\$30	\$5	\$25	\$6	\$0	\$6
3	Hardware	Includes Servers, Storage, Server Licensing, Network Switches.	\$83	\$26	\$57	\$28	\$0	\$27
4	Interfaces	Includes Interface Software/Blended Middleware.	\$38	\$4	\$35	\$3	\$0	\$3
5	Implementation Support	Third party vendor staff augmentation, go-live support and training (includes costs associated with backfilling non-IT staff and temps).	\$356	\$39	\$317	\$75	\$6	\$69
6	Application Support Team	New HMC FTE staff to be used through the implementation period including fringe benefits. These costs will become on-going after implementation period.	\$113	\$31	\$82	\$19	\$4	\$15
	Clinicals-Only Total	[Without QuadraMed Transition/Existing Application/Existing Staff Costs]	\$764	\$174	\$590	\$148	\$12	\$136



Note:

1. 5 year current cost projection for Revenue Cycle was an additional \$125 million. Budget is under review. Further evaluation required



QUESTIONS?



RESOLUTION

Authorizing the President of NYC Health + Hospitals to negotiate and execute a contract with **McKesson Technologies Inc.** to provide Radiology Integration and Practice Management Services for a period of three years with two, one-year options to renew, exercisable solely by NYC Health + Hospitals, in an amount not to exceed \$16,684,855, inclusive of all costs and expenses.

WHEREAS, currently NYC Health + Hospitals radiologic technology platforms are siloed, disparate and unintegrated and rely on outsourcing for certain off-hour readings of scans; and

WHEREAS, NYC Health + Hospitals wishes to move to a model where all scans may be read by in-house staff, where scans from one facility can be read at any other facility and where there is enhanced opportunities for quality assurance; and

WHEREAS, NYC Health + Hospitals requires the services of a vendor who can assist in transforming its radiology practices and create an integrated platform where images can be read at any site and managed through an intelligent worklist; and

WHEREAS, a Request for Proposals ("RFP") was issued on August 14, 2015 for Radiology Integration Services and the selection committee, which rated the proposals using criteria specified in the RFP, recommended that McKesson Technologies Inc. be awarded the contract; and

WHEREAS, the proposal meets all of NYC Health + Hospitals' technological and regulatory security requirements, and uptime performance expectations; and

WHEREAS, responsibility for monitoring the contract shall be under the Senior Vice President/Chief Medical Officer and interim Chief Information Officer.

NOW, THEREFORE, be it

RESOLVED, that the President of the NYC Health + Hospitals be and hereby is authorized to negotiate and execute a contract with McKesson Technologies Inc. to provide Radiology Integration and Practice Management Services for a period of three years with two, one-year options to renew, exercisable solely by NYC Health + Hospitals, in an amount not to exceed \$16,684,855, inclusive of all costs and expenses.

Executive Summary

Radiology Integration and Practice Management Services

NYC Health + Hospitals seeks to enter into a contract with McKesson Technologies Inc. (“McKesson”) to provide radiology integration and practice management services for a three year term, with two, one-year options to renew, exercisable solely by NYC Health + Hospitals, in an amount not to exceed \$16,684,855. Radiology services are currently provided at NYC Health + Hospitals’ eleven acute care hospitals, six diagnostics and treatment centers, clinics at the City’s jails under the new Correctional Health Services division, and at its three long term care facilities and at various community health clinics. Over 1.4 million radiology scans are made and read at NYC Health + Hospitals facilities annually. Additionally, 200,000 overnight radiology scans are read and interpreted by external vendors annually. NYC Health + Hospitals currently has two image storing (PACS) systems (SECTRA and AGFA), each covering 5-6 facilities. With different PACS systems, images cannot be shared by any one facility with any other. Similarly, the current Talk Tech and Voice Brook dictation systems cannot manage worklist/distribute reports outside a host facility.

The proposed McKesson program will drive patient outcome, quality, and efficiency improvements by establishing radiology network connectivity across the entire NYC Health + Hospitals system, enabling a cross-facility radiology imaging sharing protocol, optimizing radiology practice management, and generating transparent performance metrics in such a way that services, quality and productivity are improved. The program will also support operational expansion via an open platform that would allow NYC Health + Hospitals’ facilities to read the scans of providers outside the system.

In addition the proposed McKesson program will eliminate outsourcing of radiology services. 100% of all radiology interpretations will become available 24/7/365 days. Turnaround times will be reduced and a robust quality assurance mechanism will be easily put in place along with for performance tracking/reporting and continuous improvement.

The proposed McKesson program meets all technological security requirements and will protect NYC Health + Hospitals against unacceptable levels of information security risk; will adhere to the information security principles of confidentiality, integrity, availability, non-repudiation, accountability, and authenticity of information; and will assist with external and internal regulatory compliance.

A Request for Proposals (“RFP”) was issued on August 14, 2015. Eight proposals were received and all eight proposals met the minimum qualification criteria. The proposals were evaluated by a selection committee using criteria specified in the RFP. Four vendors were eliminated after the first round of scoring. The remaining four vendors provided oral presentations as well as onsite demonstrations. After multiple rounds of scoring the Selection Committee narrowed the selection down to two finalists which were McKesson Technologies Inc. and Imaging Advantage. Ultimately McKesson offered the best overall solution and was selected as the vendor to provide radiology integration and practice management services for NYC Health + Hospitals.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: New York City Health and Hospitals Corporation Radiology
Integration

Project Title & Number: DCN# 2200

Project Location: Corporate wide

Requesting Dept.: Medical and Professional Affairs

Successful Respondent: **McKesson Technologies Inc.**

Contract Amount: \$16,684,855.00

Contract Term: Three years with two consecutive one-year options to renew

Number of Respondents: Eight (8)

(If Sole Source, explain in
Background section)

Range of Proposals: \$ 12,873,919.00 to \$39,675,077

**Minority Business
Enterprise Invited:** Yes ?No If no, please explain: _____

Funding Source: ? General Care Capital
? Grant: explain _____
 Other: explain Capital and Central Budget

Method of Payment: Time and Rate
Other: explain _____

EEO Analysis: In process with EEO

**Compliance with HHC's
McBride Principles?** Yes ? No

Vendex Clearance ? Yes ? No ? N/A Pending

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

CONTRACT FACT SHEET(continued)

In the current state of radiology HHC is faced with the following challenges.

- Different PACS systems. Can't share images with each other.
- Outdated Agfa systems. Unable to share images outside the host facility.
- Talk Tech and Voicebrook dictation systems cannot manage worklist/ distribute reports outside host facility.
- QuadraMed can't share images/final reports.
- Only three facilities have existing capability to provide overnight coverage in-house.

Future state of radiology

This new solution will drive patient outcome, quality, and efficiency improvements by establishing enterprise radiology network connectivity, eliminating the outsourcing of radiology professional services, enabling a cross-facility radiology imaging sharing protocol, optimizing radiology practice management, and supporting operational and expansion via an open platform. Our vision is to build a system where any images can be read at any sites within the corporation, using a single platform and generating transparent performance metrics in such a way that service quality and productivity are improved.

- Single technology platform
- No outsourcing of radiology service
- 100% final radiology interpretations 24/7/365
- Subspecialist read for identified specialties (e.g., Neuroradiology, MSK, Pediatrics, Women's Imaging)
- Fast turnaround time for STAT cases
- Robus Quality Assurance mechanism (e.g., real time double-blind peer review for high risk cases)
- Critical Results Notification and Tracking workflows
- Pooled caseload/resources
- Standardized policies, procedures and workflow
- Mechanism for performance tracking/reporting and continuous improvement

CONTRACT FACT SHEET(continued)

Contract Review Committee

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

It was presented to the CRC on 08/05/2015 for approval to issue an RFP.

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

No Changes have been made since the presentation to the CRC. The proposed contract will be submitted at the November 09, 2015 CRC meeting.

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

- Request for Proposal process was utilized
- Advertisement posted in the City Record
- Eight (8) vendors submitted proposals
- 4 Vendors were eliminated following Round 1 of Scoring
- Remaining 4 vendors were invited for onsite demonstrations at Gouverneur Hospital
- Selection committee:
 - **Machelle Allen, MD, Chair, HHC Medical and Professional Affairs**
 - **Nia Berdebes, Elmhurst Hospital Center**
 - **Michael Ambrosino, MD, Bellevue Hospital Center**
 - **Daniel Contractor, MD, Coney Island Hospital**
 - **Frederick Covino, HHC Finance**
 - **Martin Fine, MD, Elmhurst Hospital Center**
 - **Joseph Hood, HHC Enterprise Information Technology Services**
 - **Sheldon McLeod, Kings County Hospital Center**
 - **Paul Moh, MD, Lincoln Medical Center**
 - **David Shi, HHC Medical and Professional Affairs**
 - **Roslyn Weinstein, HHC Operations**
 - **Tony Williams, HHC Enterprise Information Technology Services**



McKesson is the selected vendor based on the following criteria:

- Clinical and Operational Requirement – 30%
- Technical Requirements – 20%
- Training and Implementation Plan – 10%
- Cost and Financial Impact – 25%
- References – 5%
- Financial Stability – 10%

McKesson brings 30 years of experience in delivering and innovating in Radiology Technology Services. McKesson has provided integrated Radiology IT solutions through their PACS, VNA's and Conserus offerings. McKesson also received very positive reviews from their references:

- UnityPoint Health (formerly Iowa Health System), large IDN in Iowa, Illinois and Wisconsin
- Mount Sinai Hospital System (formerly Continuum Health Partners), New York, New York
- Children's Hospital and Medical Center, Omaha, Nebraska

Scope of work and timetable:

Scope of work and timetable enclosed.

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

This new solution will drive patient outcome, quality, and efficiency improvements by establishing enterprise radiology network connectivity, eliminating the outsourcing of radiology professional services, enabling a cross-facility radiology imaging sharing protocol, optimizing radiology practice management, and supporting operational and expansion via an open platform.

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

Not Applicable

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

HHC Does not have the expertise, tools or technology to carry out the implementation of this type of services.

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

NO.

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

Ross Wilson, SVP/ Corporate CMO
Sal Guido, AVP, Interim CIO

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

Received By E.E.O. _____
Date

Analysis Completed By E.E.O. _____
Date

Name



Radiology Integration and Practice Management Contract

Board of Directors Meeting
Tuesday, November 17, 2015



Board of Directors Nov 2015



HHC's Radiology Service Line Transformation Opportunity

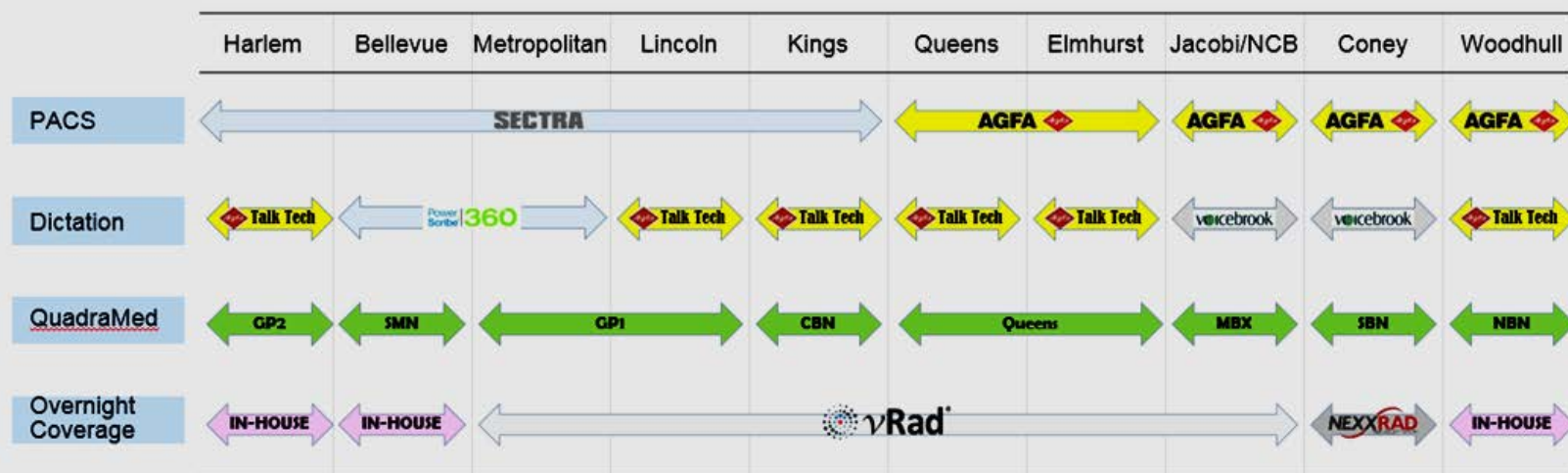
HHC has a facility-based radiologic care delivery model. Our current technology platform does not allow HHC to share images across facilities. HHC is unable to take advantage of its economies of scale in pooling clinical resources and expertise to meet our radiologic reading demand.

- ~1.4 million radiology cases are performed and read at HHC facilities annually
- 200,000 overnight radiology cases are interpreted by external vendors annually

HHC has the opportunity to integrate its radiology services by building an integrated technology platform and redesigning workflows to support a unified radiology practice.

HHC's Current Disparate Technology Infrastructure

Existing radiology system architect and challenges



Existing Challenges for Integrated Radiology Coverage

- 1.) Different PACS Systems (Sectra vs Agfa) can't share images with each other
- 2.) Outdated Agfa systems (Jacobi/NCB/ Coney/ Woodhull) can't share images outside the host facility
- 3.) Talk Tech and Voicebrook dictation systems can not manage worklist / distribute reports outside host facility
- 4.) 8 instances of QuadraMed can't share images/ final reports across
- 5.) Sites are transitioning to EPIC over the next 2-3 years
- 6.) Only three facilities have existing capability to provide overnight coverage in-house

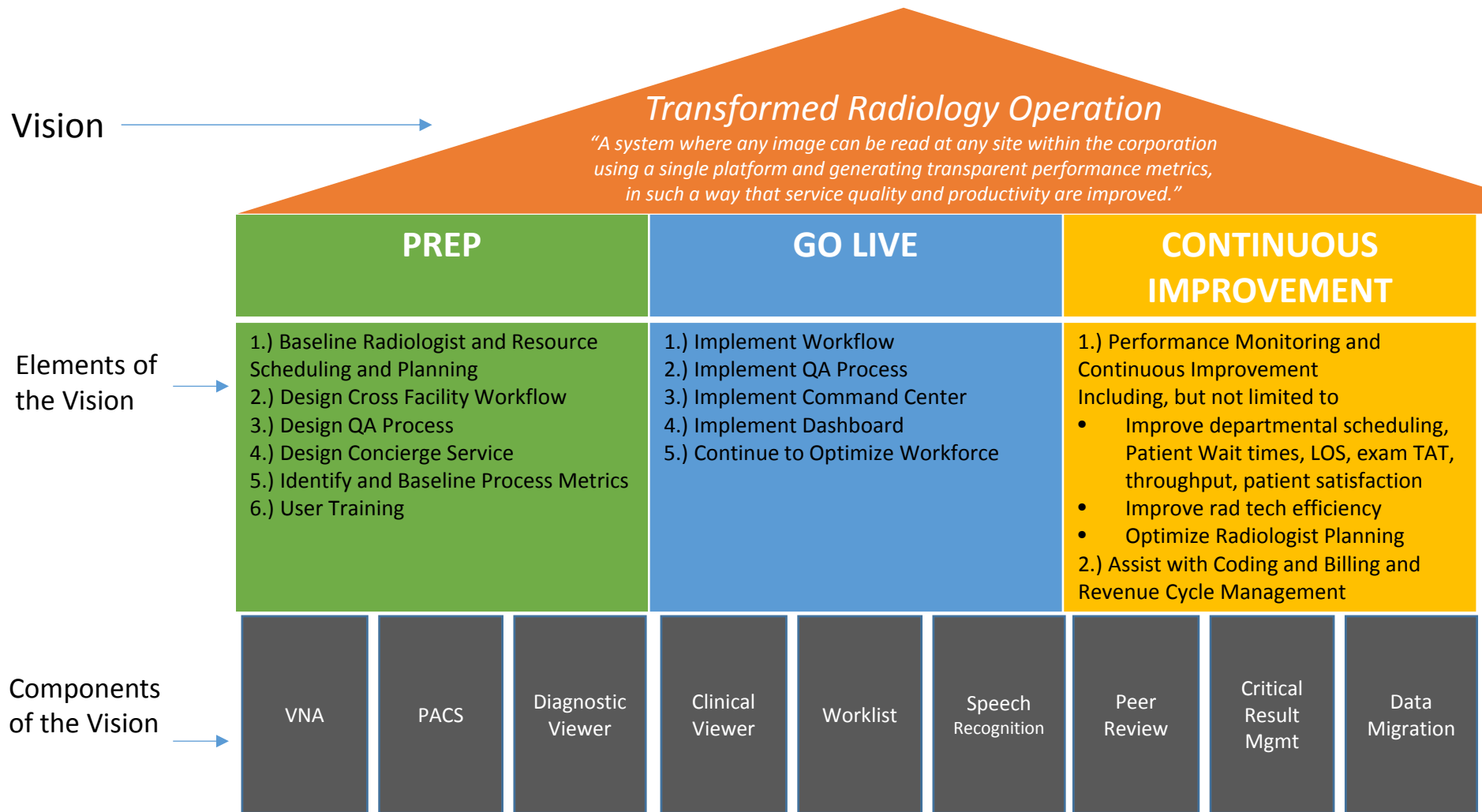


HHC's Future State Vision for Radiology Integration

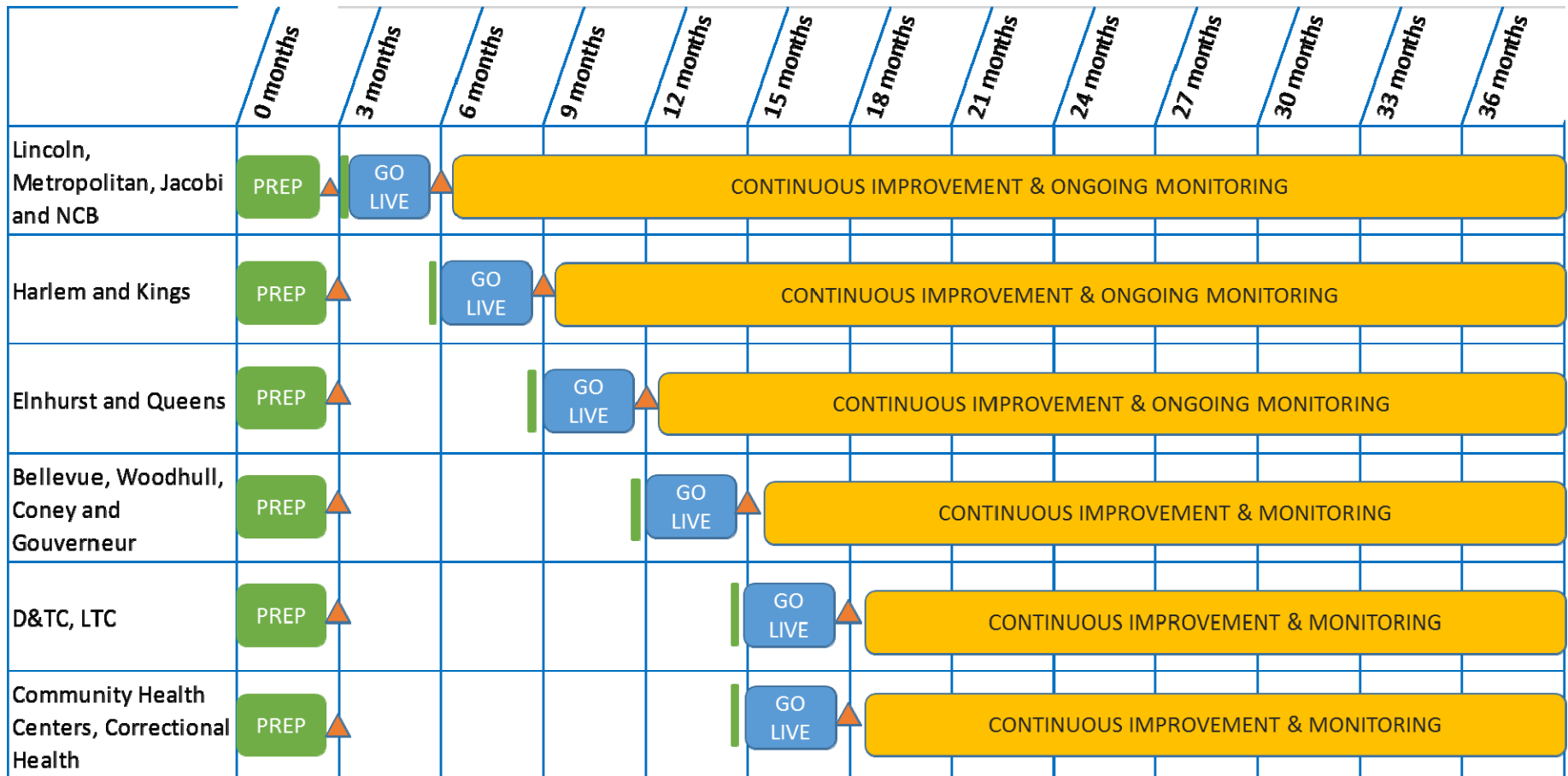
Our vision is to build a system where any images can be read at any site, using a single platform and generating transparent performance metrics, in such a way that service, quality and productivity are improved.

- Single technology platform
- No outsourcing of radiology services
- 100% final radiology interpretations 24/7/365
- Concierge service to facilitate communication btw providers.
- Subspecialist read for identified specialties (e.g., Neuroradiology, MSK, Pediatrics, Women's Imaging)
- 30 mins turnaround time for STAT cases
- Robust Quality Assurance mechanism (e.g., real time double-blind peer review for high risk cases)
- Critical Results Notification and Tracking workflows
- Pooled caseload/ resources
- Standardized policies, procedures and workflow
- Mechanism for performance tracking/ reporting and continuous improvement

Radiology Integration Framework



Radiology Integration Timeline



▲ = Tollgate Meeting / Business Review see slide 4

█ = Training Before Implementation

Procurement Methodology

- Request for Proposal process was utilized
- Advertisement posted in the City Record
- Eight (8) vendors submitted proposals
- 4 Vendors were eliminated following Round 1 of Scoring
- Remaining 4 vendors were invited for onsite demonstrations at Gouverneur Hospital
- Selection committee:
 - **Machelle Allen, MD, Chair, HHC Medical and Professional Affairs**
 - **Nia Berdebes, Elmhurst Hospital Center**
 - **Michael Ambrosino, MD, Bellevue Hospital Center**
 - **Daniel Contractor, MD, Coney Island Hospital**
 - **Frederick Covino, HHC Finance**
 - **Martin Fine, MD, Elmhurst Hospital Center**
 - **Joseph Hood, HHC Enterprise Information Technology Services**
 - **Sheldon McLeod, Kings County Hospital Center**
 - **Paul Moh, MD, Lincoln Medical Center**
 - **David Shi, HHC Medical and Professional Affairs**
 - **Roslyn Weinstein, HHC Operations**
 - **Tony Williams, HHC Enterprise Information Technology Services**



McKesson Technologies Incorporated– The Selected Vendor

McKesson is the selected vendor based on the following criteria:

- Clinical and Operational Requirement – 30%
- Technical Requirements – 20%
- Training and Implementation Plan – 10%
- Cost and Financial Impact – 25%
- References – 5%
- Financial Stability – 10%

McKesson brings 30 years of experience in delivering and innovating in Radiology Technology Services. McKesson has provided integrated Radiology IT solutions through their PACS, VNA's and Conserus offerings. McKesson also received very positive reviews from their references:

- UnityPoint Health (formerly Iowa Health System), large IDN in Iowa, Illinois and Wisconsin
- Mount Sinai Hospital System (formerly Continuum Health Partners), New York, New York
- Children's Hospital and Medical Center, Omaha, Nebraska

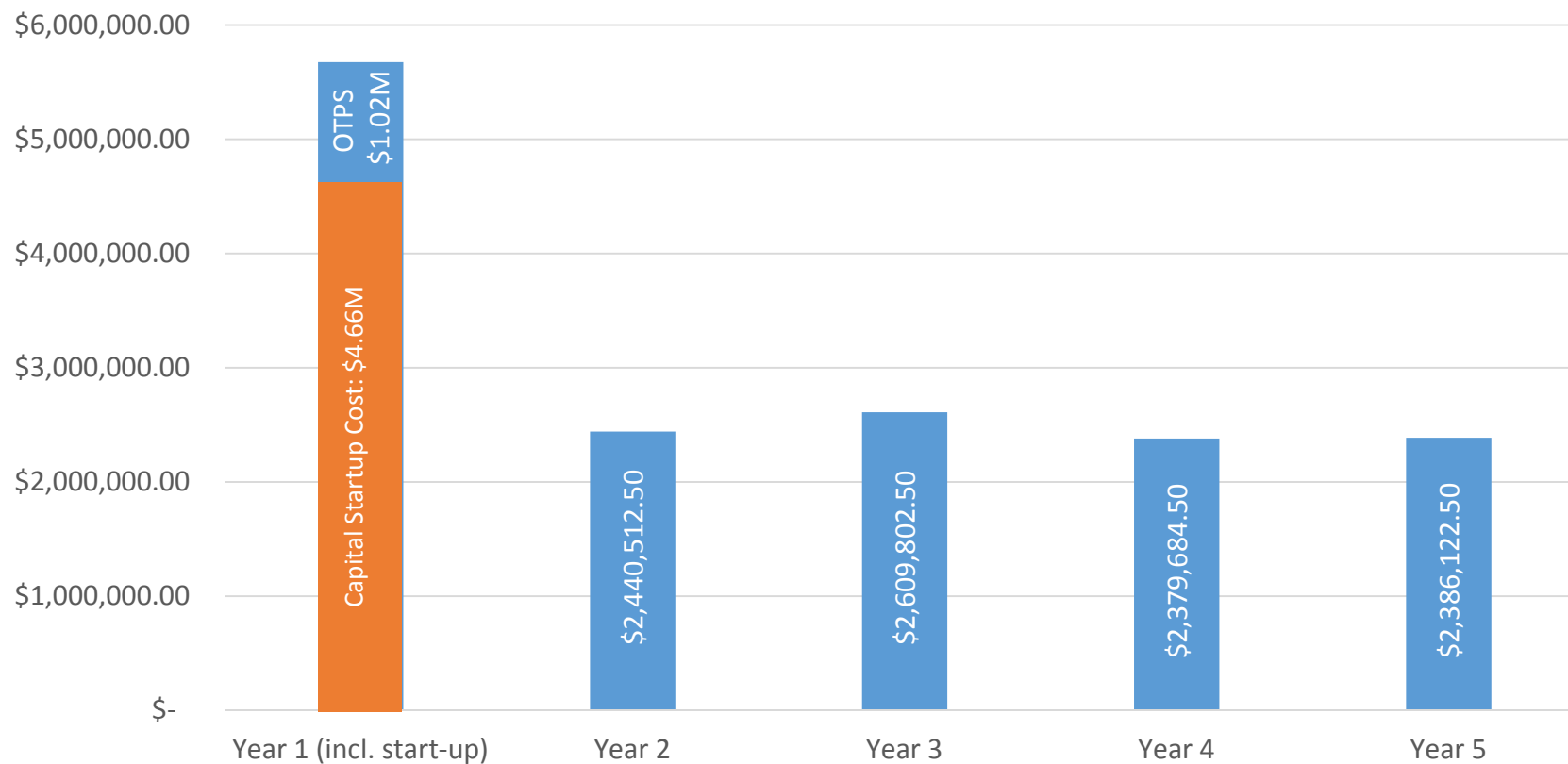
5 Year Contract Cost

Not To Exceed: \$16,684,855 over 5 contract years

OTPS Funds

Capital Funds

Projected Costs Over 5 Years



Resolution

RESOLVED, that the President of the NYC Health+Hospitals be and hereby is authorized to negotiate and execute a contract with McKesson Technologies Inc. to provide Radiology Integration and Practice Management Services for a period of three years with two, one-year options to renew, exercisable solely by NYC Health+Hospitals, in an amount not to exceed \$16,684,855, inclusive of all costs and expenses.

RESOLUTION

Authorizing the President of the NYC Health + Hospitals to execute a five year lease agreement including one five year option with Harlene Realty Corporation (the "Landlord") for approximately 600 square feet of ground floor space at 2101 Mermaid Avenue, Borough of Brooklyn, to house the Women, Infants and Children Program (the "WIC Program") operated by Coney Island Hospital (the "Facility") at a rate of \$16.66 per square foot, or \$9,996 per year to be escalated by 2.25% per year for a total rent amount over the five year initial term of \$52,280.

WHEREAS, pregnant, breastfeeding and postpartum women, infants and children less than five years of age who are determined to be at nutritional risk are eligible for WIC Program services which include monitoring children's growth rates, nutrition education, breastfeeding support, and high risk counseling; and

WHEREAS, the New York State Department of Health ("NYSDOH") had authorized Coney Island Hospital to operate WIC Programs at two sites in Brooklyn, and both sites were lost as a result of damage caused by Hurricane Sandy; and

WHEREAS, the program opened a temporary site at the Luna Park Community Center in January 2013 which was closed after nine months as a result of rent increases beyond the specified allowance for the program; and

WHEREAS, since October 2013, the WIC Program has been operating from a site within Coney Island Hospital and this site will continue to serve as a permanent program location; and

WHEREAS, the planned 2101 Mermaid Avenue site has been authorized by the NYSDOH as the second permanent site and will serve participants located in the Sheepshead Bay, Marine Park, Kings Bay and Bensonhurst communities of Brooklyn; and

WHEREAS, the WIC Program is funded through a NYSDOH grant.

NOW, THEREFORE, be it

RESOLVED, that the President of the NYC Health + Hospitals be and hereby is authorized to execute a five year lease agreement including one five year option with Harlene Realty Corporation (the "Landlord") for approximately 600 square feet of ground floor space at 2101 Mermaid Avenue, Borough of Brooklyn, to house the Women, Infants and Children Program (the "WIC Program") operated by Coney Island Hospital (the "Facility") at a rate of \$16.66 per square inclusive of utilities, or \$9,996 per year to be escalated by 2.25% per year for a total rent amount over the five year initial term of \$52,280.

EXECUTIVE SUMMARY

LEASE AGREEMENT WOMEN, INFANTS AND CHILDREN PROGRAM

CONEY ISLAND HOSPITAL

- OVERVIEW:** The President seeks authorization from the Board of Directors of the NYC Health + Hospitals to execute a five year lease agreement with Harlene Realty Corporation (the "Landlord") for ground floor space at 2101 Mermaid Avenue, Borough of Brooklyn, to house the Women, Infants and Children Program (the "WIC Program") operated by Coney Island Hospital ("CIH").
- NEED/
PROGRAM:** Pregnant, breastfeeding and postpartum women, infants and children less than five years of age who are determined to be at nutritional risk are eligible for WIC Program services which include monitoring children's growth rates, nutrition education, breastfeeding support, and high risk counseling. Most program participants are of low income. The New York State Department of Health ("NYSDOH") had authorized Coney Island Hospital to operate WIC Programs at two sites in Brooklyn, and both sites were lost as a result of damage caused by Hurricane Sandy. The program opened a temporary site at the Luna Park Community Center in January 2013 which was closed after nine months as a result of rent increases that were beyond the specified allowance for the WIC Program. Since October 2013, the WIC Program has been operating from a site within Coney Island Hospital and this site will continue to serve as a permanent program location. The planned 2101 Mermaid Avenue site has been authorized by the NYSDOH as the second permanent site and will serve participants located in the Sheepshead Bay, Marine Park, Kings Bay and Bensonhurst communities of Brooklyn; and
- UTILIZATION:** The NYSDOH projected caseload is 1,500 participants for the new Mermaid Avenue site. Caseload at the temporary Luna Park site included approximately 1,500-2,000 participants. The WIC site operating at the hospital has a caseload of 5,200 participants.
- TERMS:** The tenant will have use and occupancy of approximately 600 square feet of space on the ground floor. The initial term of the lease will be five years. The base rent will be \$16.66 per square foot or approximately \$9,996 per year. The base rent will be escalated by 2.25% per year. The lease term will commence upon lease execution. The lease will contain one five-year option to renew exclusive to the Tenant. The landlord will provide heat, air conditioning, electricity, water, sewer and housekeeping at its own expense. The landlord will be responsible for payment of real estate taxes.
- The landlord will be responsible for all interior and exterior structural and non-structural repairs to the premises, including repairs to the roof, infrastructure, mechanical systems, window frames, plumbing, electrical, waste utility lines, common areas, curbs and sidewalks.
- FINANCING:** NYSDOH grant will cover rent, operating expenses, and furniture and telecommunications equipment estimated to cost approximately \$14,000.

SUMMARY OF ECONOMIC TERMS

SITE: 2101 Mermaid Avenue
Borough of Brooklyn
Block 7017, Lot 43

LANDLORD: Harlene Realty Corporation

SIZE: 600 square feet

INITIAL TERM: Five years

OPTION: One five-year option. Option rent to be escalated by 2.25% per year.

RENT: \$16.66 per square foot, or approximately \$9,996 per year.

	Year 1	Year 2	Year 3	Year 4	Year 5
Price Per S/F	\$16.66	\$17.03	\$17.42	\$17.81	\$18.21
Annual Rent	\$9,996	\$10,221	\$10,451	\$10,686	\$10,926

ESCALATION: 2.25% per year based on FMV of \$16.66 per square foot.

MAINTENANCE: The Landlord is responsible for all structural and non-structural exterior and interior maintenance and repairs.

UTILITIES: Utilities including electricity, gas, water, sewer will be provided by the Landlord

TAXES: Landlord responsible for payment of real estate taxes

SAVITT PARTNERS

October 28, 2015

Mr. Dion Wilson
Director
Office of Facilities Development, Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, NY 10013

Re: 2101 Mermaid Avenue, Brooklyn, NY 11224
Block: 7017, Lot: 43

Dear Dion:

As we discussed, the proposal from the building's Landlord, Harlene Realty Corporation, for the WIC program to occupy approximately 600 SF is fair and reasonable. The rent of \$16.66 on a net basis is at market; however, HHC as Tenant further benefits from the fact that you are not being charged for any additional common space, nor will you be paying additional for electrical service.

The escalation of 2.25% per annum compounded is also fair and reasonable, and is consistent with market conditions.

If you have any further questions, please let me know.

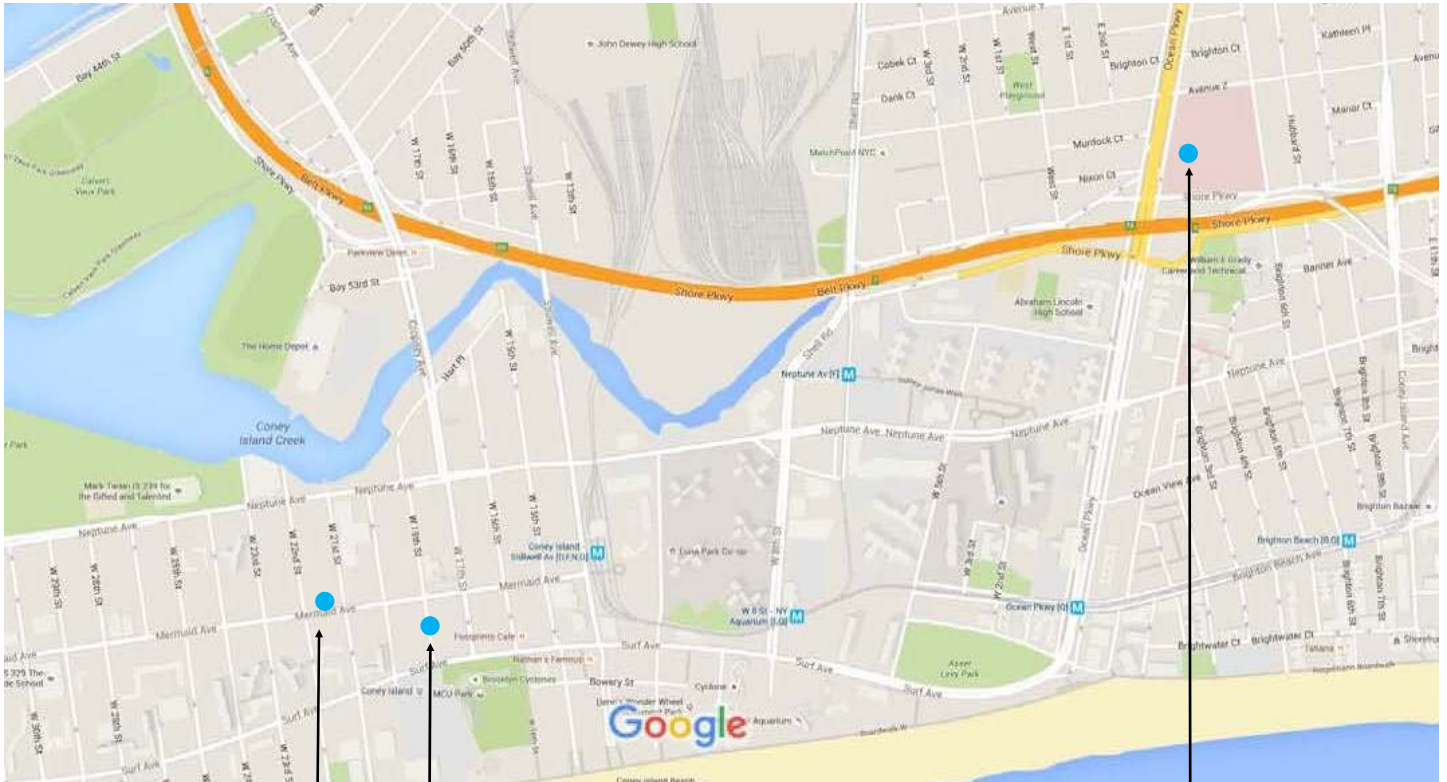
Very truly yours,

A handwritten signature in black ink, appearing to read "Michael Dubin". The signature is fluid and cursive, with a prominent initial "M".

Michael Dubin
Partner

Coney Island WIC Program 2101 Mermaid Avenue

The site is approximately 10 miles from the facility.



Ida Israel Clinic

Coney Island Hospital

2101 Mermaid Avenue

RESOLUTION

Authorizing the President of the NYC Health + Hospitals to execute an amendment to the existing Memorandum of Understanding ("MOU") with the New York City Department of Information Technology and Telecommunications ("DOITT") that permits the installation and maintenance of communication equipment at eight of the NYC Health + Hospitals facilities required for the operation of the City-wide Radio Network at no cost to DOITT to both expand the list of facilities at which DOITT equipment is sited to include Harlem Hospital Center, Metropolitan Hospital Center and Sea View Hospital Rehabilitation Center and Home (the "Facilities") and to expand the area at several Facilities for DOITT to use and the type of equipment to be installed and maintained.

WHEREAS, DOITT's responsibilities include providing New York City agencies with land-based and wireless voice, data, video and other communication capabilities; and

WHEREAS, DOITT equipment has been installed at the various of the Facilities since 2007 and is an integral part of the New York City Wireless Network ("NYCWiN"), a municipal broadband data network used primarily for first responder and critical service agencies; and

WHEREAS, in December 2011, the Board of Directors authorized the President to execute an MOU with DOITT allowing DOITT to install, repair and maintain its equipment at Lincoln Medical and Mental Health Center, Elmhurst Hospital Center, Jacobi Medical Center, North Central Bronx Hospital, Kings County Hospital Center, Coler-Goldwater Specialty Hospital and Nursing Facility, Queens Hospital Center, and Coney Island Hospital; and

WHEREAS, the term of the MOU is perpetual until terminated by either party; and

WHEREAS, in addition to the facilities at which DOITT was originally granted permission to install, maintain and repair equipment under the MOU, under the proposed amended MOU, DOITT shall also be permitted to install and maintain communication equipment at Harlem Hospital Center, Metropolitan Hospital Center and Sea View Hospital Rehabilitation Center and Home; and

WHEREAS, under the proposed amended MOU, DOITT shall have the right to slightly expand its presence at certain of the Facilities and to upgrade the equipment maintained; and

WHEREAS, DOITT shall have access to its systems and infrastructure located in risers, rooftops, penthouses, mechanical rooms, equipment closets or other locations at the Facilities required to install, repair and maintain its equipment; and

WHEREAS, DOITT's activities shall not interfere with the delivery of medical services or operation of hospital equipment at the Facilities and its equipment complies with all applicable federal statutes governing the safe emission of radio frequency signals.

NOW, THEREFORE, be it

RESOLVED, that the President of the NYC Health + Hospitals be and hereby is authorized to execute an amendment to the existing Memorandum of Understanding with the New York City Department of Information Technology and Telecommunications that permits the installation and, maintenance and repair of communication equipment at eight of the H+H facilities required for the operation of the City-wide Radio Network at no cost to DOITT to both expand the list of facilities at which DOITT equipment is sited to include Harlem Hospital Center, Metropolitan Hospital Center and Sea View Hospital Rehabilitation Center and Home (the "Facilities") and to expand the area at several Facilities for DOITT to use and the type of equipment to be installed and maintained.

EXECUTIVE SUMMARY

MEMORANDUM OF UNDERSTANDING NEW YORK CITY DEPARTMENT OF INFORMATION TECHNOLOGY AND TELECOMMUNICATIONS

The President seeks authorization from the Board of Directors to execute an amendment to the existing Memorandum of Understanding (the "MOU") with the New York City Department of Information Technology and Telecommunications ("DOITT") to permit the installation, maintenance and repair of additional communication equipment at various Health + Hospitals facilities (the "Facilities") required for the operation of the City-wide Radio Network.

DOITT's responsibilities include providing New York City agencies with land-based and wireless voice, data, video and other communication capabilities. DOITT equipment has been installed at the Facilities since 2007 and is an integral part of the New York City Wireless Network ("NYCWIN"), a municipal broadband data network used primarily for first responder and critical service agencies to enhance situational awareness, improve responder safety and enable remote decision making; and

In December 2011, the Board of Directors authorized the President to execute an MOU with DOITT which would allow DOITT to install, repair and maintain its equipment at Lincoln Medical and Mental Health Center, Elmhurst Hospital Center, Jacobi Medical Center, North Central Bronx Hospital, Kings County Hospital Center, Coler-Goldwater Specialty Hospital and Nursing Facility, Queens Hospital Center, and Coney Island Hospital.

The MOU provided the space on the roofs of the Facilities to DOITT for its use without charge for a term that continues until terminated by either party.

In addition to the facilities at which DOITT was granted permission to install, maintain and repair equipment, communication equipment, under the original MOU, under the proposed amended MOU DOITT will install and maintain communication equipment also at Harlem Hospital Center, Metropolitan Hospital Center and Sea View Hospital Rehabilitation Center and Home. Further, the amended MOU will permit DOITT to upgrade its equipment and, in certain cases, slightly expand the area occupied. Under the amended MOU DOITT will continue to have access to its systems and infrastructure located in risers, rooftops, penthouses, mechanical rooms, equipment closets or other locations at the Facilities required to install and maintain its equipment. DOITT's activities shall not interfere with the delivery of medical services or operation of hospital equipment at the Facilities and its equipment complies with all applicable federal statutes governing the safe emission of radio frequency signals.