

<p><u>CALL TO ORDER - 3 PM</u></p> <p>1. Adoption of Minutes: June 30, 2016</p>	<p>Dr. Raju</p>
<p><u>Chair's & President's Report</u></p>	<p>Dr. Raju</p>
<p>>>Action Items<<</p>	
<p>2. RESOLUTION authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute an agreement with The Boston Consulting Group to provide consulting services to guide the structure and early operations of the NYC Health + Hospitals' Transformation Office over a six month term for a cost not to exceed \$3.65 Million with two six-month options available exclusively to NYC Health + Hospitals for total amount not to exceed \$10.95 Million. (Finance Committee – 07/07/2016) EEO / VENDEX: Pending</p>	<p>Mr. Rosen</p>
<p>3. RESOLUTION authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to negotiate and execute a five-year contract with Canon Solutions America to provide System-wide Managed Print Services with two, one year options to renew solely exercisable by New York City Health and Hospitals Corporation, in an amount not to exceed \$74.3 million for seven years. (IT Committee – 05/12/2016 -- Previously Presented and Tabled - Board Meeting 05/26/2016) EEO: Conditional / VENDEX: Pending</p>	<p>Mrs. Bolus</p>
<p>4. RESOLUTION authorizing the Resolution adopted February 25, 2016 regarding the revision of the previously approved Draper Hall lease to authorize the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute an amendment of the December 24, 2014 sublease with Draper Homes Housing Development Fund as nominee for Draper Hall Apartments LLC ("Tenant I") to provide for the return to NYC Health + Hospitals of approximately 15,150 square feet included in such lease (the "Draper II Site") on the campus of Metropolitan Hospital Center and to simultaneously execute a sublease with Draper Family Housing Development Fund Corporation or such other housing development fund company as shall be approved by both NYC Health + Hospitals and the New York City Department of Housing Preservation and Development ("HPD") (the "HDFC") as nominee for Gilbert on First LLC (in such capacities being referred to together with the HDFC as "Tenant II") of the Draper II Site for a term of 99 years, inclusive of Tenant II options for the development of a 16 story structure on the Draper II Site with approximately 153 apartments for low and moderate income individuals and families at a rent payable to NYC Health + Hospitals of not less than \$87,606 per year. (Capital Committee – 07/07/2016) VENDEX: Pending</p>	<p>Ms. Youssouf</p>
<p>5. RESOLUTION Authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute an extension of the existing agreements with Arcadis U.S., Inc. and with Parsons Brinckerhoff, Inc. for a term of twelve months for an amount not to exceed \$2,366,826.50 for both of such contractors drawing on funds left unused from the prior contract. (Capital Committee – 07/07/2016) EEO: Parsons Brinckerhoff-Approved; Arcadis -Conditional / VENDEX: Pending</p>	<p>Ms. Youssouf</p>
<p>6. RESOLUTION authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute a sub-sublease with the Howard Hughes Corporation for about two years and approximately 18,740 square feet of space on the 31st floor at 199 Water Street, New York, to house HHC Assistance Corporation d/b/a OneCity Health Services at a rent of \$33/square foot or \$463,815/year after factoring three months of free rent for the first year and \$33.66/square foot or \$630,788.40 for the second year for a two year total of approximately \$1,094,603.40 plus the cost of sub-metered electricity. (Capital Committee – 07/07/2016)</p>	<p>Ms. Youssouf</p>
	<p><i>(over)</i></p>

<p>7. RESOLUTION authorizing the New York City Health and Hospitals Corporation (NYC Health + Hospitals) to approve a Capital Project for an amount not to exceed \$28,349,000 for the design, construction and outfitting of a new Diagnostic and Treatment Center at 155 Vanderbilt Avenue, Staten Island, operated by NYC Health +Hospitals. (Capital Committee – 07/07/2016)</p>	<p>Ms. Youssef</p>
<p>8. RESOLUTION authorizing the New York City Health and Hospitals Corporation (the “NYC Health + Hospitals”) to execute a revocable license agreement with the Volunteer Heart Resuscitation Unit and Ambulance Corporation of Staten Island for its continued use and occupancy of 4,284 square feet of space in the Surgical Pavilion to house the administrative functions of an ambulance service and 500 square feet of space for parking on the campus of Sea View Hospital Rehabilitation Center and Home at an occupancy fee rate of \$7,757 per year for a five year total amount of \$38,785. (Capital Committee – 07/07/2016) Vendex: Pending</p>	<p>Ms. Youssef</p>
<p>9. RESOLUTION authorizing the New York City Health and Hospitals Corporation (the “NYC Health + Hospitals”) to execute a license agreement with the New York City Human Resources Administration permitting HRA’s continued occupancy of approximately 325 square feet of space in Lincoln Medical and Mental Health Center through June 30, 2017 with two one-year renewals for the operation of the New York City Identification Card Program with the occupancy fee waived but with HRA responsible for supplying its own security guard and paying the cost of the additional cleaning required in the amount of \$294/month such amount to increase by 2% annually. (Capital Committee – 07/07/2016)</p>	<p>Ms. Youssef</p>
<p>10. RESOLUTION authorizing the Executive Director of MetroPlus Health Plan, Inc. to negotiate and execute a contract with Finity, Inc. to provide education, engagement and rewards services for a term of three (3) years with three 1-year options to renew, solely exercisable by MetroPlus, for an amount not to exceed \$11.5 million per year. (MetroPlus Board – 07/05/2016) EEO: Approved / VENDEX: Pending</p>	<p>Mr. Rosen</p>
<p>11. RESOLUTION authorizing the New York City Health and Hospitals Corporation (the “NYC Health + Hospitals”) to execute an agreement with COPE Health Solutions to provide consulting services to help structure the partners in the NYC Health + Hospitals-Led Participating Provider System-PPS under the Delivery System Reform Incentive Payment-DSRIP program to yield a network obtaining 90% of its patient service revenue from value-based payments including structuring the method for making DSRIP payments to lead to such a state over a term of one year with two, one-year options to renew solely exercisable by the NYC Health + Hospitals for a total amount not to exceed \$6,810,000 in the initial 12-month period, 6,810,000 in the first renewal term and \$5,450,000 in the second renewal term for a total not-to-exceed amount for the three-year period of \$19,070,000. (HHC Assistance Corp Subsidiary Board – 07/25/2016) EEO: Approved / VENDEX: Pending</p>	<p>Dr. Raju/ Dr. Wilson</p>
<p><u>Committee Reports</u> ➤ Capital ➤ Finance ➤ Governance</p>	<p>Ms. Youssef Mr. Rosen Dr. Barrios-Paoli</p>
<p><u>Subsidiary Board Reports</u> ➤ MetroPlus Health Plan, Inc. ➤ HHC Capital Corporation</p>	<p>Mr. Rosen & Dr. Barrios-Paoli</p>
<p><u>Executive Session / Facility Governing Body Report</u> ➤ Queens Hospital Center</p>	
<p>Semi-Annual Governing Body Report (Written Submission Only) ➤ Kings County Hospital Center ➤ Dr. Susan Smith McKinney Nursing & Rehabilitation Center</p>	
<p>2015 Performance Improvement Plan and Evaluation (Written Submission Only) ➤ Segundo Ruiz Belvis A Gotham Health Center</p>	
<p>>>Old Business<< >>New Business<<</p>	
<p>Adjournment</p>	<p>Dr. Raju</p>

NYC HEALTH + HOSPITALS

A meeting of the Board of Directors of NYC Health + Hospitals was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 30th day of June 2016 at 3:00 P.M. pursuant to a notice which was sent to all of the Directors of NYC Health + Hospitals and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Lilliam Barrios-Paoli
Dr. Ramanathan Raju
Josephine Bolus, R.N.
Dr. Vincent Calamia
Barbara A. Lowe, R.N.
Mr. Robert Nolan
Mr. Mark Page
Dr. Herminia Palacio
Mr. Bernard Rosen

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.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on May 26, 2016 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 May 26, 2016, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

Dr. Barrios-Paoli thanked the Board members who participated in the Northwell Labs educational session held on June 28, 2016.

Dr. Barrios-Paoli updated the Board on approved and pending Vendex.

Mrs. Bolus announced that the annual Marjorie Matthews Community Advocate Recognition Event will be held at NYC Health + Hospitals/Coler on July 20, 2016, acknowledging appreciation for the vital services volunteers provide to NYC Health + Hospitals facilities and the patients that are served.

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

Dr. Christina Jenkins provided the Board with an update on the progress of the DSRIP program. She explained that DSRIP program efforts are aligned with the NYC Health + Hospitals transformation, enabling sustainability through growth, improved access to primary care, and improving the patient experience.

ACTION ITEMS**RESOLUTION**

2. Adopting in the name of the New York City Health and Hospitals Corporation ("NYC Health + Hospitals) Board of Directors the twelve **Community Health Needs Assessments** prepared for each of

NYC Health + Hospitals' eleven acute care and for the Henry J. Carter Specialty Hospital and Rehabilitation Center.

John Jurenko, Vice President, updated the Board on the progress being made System-wide on community health needs assessments.

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

RESOLUTION

3. Authorizing the New York City Health + Hospitals to negotiate and execute a **Physician Services Agreement** with the **State University of New York/Health Science Center at Brooklyn** for the provision of General Care and Behavioral Health Services at NYC Health + Hospitals/**Kings County** and NYC Health & Hospitals/**Coney Island** for a period of four years, commencing July 1, 2016 and terminating on June 30, 2020, for an amount not to exceed \$86,659,516, AND further authorizing NYC Health + Hospitals to make adjustments to the contract amounts, providing such adjustments are consistent with the System's financial plan, professional standards of care and equal employment opportunity policy except that the System will seek approval from the Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the not to exceed amount identified in this resolution.

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

RESOLUTION

3. Authorizing the New York City Health and Hospitals Corporation (the "NYC Health + Hospitals") to execute a contract with **Deloitte Consulting, LLP** to provide implementation services for the **PeopleSoft Enterprise Resource Planning System**. The contract will be for a term of three (3) years with two one-year options to renew exercisable solely by NYC Health + Hospitals for an amount not to exceed \$18,203,795 during the initial three-year term.

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

RESOLUTION

5. Authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute a five-year **lease extension** with **UE Forest Plaza, LLC** for 1,975 square feet of space at 2040 Forest Avenue, Borough of Staten Island to house the **Mariner's Harbor Houses Family Health Center** at a base rent of \$32.50 per square foot to be escalated by 3% per year and a common area maintenance charge of \$2.74 per square foot or \$5,412 per year and real estate taxes in the amount of \$6.97 per square foot or \$13,764 per year for a five year total of approximately \$436,665.

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

RESOLUTION

6. Authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute a five-year revocable **license agreement** with the **American Cancer Society, Eastern Division, Inc.** for its continued use and occupancy of 120 square feet of space on the campus of **Queens Hospital Center** and 120 square feet of space on the campus of **Elmhurst Hospital Center** to provide non-clinical patient support services with the occupancy fee waived.

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

BOARD COMMITTEE AND SUBSIDIARY REPORTS

Attached hereto is a compilation of reports of the NYC Health + Hospitals 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.

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

FACILITY GOVERNING BODY/EXECUTIVE SESSION

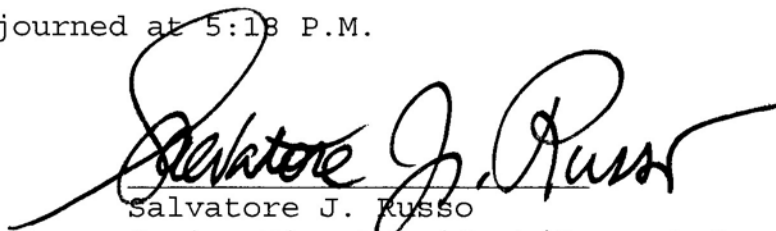
The Board convened in Executive Session. When it reconvened in open session, Dr. Barrios-Paoli reported that, (1) the Board of Directors, as the governing body of NYC Health + Hospitals/Elmhurst, received an oral written governing body submission and reviewed, discussed and adopted the facility's report presented; and (2) as governing body of NYC Health + Hospitals/Bellevue, the Board reviewed and approved its semi-annual written report.

Additionally, the Board received and approved the 2016 quality assurance and performance improvement and evaluation for NYC Health + Hospitals/Morrisania, a Gotham Health Center.

Finally, the Board approved Dr. Christina Jenkins, the CEO of OneCity Health, as Vice President.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 5:18 P.M.



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

COMMITTEE REPORTS

Audit Committee – June 9, 2016

As reported by Ms. Emily Youssouf

An Audit Committee meeting was held on Thursday, June 9, 2016. The meeting was called to order by Ms. Emily Youssouf, Committee Chair who announced that the report on the Audit Plan is deferred pending KPMG's arrival. Therefore, the meeting proceeded with the Internal Audits update.

Mr. Telano thanked her and saluted everyone. Today we will be speaking about four reports that were conducted since our last meeting, actually since February. The first one being discussed is on page three of my briefing, which is of the Home and Healthcare Agency. I have to note that this audit was done prior to the new executive director coming onboard I believe in May. So overall, we found that the operations within this agency is not efficient. Some of their processes were outdated, the use of fax and/or manual forms rather than email and other electronic data. We also noted that the agency lacks accreditation from a reputable accreditor. We also noted that some of their competitors share office space within their facility and that the intake planners do their work very manual and that the claims process needs to be improved in which that they are not done efficiently.

We also noted that there was some problems with the invoicing of supplies in which they have a contract with a vendor. Items were being purchased outside the contract, and the invoices were not being properly compared to the purchase orders or the prices. I know you wanted me to have a quick overview and have the individuals come to the table. Can we do that now?

Ms. Youssouf said yes, I know that they are addressing the items, so if you can come up and briefly tell us how you are addressing them. Please introduce yourselves for the record. They introduced themselves as follows: Ross Wilson, Chief Medical Officer; Lauren Johnston, Chief Nursing Officer & Home Care Responsibility; Anthony Rossano, Chief Financial Officer.

Ms. Johnston stated as Mr. Telano mentioned, the audit was done at the beginning of the tenure of our new executive director, who was thrilled that we had applied the resources of the Audit Committee to come in and take a look at our business practices because she knew that there were some issues, and this helped to really pinpoint where many of the difficulties lie.

Dr. Wilson added that I would like to go back one step in the process, which is that the Home and Healthcare Agency is a really important part of our healthcare ability, particularly our ability to provide home care and care coordination to the uninsured as well as other areas, and we've been growing slowly and recently had grown into Brooklyn. Because of concerns about its integration and also its efficiency, its management structure was moved and changed. So just over a year ago we moved all the care-coordination structures, Health Home, Home Care, etcetera, into the Division of Medical and Professional Affairs. It previously had been located elsewhere in the organization from a managing point of view. We did that to try and get integration and also to get efficiency.

When we took it over, we were concerned that there were a lot of opportunities for improvement, and part of the many changes that we put in place was to request an audit to actually find out what else we were not finding. For general contextual comments, this audit has been helpful in confirming things that we already knew, some things we were already fixing. It provided a deeper look at some things we didn't fully understand. So that's the context of improvement. A lot has changed since this is occurring and some is still changing, but I think I just want the Committee to be clear that this is part of the journey around improving and strengthening what we regard as an important component of care coordination.

Ms. Youssouf said that I appreciate that. That is why I always tell everybody that Internal Audits is your friend because they find these things out specifically to give those in charge the opportunity to understand, you know, what's going on and to make the right changes. I appreciate both your comments on that. Would you like to briefly talk about a few of the changes?

Ms. Johnston stated that I will start with the thing that has not been resolved yet, and that is an external accreditation. By the end of June we will make a decision about whether we will be using the Joint Commission or the Home Care Specialty Agency, but we do anticipate starting the process of accreditation shortly. As far as the other things are concerned on the list of issues that Mr. Telano found, actually all have been either completely resolved or about to be finished in the resolution, and we certainly invite them to come back and make another visit to see the progress that we're making. The tool that has probably made the greatest impact on the life of our staff and of our processes is EPIC. They were all done by hand before. Everything was a handwritten note. People were physically either faxing things or driving across the city to drop off paperwork. It was probably the single largest impediment we had to having any kind of true system. So EPIC has changed that again in early April. We are completely automated at this point. We are

still working a little bit on the billing end as I understand it, but we are optimistic that that will also be resolved. I'm sure that when Mr. Telano comes back and makes another visit he'll find a very different agency than he saw last year.

Ms. Youssouf asked if there were any questions or comments. She thanked them and wished them good luck.

Mr. Telano continued by stating the second report that I will be speaking about is on page six of the briefing, and this was of One-to-One Nursing Supervision at Carter. He asked the representatives to come to the table. They did and introduced themselves as follows: Floyd Long, Chief Executive Officer; Stanlee Richards, Director; Leah Matias, Chief Nurse; Manuela Brito, Chief Financial Officer.

Mr. Telano said that the primary issue we found is that there are a few patients and residents that have been in One-to-One care for an extensive period of time ranging from 246 days to 700 days, and in some instances they provided these patients with ankle bracelets to monitor them leaving the unit area. Then it was found out that the bracelet did not work adequately and as a result new software was needed. We also noted that in light of the length of time that these individuals were on One-to-One Observation, the recordkeeping substantiating as to the reasons they were on this care and also many other individuals on One-to-One care was lacking. There was no sufficient doctors' notes justifying some of the rationale as to why these decisions were being made.

Ms. Youssouf asked them to briefly tell us how you fixed or are fixing these issues. Mr. Long responded yes, and just to set the state for the use of One-to-One, it is a clinical physician's order that initiates the One-to-One. It is used to primarily enhanced observation while giving the resident or patient the maximum amount of physical freedom. Therefore, we frown on using physical restraints, and the industry does too. We have been very successful in eliminating physical restraints throughout our facility, both the hospital as well as the nursing-home segment.

One-to-One is primarily for safety reasons. Residents and patients may pull out their trachea tubes and they could have immediate consequences. Elopements, residents who are confused leaving the building could potentially be in immediate harm if they went to the public unescorted, so there are a number of reasons that One-to-Ones arise. Oftentimes the patient or resident is admitted on a One-to-One order, so it's our objective to evaluate that patient and look for alternatives, use technology such as the transmitter bracelet equipment as well as some type of padding device to assist the resident in being safe in their area.

Dr. Barrios-Paoli asked if these are mostly patients with Alzheimer's or dementia. To which Mr. Long answered that the two who are elopement risks are traumatic brain injury (TBI). Some traumatic event caused confusion, and along with that confusion in one case comes unpredictable behavior as well, so it really is a safety issue when it comes to the use of One-to-One. Three of the cases that Mr. Telano noted an excessive amount of One-to-One even post-review and post-audit, two of those three continue to remain on One-to-One.

Ms. Youssouf asked if they are going to stay in Carter. Mr. Long responded yes, these are nursing home residents, which means the nursing facility is their home. We are working with the families to cooperate with us to look for an alternative setting; however, it has to be with the cooperation of the family who is responsible for the care and decision making for the resident.

Ms. Youssouf asked, as far as the physicians' orders and medical records, is that system being implemented?

Ms. Matias responded that we audited the forms Mr. Telano's team has provided us with recommendations from April and May. We have increased our compliance with the rationale and its continuation by 95 percent still working with little, small gaps in our documentation system. Since then we have also revised the form to make it more nurse and physician friendly to ensure there is a completion plan and the appropriate documentation of our weekly rounding, which is one of our countermeasures to significantly reduce our One-to-Ones by 55 percent. Long before Mr. Telano's group came on, Mr. Long identified this as a gap in the process that requires improvement. Hence, we have been very successful in administering oversight of this weekly rounding.

The chiefs, the medical director, the director of nursing and myself take turns in supporting the clinical team to find alternatives and support them and give them some guidance realizing some risks will be an appropriate assessment and timely assessment and focusing on those behaviors, specific behaviors that resulted in the need for One-to-One. So we are very proud and with the support of Mr. Telano's group, who actually focused our team to do a better job with managing the One-to-Ones.

Ms Youssouf asked if you have set up some kind of system to do spot checks to make sure that it doesn't fall off from the 95 percent.

Ms. Matias answered yes, we have some admissions from acute with One-to-Ones, and even those who are successfully able to leave off by creating some countermeasures such as providing more diversional activities for opportunity and individualized care. We also are looking to something out of the box, which includes specialty mattresses and specialty beds that allows for prevention of falls

without restriction of or restraining the resident. We have put in local alarms to supplement our monitoring system to prevent elopements, and with those combinations we were able to reduce by 55 percent.

Ms. Youssouf thanked them and asked Mr. Telano to continue.

Mr. Telano said continuing onto page eight of the briefing, auditing of implantable devices were done at the Queens and Elmhurst facilities. He asked for the representatives to approach the table. They did and introduced themselves as follows: Chris Hristoff, Director of Hospital Police; David Baksh, Associate Executive Director; Robert Malone, Deputy Chief Financial Officer; Marzya Sdrewski, Associate Executive Director; Bill McDonagh, Associate Executive Director.

Mr. Telano stated that a quick synopsis of some of the issues was that there was no electronic inventory system at Queens in the Interventional Radiology Department or in the operating room at Elmhurst. In addition there was inadequate security as there was no cameras in some of the key areas in which implantable devices are stored, and even though they do have an inventory system in Queens for the operating room, it's not maintained accurately as some count differences were found and descriptions of the devices and the locations were not always accurate. We also found some billing and coding issues at both locations.

Ms. Youssouf asked them to give a brief summary of how you addressed these issues.

Mr. Hristoff responded that we addressed the security issues in the perioperative and storerooms by installing new IP cameras as well as we limited access to OR areas strictly to OR personnel. We had one problem with a lock that wasn't functioning properly, which was replaced on the one door that it was discovered. Other than that security at this time, we have card access to all the doors entering into the operating room area. One single door has a key master, and the card access is limited strictly to all personnel as well. As the audit recommended a new camera was placed in that stockroom.

Mr. Baksh added that we are going to have to piecemeal it a little bit. For the Interventional Radiology (RI) suite at Queens, for the electronic system that Mr. Telano alluded to, we had already identified that that was a concern for us and had done our research. We had two vendors come in to see what we could put in place. Our system facility has space tracks, and our plan was at that time to actually do a joint venture. They wanted to increase some on their side and then bring us in. So that got put on hold because as you know we were selected, both hospitals were selected as going live on EPIC first, so that was tabled to be put in place until we get a steady state, and we are almost there. Now the fiscal year is going to end, so the beginning of the new fiscal year we are going to renovate that process, bring IT into it because at the time Information Technology was looking for an enterprise-wide system which could possibly interface with EPIC, so it made sense not to do it twice and spend money that we probably should. So we are going to try to fix that within the next month.

Mr. Malone commented that for the billing and coding issues that occurred specifically at Queens, we were very reliant at that point on the reconciliation of paper records, medical records from ambulatory surgery for the implantables which were intraocular lenses, and two of the cases the records had not been transferred to the coding unit in the HIN department. However, we also have benefitted from the go-live with EPIC because now the records are all electronic, so the reports generate automatically into the HIN department, and the coding occurs off the computer.

Ms. Youssouf stated that that is good to hear. I'm glad EPIC is beginning to pay off in many ways.

Mr. Baksh stated that before my colleagues go on, I'd like to make one more comment, and it's related to the Interventional Radiology (RI) suite related to the cameras. We cannot put up cameras in that area that was designated because there are patients that are constantly in that area before they go into different suites, so we have a 24-hour process for making sure the Interventional Radiology suite is secured and that stays under our nurses that are on duty 24/7.

Ms. Youssouf asked how it is being made secured. To which Mr. Baksh responded that once the IR procedures are done for the day, there's a lock and locks on the cabinets, so the cabinets lock and the doors lock. The key only resides with the charge nurse who is tied to Radiology for that 24-hour shift. In the event there had to be a procedure that had to be done emergently, while the clinical staff would be coming in, she could be able to go in and prep the room and be able to get the supplies that they need.

Mr. Telano continued and stated that the last audit I will be discussing is on page 11 of my briefing related to the medical/surgical inventory controls at Harlem. He asked for the representative to come to the table and introduce yourself. They introduced themselves as follows: Ebone Carrington, Chief Executive Officer/Chief Operating Officer; Caswell Samms, Chief Financial Officer; Ronnell Boylan, Hospital Police; Mark Sollazzo, Materials Management; Violetto Palmiere, Finance.

Mr. Telano said that during the first day of our audit, we conducted an unannounced physical count of items. We counted 105 items, and 80 of them had incorrect counts. We found that there was a lack of controls of items going in and out of the storeroom. Items were not being verified, when being delivered to the units, and upon receipt at the various nursing units they were not being confirmed. We also noted within the units that some of the storage-room doors were being manipulated, tape on the lock for example to keep them open, and we also noted that in the receiving area there were 189 employees that had unauthorized access to the loading dock area. It was being used as a shortcut for the employees to come into the building. Lastly, the intravenous solutions storeroom had some control issues in which the movement of the stock was not always being monitored adequately because they did not have a supervisor on hand for that particular storeroom.

Ms. Youssouf stated that I know that we are glad you recently joined the Corporation and took on Harlem, so we understand that some of these things are legacy issues I'm sure, but could you explain, you or your staff, what you are doing to address or have you addressed these issues?

Ms. Carrington answered that from a management and an infrastructure perspective I will begin. Then I will ask my colleagues to give further details. We were aware that there was some issues at the mid-management and senior-management level in terms of the ability to oversee several aspects of the department, and there was a director of Supply Chain who had been identified to work to collaborate with the leadership and also to help to ensure that the operating procedures were being better adhered to. We, very shortly after identifying that individual, lost them to a competing system, so we are aware of some of the lack of internal controls. Since then we have partnered with Material Management and Finance, who better understand the need to document those internal controls, and it is also under the portfolio of the Chief Financial Officer at present so that we can do more intermittent monitoring and ensure that the inventory and audit controls are better addressed.

From the nursing perspective it is not common practice, however, for ease of access into certain of the medical/surgical supplies. They were checking the doors to ensure that people who are rotating on the unit had access, and that process has been addressed by our chief nurse and our DNs to verify that that is not the case on a daily basis, and the charge nurses off shift do the same. From a high-level perspective with the loading dock, this issue existed in 2013 where it was in fact a thoroughfare where all employees from the hospital were using as a pass-through. There were several interventions that were made including the creation of the gate, air phone, card access, so the 189 employees that had access to the loading dock during this audit were comprised of safety, housekeeping, engineering and some folks that we thought did need the access, but that has also been further truncated to make sure that it's really only those who have the necessary reasons to be on the loading dock.

Mr. Samms added that Internal Audits is my friend. As Ms. Carrington pointed out, Finance is going to be working very closely with Materials Management, taking these issues head on. We will be meeting on a routine basis. I'd probably say 85 percent of these issues have already been addressed. We continue to address and will continue to be monitoring them on a very routine basis. A lot of the procedures that were not put in place have been developed and implemented, and we will also have Finance do unannounced audits ourselves to make sure all these issues are maintained on a continuous basis. We are also working and collaborating with other facilities to bring in some best practices to make sure all these issues are continued to be monitored on a daily basis.

Ms. Youssouf asked if inventory was being done by hand. Do we know what happened? Was there a consequence to any of the individuals that all this stuff was not accounted or missing or whatever?

Mr. Solazzo responded that what was happening was the issuing of items were not done on a timely basis. Then the next morning when it's time to run the re-audit report, we had to manipulate the system to adjust what was actually on the shelf, and then the issuance was done afterwards, and that was being reconciled and that kept throwing off the system as far as that goes. Items that were leaving were validated by a supervisor to make sure that the counts were correct, but it wasn't being done all the way through. Sometimes it was spot checked like a ten-percent check, and now he's been told he has to count every item before it leaves the storeroom.

Ms. Youssouf asked is this done manually, or is this connected somehow to the inventory system? Mr. Sollazzo answered that the inventory system is the Oracle system that we all use at HHC. That's where we generate our reports. That's where we generate all the expense reports out of there. The manual system is just a double checking of what's on the shelf that we do a walk around and count manually what the system puts as reorder, and we double check it to make sure that it's correct.

Ms. Youssouf asked have you changed the first part that you described. To which Mr. Sollazzo responded yes. What we do now by recommendation of the Audit Committee when the auditors were there, they recommended that we issue into the system before the items leave the storeroom.

Ms. Youssouf asked if they are doing periodic checks.

Mr. Sollazzo answered yes, they made one more recommendation, an index-card system, which is a manual system, but it's to kind of back up the automated system, so when items are received, we put a balance. When it's removed, the person who is removing the item initials it, puts the amount that's being removed.

Mr. Samms added that it is already implemented, the perpetual inventory system. Similar to like what we had at pharmacy where we had no findings, we are implementing that same process at Materials Management as a back up to make sure that we have no issues going forward.

Ms. Youssouf asked if there was any loss of equipment or any financial issue with this or products? Mr. Martin answered that they do not know. That that is the problem.

Mr. Telano added right, that is the problem.

Ms. Youssouf asked as far as making sure the things aren't taped so the doors are opened, how have you addressed that and whose responsibility is that? Is that yours?

Mr. Boylan responded yes, Hospital Police, we do three patrols a day and check every door. In this situation it was one of the E-Plex locks, and we thought the battery died, so we changed the lock -- changed the battery, and then the auditors found that the battery was dead and people were taping the door, so we checked the device and replaced the battery and found out that the device was faulty and killing the battery. We fixed it the same day.

Ms. Youssouf asked if you are going to be checking those on a regular basis. To which Mr. Boylan answered yes. We have a schedule for the locksmith to go around and check all the E-Plex locks as well as the officers on patrol as a back up to that.

Ms. Youssouf asked Mr. Telano if there was anything else. Mr. Telano responded no, that that concludes my presentation.

Ms. Youssouf thanked him and said let's move onto the compliance report.

Mr. McNulty introduced himself as Wayne McNulty, Senior Assistant Vice President/Chief Compliance Officer. He stated that we will start on page three of the Corporate Compliance report and the report of monitoring of excluded providers. We have no excluded providers to report for the period of February 2016 to May 2016. Moving along to page four of the report, Section II, reporting of privacy incidents in the first quarter of calendar year 2016, January 1st to March 31st of 2016. We had received 27 complaints of violations of HIPAA policies and procedures. We found after investigation ten of those complaints would be actual violations of HIPAA's policies and procedures and five would be breaches of confidential protected health information.

If you please turn to the bottom of page five, I will go through the five breaches of protected health information starting with Coney Island Hospital starting on the bottom of page five going to the top of page six. This incident occurred when a nurse employee went into the records of another employee who was a patient at the facility. Disciplinary charges are pending with respect to that nurse. Moving along to Kings County, we had two incidents there. The first incident involved the disclosure of protected health information to an attorney. The disclosure was pursuant to a patient authorization; however, the patient limited the information that was to be disclosed, and more information was disclosed to the attorney than was intended by the patient, so that was ultimately a breach of protected health information. The second incident with respect to Kings County occurred when an attorney received the wrong information, received information from the wrong patient, not the patient the attorney was representing, and that led to a breach notification was sent to that particular patient.

Turning to page seven, we had two incidents at Lincoln Medical Center. They both were unrelated but the same type of incident. One incident was a prescription was given to the wrong patient, and that occurred in the Pain Management Department, and the same incident -- a different incident occurred in the Emergency Department where a prescription was given to the wrong patient, which resulted in a breach in protected health information. With the new electronic prescription law, the chances of this happening in the future is pretty slim. This is actually the first time I have seen this happen at any facility, but now everything is electronic for the most part.

Dr. Barrios-Paoli asked if there were two different providers. Mr. McNulty answered that two different providers, one in pain management, and one in emergency.

Dr. Barrios-Paoli then asked if there were any consequences. To Mr. McNulty responded yes, both physicians were disciplined and had to be retrained.

Moving along to Section III on page eight, compliance reports for the first quarter of 2016, we received 98 compliance complaints during the first quarter. One of those complaints were a Priority A complaint, which means a complaint that is of a very serious nature. We will discuss that complaint in executive session because it's an ongoing investigation.

Moving onto page 11 of the report, at this time I would like to discuss actions that have been taken in Health and Home Care to reduce the risk of falsification of records. If I can bring to the table the Chief Nursing Officer of the Corporation, Lauren Johnston, to discuss this matter. Just by way of background, we have a Compliance Committee that focuses on Home Care, and at the Compliance Committee one of the risks that we identified as part of our corporate-wide risk identification process was the potential risk of individuals falsifying records, so Ms. Johnson is going to talk about the different strategies that have been taken in Home Care to reduce that risk.

Ms. Johnston stated that we like compliance too. We discovered these cases and sent them on to Mr. McNulty to take a look at them, and in both cases we feel that we have a strategy in place now that will reduce the likelihood that this will reoccur. Again, I will point to EPIC as being a great tool that we have now with an electronic stamp that is real-time that will be very helpful. There is essentially two pots of folks that we have working for us, our professionals and our nonprofessionals, and what we do now is make an initial call to a sample of the patients who are getting a service and give them another callback within 30 to 60 days of the service and ask a specific set of questions to make sure that they in fact got the care that was documented. So we are talking to the patients and the families, not to the staff. In addition, we started in May a process for the nonprofessionals that they have to call into Home Care upon their arrival to a site where they are delivering care.

Ms. Youssouf asked how do you know that they are really at the site: To which Ms. Johnston responded that If they don't have access to any kind of a phone, then they will use their own phone, and, yes, there is a question about where they are, but if there's any doubt, we'll talk with the patients as well, so we do follow up with them.

Mr. McNulty commented that I want to note before we go onto the next section that the incident that you discussed is one of my Priority A's that we'll discuss in executive session.

Mr. McNulty continued with Section V, compliance training, on page 12 of the report, the Office of Corporate Compliance has made available compliance training system-wide to the entire members of the workforce including physicians, healthcare professionals, group 11 employees and members of the Board of Directors. With respect to the members of the Board of Directors, we have 13 of the 16 members have completed compliance training and seven of the nine designee members have completed the compliance training.

Mr. McNulty stated that I'll move onto physicians and healthcare providers and general workforce members. With respect to healthcare providers, which is any individual that's licensed under Title 8 of Education Law, nurses, occupational therapists, respiratory therapists, we had 16,000 out of the 18,000 workforce members trained for 90 percent system wide. For physicians we have 4,700 out of 5,300 for 89 percent system-wide. General workforce, which is our group 11 employees, we have 5,000 out of 7,000. The general workforce that was just implemented in November. We have 71 percent and are moving to push that forward. I reached out to all the hospital CEOs to make sure that that number goes up.

If we can turn to page 13, I just want to provide an update on DSRIP/OneCity Health compliance activities. The DSRIP/OneCity Health Compliance Committee convened in May as chaired by myself and Dr. Jenkins, who is the executive director of OneCity Health and in charge of all DSRIP compliance activities along with myself, and also on the committee is Ms. Johnston and Dr. Wilson and Mr. Russo. There were three issues that we discussed, three pertinent issues, and one issue was DSRIP compliance training. Greater New York Hospitals Association has made training available and developed it through its membership so that DSRIP partners who do not have compliance programs in place could utilize that training. We have taken that training, supplemented it somewhat, but that training will be available to those DSRIP partners that do not have a compliance program in place.

Ms. Youssouf asked if we know how many do not have compliance program. Mr. McNulty answered that most of the members do not have a compliance program because they are not required by law. They don't bill over 500,000 to the Medicaid program. They are not required by law to have one.

Ms. Youssouf asked how you are going to the compliance training. Is it going to be web-based again?

Mr. McNulty responded that it is going to be web-based and available on our system for them to access through the Internet, and we will send them the slides also. They don't have to use the slides, but we want to make it available to them so that they could use the slides with a disclaimer that they should refer to their own counsel obviously with respect to the contents of the slides.

Mr. McNulty stated that with respect to the DSRIP compliance line, although we currently have a compliance line, the committee agreed that it would be better that we separate that from the NYC Health + Hospitals compliance line so the DSRIP partner can access a specific number and not the NYC Health + Hospitals compliance number, so we are going to institute that and put that into place.

Moving along to an update HHC ACO compliance activities on the bottom of page 13, Section VII, CMS has granted HHC ACO a three-year extension of participation in the Medicare Shared Savings Program. With respect to quality indicators, they have increased in 2016 from 33 in 2015 to 34 in 2016.

Turning to page 14, with respect to the ACO compliance plan, the regulations call that the compliance plan be regularly reviewed and updated or periodically reviewed and updated. We are in the process right now of updating the compliance plan, and we will have that plan for presentation before the Audit Committee in September. We have previously reported a couple of Audit Committees ago that there were corrective action plans in place to remediate the deficiencies of previously reported quality measures that were reported to CMS, and it has been reported to me that those measures and remediation are on track. I just want to announce that with respect to the participating providers, the HHC ACO has expanded to include the Community Healthcare Network, which is a FQHC and the first non-affiliated participating providers in the ACO.

Moving onto Section VIII, the United States Department of Justice Yates Memorandum. In September 2015, the Deputy Attorney General Sally Quillian Yates issued a memorandum, and the subject of the memorandum was the individual accountability for corporate wrongdoing. The memo covered six key points: is that corporations must reveal all relevant facts relating to responsible individuals to the Department of Justice to be eligible for cooperation credit. Two, on page 15, both criminal and civil investigations should focus on individual wrongdoers as opposed to the corporation itself. Three, it is expected that criminal and civil attorneys shall establish an open channel of communication, which allows the government to better understand each individual case and determine available remedies. Culpable individuals may not be released from their respective liability, an individual wrongdoer's ability to pay should not be a factor into whether suit is brought against that individual.

What is the significance to board of oversight responsibilities? Generally, the board should be aware that the Yates memo states that absent extraordinary circumstances the Department of Justice will generally not release culpable individuals from civil or criminal liability when resolving a matter with a corporation. It is the understanding of the Office of Corporate Compliance that this reflects a change from prior practice when releases of a corporation's officials, agents and employees may have been more routinely included in settlement agreements with the Department of Justice. Senior Vice President and General Counsel, Mr. Russo, will discuss any questions regarding the Yates Memo in executive session.

Moving onto Section IX of the report, the development of written policies and procedures, we had reported several times that we were working on developing written policies and procedures for system-wide compliance risk areas, and they include mandatory reporting and overpayments, excluded provider screening, overview of the Civil Monetary Penalties Law and the prohibition of acts that constitute criminal healthcare fraud, overview of Stark Law and Anti-Kickback Statute and the prohibition of improper business arrangements and referrals and overview of the False Claims Act and the prohibition of the submission of false claims. We are currently finalizing these operating procedures. We are just making sure there are no grammatical errors and so forth in them, and under the final review of outside counsel, we will have five of those operating procedures ready by the end of June. The Stark and Anti-Kickback is a very complicated procedure, so we'll probably have that in July, hopefully by the end of July. We have a plan as far as education with respect to these operating procedures to make sure there's a plain language version for each one of these operating procedures.

Moving onto Section X of the report, Section X and Section XI, we met with the Gotham Board of Directors, the Gotham Health FQHC Board of Directors in April and in May of 2016. In April we met at the Segundo Ruiz Belvis Diagnostic and Treatment Center and we provided compliance training to all members of the Gotham Board of Directors. We provided an overview of the NYC Health + Hospitals and Gotham FQHC co-applicant agreement, a general overview of compliance and the importance of board member compliance training and an overview of fraud, waste and abuse. When we met in May of 2016 of the compliance committee of the Gotham Board, the compliance committee of the Gotham Board has adopted the NYC Health + Hospitals principles of professional conduct by official resolution, and the full board of Gotham is expected to adopt the same in June of 2016.

Moving onto item number XII of the report, we have revised the guide to compliance at NYC Health + Hospitals. This will cover all areas of fraud, waste and abuse, workplace violence and safety, human-subject research, all the policies that we have in place, just an overview of those particular policies. We will have a presentation before the full Board of Directors in July at the Board of Directors meeting.

With respect to our previously reported items to the Audit Committee, Section XIII, the Medicare claims denials received from the National Governmental Services. The National Governmental Services is the Medicare subcontractor that evaluates Medicare claims

throughout the country. They had sent us numerous notices on page 19 with respect to Medicare claims that were denied, and as you recall, the head of Revenue Management, Maxine Katz, came before the Audit Committee a couple months ago to talk about the different activities that have been taking place in Revenue Management to reduce the number of denials.

With respect to duplicate claims, the Office of Revenue Management has inactivated the system's processing logic that originally created such duplicate claims, and the Office of Corporate Compliance has scheduled with NGS to provide Medicare training to the different departments throughout the facilities.

Mr. McNulty then stated that that concludes my report.

Ms. Youssouf indicated that KPMG has arrived and asked to come to the table and introduced themselves. They did as follows: Jim Martell, Partner; Mike Breen, Lead Engagement Partner; Joe Bukzin, Senior Manager.

Mr. Breen began by stating that let me start off on slide three, going through the coordination team. One comment I'd say a lot of continuity from what we had from last year and even the year before. We have some of the core engagement team members. We also have some of our other resources, Minority Business Enterprise as well as our Women's Business Enterprise, subject matter professionals, assistance that we have during the audit, and then we also have some other partners and managing directors. That is where Mr. Martell would fit in as sort of a resource if you will.

Next line, slide four, in regard to deliverables, number of deliverables you have the New York City Health + Hospitals audit statement as of June 30. You have the MetroPlus health plan. That's a calendar year standalone report for statutory purposes, and that's 12/31. You got HHC Insurance Company, that's also calendar year, and then also HHC ACO, and that's a June 30 entity as well. There's a management letter that we present to this Committee, and that goes through our findings if you will from an internal-controls perspective as well as other operational matters we found during the audit. There's some cost reports, a handful of those that we go through throughout the year. There's also an annual debt compliance letter saying that the Corporation or H+H is in compliance with the debt compliance perspective.

Next slide, slide five, goes through kind of the objectives of an audit. We are trying to express an opinion, and the statements are in accordance with generally accepted accounting principles. Responsibilities, let's just go through a couple at a high level from a management perspective. Management is fairly presenting the financial statements as well as the footnotes in accordance with generally accepted accounting principles, and the other thing too I just want to mention there management is also responsible for internal controls, financial reporting.

Next slide, Audit Committee responsibilities. That plays more of an oversight role in regard to financial reporting as well as internal controls over financial reporting. Audit responsibilities -- this is kind of what I mentioned before from just expressing an opinion on the financial statements that they are free from material misstatement. In regard to internal controls, we evaluate the internal controls, but it's just with regard to our procedures. It is not expressing an opinion on internal controls. From an independence perspective, slide nine, I just wanted to point out some of the independence, quality controls that we have in place. One of the things I'll mention is we have a partner rotation system to make sure that the partner rotation rules are being applied.

We have controls over investments, and even from Health + Hospitals' perspective, there are debt securities out there that KPMG cannot invest in for example. The last thing, just employment relationships, making sure of an employment relationship and also someone from KPMG that came to work at the Corporation and created a conflict in that respect. I am going to turn it over to Joe Bukzin, he is going to go through a timetable with the next set of slides.

Mr. Martell said that what I'll ask Mr. Bukzin to do is just talk about the highlights, the changes, things of that matter. Everything that Mike went through has been consistently applied or consistently followed. The key thing now is really just to talk about some of the changes of where we are and what we are doing.

Mr. Bukzin began by stating that we are picking up on page ten. Page ten and 11 really highlights the audit timeline, which really coincides with the deliverables that Mike described and walked through before. Depending on the timing of the reports, some are calendar year end, Health + Hospitals obviously with 6/30 timing, and then there's some ancillary reporting relating to cost reports. That's all reflected within the timeline here in terms of our audits around planning, going through control evaluation or dealing with financial statements and ultimately rendering and presenting to this Audit Committee.

Ms. Youssouf commented that you plan on giving us the management letter in December, we usually get it before then, at least a draft of it.

Mr. Bukzin said that in the prior year we formally presented at the December meeting and issued shortly thereafter. I know from our preliminary discussions with the management team that date will likely need to be moved up, so we will be prepared to present a draft at an earlier date.

Mr. Bukzin continued with let's slide to page 13. I just want to highlight the audit matters. These are fairly consistent with the prior year in terms of the significant audit areas that involved some level of subjectivity or assumptions and judgments of managing employees. Again, we use subject matter professionals in these areas like actuaries and reimbursement professionals. Then we just identified a couple of other audit areas and focused as part of the audit such as transactions with the City as an example.

Continuing to page 14, I want to highlight a couple of changes and things we are aware of just from our conversations with the management team. We have year two for the DSRIP program, and there will be some transactions related to distributions to participants and perhaps even some more cash coming in related to that program. UPL that will be part of our reimbursement review. Then the EPIC implementation costs. We are aware that a couple of the facilities have gone live and there will continue to be costs associated with that project. In terms of IT matters, we go through the general IT controls, such as user access, privileges, segregation of duties, things of that nature. Typically we'll have some observations to discuss and talk about with the management team.

Page 15 highlights our use of other groups as part of the audit process. We have Minority Business Enterprise and Women's Business Enterprise and working with Chris Telano and his staff to assist us. We identified those areas and some of the responsibilities associated with that. We did work with Chris Telano in terms of a timeline for using Internal Audits.

Page 16, in terms of risks related to fraud, we identified some of those fraud risks and how we respond to them in connection with our procedures as well as interviews with team members of the management team. We'll ask those hard questions about risk and fraud. If anything does come out as a result that could impact or we become aware of fraud, we would be required to communicate that to the Committee.

Page 17, this identifies the individuals that we have planned to meet with as part of those discussions. I will acknowledge just the fact that Julian John is identified as the Corporate Comptroller, so when that changes, we will of course interview Julian before he departs and whoever fills that spot.

Pages 18 and 19, similar to our prior years we always consider as well as management considers liquidity and the risks associated with Going Concern. Many of those topics include quantitative measures such as working capital, cash from operations, performance as well as looking at budgets, projections, forecasts and management plans in the future. That's described over the next couple of pages, and that's consistent and similar to what we have done in the past.

Page 20 just highlights a couple of new accounting pronouncements. The first one that really does provide some clarification over supplementary information related to GASB 68, so there's some supplementary information. Usually it's at the back of the report. This is giving some clarity around some of the information that should be presented.

Ms. Youssouf asked if there is anything that we need to know about this? To which Mr. Bukzin responded that on the surface it appears to be just disclosure if any. It's not going to impact the recording of the liability that occurred a couple of years back relating to implementation of GASB 68.

Ms. Youssouf asked about 76? Mr. Bukzin answered that 76 really just structures the financial reporting rules if you will, the hierarchy and gives some credence to, hey, look, there's some un-authoritative guidance out there that if you can't find your particular set of circumstances in the authoritative guidance, maybe use some analogies and look to some of the non-

authoritative pieces as well. It's really just structuring where to look and how to interpret and apply to generally accepted accounting principles.

Mr. Martell added that both of these are more clarification, not new implementations.

Mr. Bukzin stated that that summarizes the audit plan of this year.

Ms. Youssouf thanked KPMG and asked if there were any questions. Hearing none, Ms. Youssouf called for the executive session.

Ms. Youssouf stated that during executive session we discussed matters that had legal advice to the Corporation.

Capital Committee – June 9, 2016**As reported by Dr. Lilliam Barrios-Paoli on behalf of the
Committee Chair Ms. Emily Youssouf****VICE PRESIDENT’S REPORT**

Roslyn Weinstein, Vice President, Operations, advised that there would be one action item and one information item on the agenda. Ms. Weinstein addressed the information item first, providing an update on the New Boiler Plant Project at Coler Rehabilitation and Nursing Care Center. She said Phase I of the project was underway, which would transfer the facility from high steam to low pressure boilers. She noted that this was an Energy and Federal Emergency Management Agency (FEMA) project. The project was expected to cost \$28 million, and was funded through the Department of Citywide Administrative Services and New York City.

Ms. Weinstein noted that the July agenda would include a lease for additional space across from 199 Water Street, where the Delivery System Reform Incentive Payment (DSRIP) program would be occupying space.

That concluded Ms. Weinstein’s report.

Action Items

Authorizing the New York City Health and Hospitals Corporation (the “Health Care System”) to execute a five-year lease extension with UE Forest Plaza, LLC (the “Landlord”) for 1,975 square feet of space at 2040 Forest Avenue, Borough of Staten Island to house the Mariner’s Harbor Houses Family Health Center, operated by Coney Island Hospital (the “Facility”) at a base rent of \$32.50 per square foot to be escalated by 3% per year and a common area maintenance charge of \$2.74 per square foot or \$5,412 per year and real estate taxes in the amount of \$6.97 per square foot or \$13,764 per year for a five year total of approximately \$436,665.

Walid Michelin, MD, Chief of Staff /Director of Business Development & Grants, read the resolution into the record. Dr. Michelin was joined by Brian Petillo, Associate Director, Coney Island Hospital.

Ms. Weinstein explained that off-site clinics were in process of being transitioned to Federally Qualified Healthcare Centers, under Gotham Health, allowing for better reimbursement rates and to better meet the needs of patients. She noted that in the case of this particular clinic, it would mean better service for Staten Islanders.

Dr. Michelin confirmed that rates would increase and advised that the transition would assist in standardization of processes and the move towards primary care services. A streamlining of staff would also occur, reassigning individuals based on utilization. There being no further questions or comments, the Committee Chair offered the matter for a Committee vote.

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

Information Item**NYC Health + Hospitals / Coler: New Boiler Plant Project – Phase I**

Ms. Weinstein provided the project update during her Vice President’s report.

Equal Employment Opportunity Committee – June 9, 2016**As reported by Mr. Robert Nolan**

Salvatore J. Russo, Senior Vice President and General Counsel, Legal Affairs, stated that as he mentioned at the last meeting, the activities of the Equal Employment and Affirmative Action Office has been split up into three different functions. The first falls under his Office of Legal Affairs and that Blanche Greenfield, Senior Counsel, oversees the EEO Officers’ response to the complaints that are made by employees either internally to the officers or to external agencies. He further stated that the EEO officers investigate the complaints, work on issues of reasonable accommodation and provide EEO training to staff.

Matilde Roman, Interim Chief, Diversity and Inclusion, stated that the Office of Diversity and Inclusion is intended to serve as a resource to internal stakeholders to support and provide technical assistance to enable meaningful access, inclusion and patient centered care by providing employees with the appropriate resources and tools necessary to effectively serve the diverse populations and foster a strong culture of inclusion in the workplace. Recently, the office directed the implementation of the newly enacted NYC Gender Equity policy on gender neutral bathroom signage. All of the systems’ health care facilities have been directed to change signs in bathrooms and other single sex areas. Going forward they will be designated gender neutral and available to all persons consistent with their gender identity and expression regardless of their assignment at birth. Information on this is being sent to staff to help reinforce this message and to help navigate critical conversations that might arise as a result of this new policy. Ms. Romans’ office

is also working closely with Supply Chain Services to review current policies and to improve efficiencies including how we analyze and use our data to better inform the Committee. In addition, the office is in the process of developing a template to standardize how the vendors will deliver their Plans of Action to alleviate job group underutilizations to the Committee moving forward. Finally, the office is gathering information on local trade associations that have connections with minority and women applicants to create a resource list to support vendors who might be interested in making those connections to assist them to eliminate underutilizations. Keith Tallbe, Associate Counsel, Supply Chains Services, outlined some of the efforts moving forward and stated that since his role is to review all H+H contracts from execution that it made sense that the M/WBE goals and workforce goals be part of his due diligence to make sure the contracts meet all of our legal obligations. He hired Ava Laughman to help manage the day-to-day operations getting the vendors to get their paperwork in place. He has also begun to implement B2GNow industry standard software to capture the data for vendor diversity and compliance monitoring goals. His department is also responsible for day to day operations of vendors' workforce diversity and Sharon Foxx is responsible for that function. He then stated that when his office assessed the numbers that had been tracked it was only NYS Certified M/WBE vendors. H+ H had not tracked other diversity classifications whether federal or city classifications. One of the difficulties that was presented was trying to match our policies and procedures to other corporate goals there are for our vendors. He further stated that the System is unique in that the NYS law envisions that H + H will be able to meet a 30% subcontractor M/WBE goal, but in healthcare, with so many large national and multi-national vendors, it is difficult to meet the goal for NYS certified vendors. Going forward, his office will also capture federal data, city data and/or state data and other third party identified diversity classifications. They will report further on this process in a few months to gauge how the vendor portfolio is improving.

Dr. Raju explained that it is important that a public system like ours must be certain that there is Patient Equity. He further stated that more and more people understand that the disparity in health care is because of the lack of equity of care. Externally, we need to figure out how to get additional patients and internally we have to work with the employees to be proactive and to figure out that our focus needs to be on educating employees on equal opportunity and patient equity. In the future, it looks like H + H must be aware of not only diverse employees or contractors, but also looking to see if there is a particular pool of patients not getting equitable care which they deserve regardless of the color of their skin, sexual orientation, language that they speak or county that they come from. He also stated that it is his dream that one day we will be discussing the patient experience at these Committee meetings and they would not be about what the vendors have done.

2016 Conditionally Approved Contractors Update

Sodexo Laundry Services Inc. and Crothall Facilities Management, Inc. came before the Board. Sodexo eliminated three minority underutilizations and two female underutilizations from last year. They have a total of three underutilizations for females for 2016. The first is in the Senior Management Job Group 1D which was also underutilized in 2015. Sodexo representatives stated that there was no turnover in this job group in the past year. The other two are new this year and they are Professionals Job Group 2C and Landscape and Stock Workers job group 8A. Crothall Facilities Management, Inc. eliminated two of the three female underutilizations from last year and this year only had one underutilization for females in Middle/Lower Level VPs and Directors Job Group 1B which was also underutilized in 2015 as well. They stated that due to the high cost of living in New York City, it had been difficult to recruit for this job group.

Finance Committee – June 9, 2016 **As reported by Mr. Bernard Rosen**

Senior Vice President's Report

Mr. P.V. Anantharam informed the Committee that Paul Pandolfini, CFO, Coney Island Hospital had announced his retirement in July 2016 and is looking forward to spending time with the family. Mr. Pandolfini has had an expanded career at H+H for more than twenty years and he was a very strong advocate for getting a new hospital and was successful in getting an inpatient unit opened. The new Coney Island Hospital under the FEMA project is underway and when completed, H+H will invite Mr. Pandolfini back for the opening.

Mr. Anantharam stated that Julian John, Corporate Comptroller and former CFO of Kings County Hospital was moving on to another greater challenge with a former colleague from H+H as the CFO at Interfaith Hospital. Mr. John began his career at H+H in 2000 at Kings County Hospital where he spent the bulk of his career. Congratulations to both on their new endeavors.

Dr. Raju extended thanks to both for their services to H+H and for being great leaders in supporting the mission of the organization.

Mr. Anantharam stated that May 2016 was a good month for H+H cash flow which was at a high level and Mr. John would update the Committee on the status. Over the past three months, H+H cash condition has improved significantly due to the City's maintenance of the local share of the supplemental payments that were forwarded to HHC. The current balance does not include any of the anticipated payments for UPL. Dr. Raju has had some successful discussions with CMS that resulted in the advancement of payments to H+H totaling \$200 million and the State is working on processing those payments. Ms. Dehart would update the Committee on those actions. On a more positive note, the packet included in the financial plan that was released by the City a month ago the structure of the plan is not significantly different relative to the overall gap in 2020 of \$1.9 billion compared to the current

projection of \$100 million less with more structure on how the deficit will be resolved. Mr. Covino would present the plan to the Committee. The headcount continues to show improvement that is reflected in the actual reductions during the month.

Dr. Raju asked how many FTEs were attrited in the past six months to which Mr. Covino responded that 927 global FTEs were attrited since November 2015 through April 2016. The calculations for May and June 2016 were not yet completed; however, the part time FTE separations were completed and with those reductions the total FTE reduction increased to 1,200.

Board Chair, Dr. Barrios-Paoli asked Mr. Anantharam if there were any major changes as part of the City's Executive Budget that was recently approved by the City Council.

Mr. Anantharam in response stated that there were no material changes for H+H; however, there are ongoing discussion with the City on their assistance in the advancement of the primary care initiative. September 2016 is the next iteration of the ten-year capital plan and H+H will be evaluating its capital needs in conjunction with discussions with OMB on how those needs can be addressed.

Dr. Raju thanked Mr. Martin, the hospitals' CEOs and Mr. Covino who were extremely instrumental in getting the headcount down. Mr. Covino interjected that Donna Benjamin was very active in that process and lead the charged on an incredible amount of work in getting those actions done with the facilities.

Cash Flow

Mr. John reported that H+H ended H+H ended May with a cash balance of approximately \$372 million (23 days cash on hand). H+H did not receive any DSH or UPL funds during the month. Based on conversations with CMS and the State there was a revision or the DSH & UPL collection schedule, whereby H+H anticipates receiving \$275 million in UPL funds and \$156 million for DSH MAX in June. Outpatient UPL receipts for SFYs 12 -16 were deferred to FY 17. Additionally, H+H deferred the FY 15 Malpractice and Debt Service payments to the City to FY 17. However, the FY 15/FY 16 FDNY payments will be made in June. If the outstanding UPL and DSH funds are received as anticipated, H+H will end the year with an approximate \$118 million cash balance or 7 days of cash on hand.

Committee member Emily Youssouf asked was the amount of the deferred payments. Mr. John stated that the deferred payments totaled \$291 million for malpractice and debt service.

Dr. Raju asked what the projected year-end cash balance is for the current FY 16. Mr. John stated that it is \$118 million; however it does not include the \$200 million advanced payment.

Mr. Anantharam added that the \$275 million is built into the plan and H+H will end the year at \$118 million. The last plan reflected a year-end closing balance of \$104 million; therefore this is an improvement in the plan that allows H+H to defer some of the risky item in the plan from FY 16 to 17. The plan is more stable for FY 16 and 17.

Ms. Youssouf asked when the deferred payment is due.

Mr. Covino interjected that the \$297 million on behalf of FY 15 is scheduled to be paid in FY 17 and FY 18 with the bulk in FY 17 with half of the medical malpractice balance deferred to FY 18 of \$62 million.

Ms. Youssouf asked how it would be paid out whether it would be monthly or a lump sum. Mr. Covino stated that it would be based on the timing of the supplemental Medicaid payments and cash availability.

Committee member Mark Page asked if the City was carrying the \$291 million deferred payment as an accrued revenue. Mr. Anantharam stated that it is on the City's books as a long term receivable or an obligation for H+H.

Mr. Rosen summarized that there were FY 15 payments due that were paid in FY 16 early in the year.

Mr. Covino interjected that it was FY 14 payments that were paid early in FY 16 totaling \$309 million due to FY 14.

Mr. Anantharam added that there has been a consistent lag in H+H payments due to the receipt of supplemental payments that are received at various times. This FY 16 the City has forgiven H+H for \$337 million.

Mr. Rosen asked besides the deferred payments what else remains outstanding. Mr. Anantharam stated that the City has forgiven H+H debt service obligations in the baseline starting with FY 17 through the life of the plan. The only large obligation that is outstanding is the medical malpractice.

Ms. Youssouf asked if the \$297 million included the debt service. Mr. Anantharam responded in the affirmative.

Mr. Page asked if it included debt service for FY 15. Mr. Covino stated that it was included and that it was forgiven prospectively from FY 16 forward.

Ms. Youssouf asked what the amount of the debt service payment is. Mr. Anantharam stated that it is \$165 million and \$180 million next year.

Dr. Raju stated that the City was extremely supportive to H+H in that the baseline of the debt service and \$200 million each as part of the City's contribution to the maintenance of the share.

Mr. Page added that the maintenance of effort in this context is what the City would have paid at the level of DSH and UPL that H+H has been carrying.

Dr. Raju stated that it was an important effort on the part of the City given that there were delay issues regarding the release of those payments and now the City is putting their share upfront in a way that H+H can better manage is a major contribution to that effort.

Ms. Dehart stated that as mentioned by Mr. John and Mr. Anantharam H+H cash plan for the remainder of the year includes \$275 million in UPL and \$156 million in DSH. Dr. Raju has had productive direct conversations with CMS about the immediate need for both cash flow relief and finalization of our outstanding UPL payments. CMS has agreed to approve a \$200 million advance against the 2015 inpatient UPL which remains under review. H+H expects to receive that payment by mid-June. CMS has further agreed to expedite finalization of all UPLs for prior years through 2014. H+H finance is working with both CMS and the State to document methodologies used to finalize these payments, in an effort to make subsequent reviews more routine and timely. Projected DSH payments in the current fiscal year have been reduced from \$265 million to \$156 million, reflecting preliminary State estimates of funding available for this federal fiscal year ending in September 2016. To date, the state has only committed to providing \$54 million of that funding by June 30th. H+H will continue to work with them to try to expedite payment of the balance in June 2016.

Mr. Page in summarizing stated that based on the reporting it would appear that \$400 million is due this year; \$200 million is expected in a week or two and there is \$50 million that may or may not be forthcoming this FY 16 and \$150 million outstanding for FY 16.

Ms. Dehart stated that \$50 million is expected this FY 16. Mr. Rosen asked what the status of the \$150 million was and whether there are outstanding issues that require further negotiations before those payments are released.

Ms. Dehart stated that it is a projection for CMS of what will be available from them in their cash allotment for DSH payments through September 2016. H+H is working with them to get a better sense of what will be available and if it is safe to pay by June 2016.

Key Indicators Report

Due to a change in the reporting from monthly to quarterly there was no reporting for the month.

Cash Receipts and Disbursements Reports

Global FTE Target

Mr. Covino stated that in April 2016 global FTEs declined by 373, bringing the total reduction since November to 927. April's reduction included 263 in agency personnel (agency numbers have been held flat since January to avoid overstating reductions due to delays in payments to Temp Agencies. The reporting is now being done on hours worked which will provide a more accurate indicator of FTEs – this measure was not available for all facilities until December) and 110 H+H personnel. The May number will continue this trend with full and part time down by 206 FTEs. However, Global FTEs are still up 75 this fiscal year and 995 above the target for June of 2016. It was important to note that temporary employee levels were not updated for February or March. The current measure is based on dollars paid. As the days in accounts payable for temps is well above 100 days: it was decided that it would be inappropriate to report the reduction. It would appear that the paid data does not accurately reflect a reduction in work force but instead a delay in bills paid. The good news is that Finance has been working with Medassets to get hours worked for the majority of temp employees. The methodology will be in place to report an updated number for April 2016. The preliminary analysis does show a significant decline in the number of hour's work, which will hopefully translate into a significant decline in temps in the April update. A comparison to prior Fiscal Year comparing April cash receipts versus last year, receipts for the month are down \$13 million with increases in City payments (\$200 million for DSH maintenance) and MetroPlus Risk Pools of \$98 million offset by DSH payments made in April of FY 15 \$200 million and Pool distributions of \$102 million Supp/SLIPPA and indigent care. H+H anticipate \$156 million in DSH payments in June and \$68m in Supp/SLIPPA. Fiscal Year to date receipts are up by \$468 million. This increase is primarily in tax levy receipts from the City \$422 million and DSH/UPL \$170 million offset by a decline in Outpatient Medicaid and Pool distributions. Disbursements for the month were down \$50 million due reductions in OTPS payments (extending days in AP), and delayed fringe benefit payments (to City for retirees and equalization). Increase due to growth in GFTEs and Affiliations due to CB. Fiscal year to date Disbursements are up by \$386 million. This increase is primarily due to payments made to the City \$274 million, increased staffing levels and collective bargaining for the affiliates contained in the new contracts. A comparison to budget comparing March cash receipts vs Budget, receipts were up \$8 million for the month and down \$31 million fiscal year to date, as workload is not meeting the anticipated growth forecasted in the budget. Comparing March cash disbursements vs Budget, Disbursements for the month were \$8 million over budget (PS and fringe were up as a result of GFTEs at the budgeted levels). Fiscal year to date March Disbursements were \$132 million over budget. This variance is primarily due to increased staffing levels, increased OTPS expenditures and prior year affiliates costs.

Ms. Youssouf asked if vendors were complaining about the delay in getting paid. Mr. Covino stated that there has been some pushback but it doesn't appear that H+H is outside of the normal window but there is some effort to try to push it up. Ms. Youssouf asked what was considered the normal.

Dr. Raju stated that it is the normal compared to the industry and H+H is in much better shape.

Mr. Covino stated that one of the major incentives is that with some of the vendors there are discounts which has reduced the number of days from 90.

Ms. Youssouf asked if it is H+H's goal to get back to 90 or more days. Mr. Covino stated that every effort is being made to maintain some of those advantageous relationships with some of the vendors and still reach 90 days; however, the efforts will continue in focusing on doing the best possible.

Mr. Page asked what would be the value of H+H weekly payments. Mr. Anantharam stated that for OTPS it would be approximately \$25 million.

Mr. Rosen added that overall based on past experiences vendors will stay with H+H knowing that the payments will be forthcoming although there might be some delays in payments.

Ms. Youssouf asked if the increased staffing levels for the affiliations outweigh the reduction in employment for attrition.

Mr. Covino stated that was not the case but rather it relates to the budget and included in the budget was a reduction of a 1,000 FTE target compared to the current reduction status. Although there has been significant progress in reducing the headcount since November 2015, the FTE count is over the target by 75 since the beginning of the FY versus being down a 1,000 FTEs.

Mr. Page added that the year-end total FTE target is 47,500 and if the target was computed monthly what would it be for the month of June 2016. In essence is H+H at the FTE target. Mr. Covino stated that the target has not been achieved. Although H+H is sloping down and catching up with the target through April 2016, there are 75 FTEs over the global FTE target.

Mr. Anantharam clarified that as H+H did its Executive recalculation the FTE targets were restated and based on that projection, there was a monthly decline since December 2016 with current projections of a decline through the end of FY 17 to get to that target.

Mr. Covino added that an additional 1,000 FTEs were added to the June target as reflected on the report.

Mr. Page stated that in terms of the cash flow projections, the \$118 million assumes the deferred payments so how much of a deferral in City payments is being carried through 6/30/16 to get to the \$118 million. Mr. Covino stated that it is \$297 million.

Mr. Page stated that it was important to note that even with the City's support, H+H still has a lot of work to do in terms of remaining financially solvent.

Dr. Raju added that given H+H experience it has been difficult to make a comparison to last year's year-end cash balance of \$500 million given that there were outstanding payments that were not included in that balance totaling \$384 million. What is important for H+H is to focus on the direction necessary to properly manage its cash flow, attrition and aggressively pursuing City and State supplemental payments.

Mr. Page added that it is important to understand what the numbers that are being reported actually mean and to have a sense of where H+H is relative to the data that is being reported given that there appears to be a number of issues that are outstanding that impact the year end number.

Dr. Raju added that is of concern to H+H in that the comparison is not comparable to prior year data and what is apparent is that the issues that surround H+H cash flow must be reflected in the balance so that the appropriate comparison of what is outstanding with the City and State that will impact or has impacted the cash flow is clearly defined and reflected in what is being projected as part of H+H effort to manage its resources appropriately.

Ms. Youssouf agreed adding that it is difficult to understand what is being reported in terms of what is included or not included in the cash flow/balance from month to month and there should be a better way of presenting and reporting that data. Dr. Raju agreed.

Mr. Page asked where in the cash flow are the EMS and UPL payments reflected. Mr. Anantharam stated that those payments are due the end of this FY 16.

Executive Financial Plan Overview

Mr. Covino stated that the overview would be based on a two part discussion of the plan. The base receipts and disbursements would be the bulk of the discussions and corrective actions as part of the plan that has been detailed extensively in the One City Report. The base receipts forecasted in the plan are based on utilization remaining flat over the next four years which is an important assumption in the plan and is also the source for all of the assumptions below the line.

Ms. Youssouf asked if the projection for both the revenue and expenses was flat over the life of the plan.

Mr. Covino stated that it was not. The details of both would be discussed in more details to explain the assumptions. For Medicaid, the plan reflects a reduction in FY 17 due to an extra payment cycle that occurred in FY 16 in addition to non-recurring payments in FY 16 for Meaningful Use as well as a retro rate increase of 2% for prior year and a fee-for-service adjustment for prisoners. In the out years the plan reflected a 1% increase for Medicaid due a rate trend increase for managed care which is half of the Medicaid. The anticipated rate increase of 2% annually translates to a 1% rate increase year over year. Both Medicare and other managed care remained flat over the life of the plan. The major reductions in the base plan relate to the supplemental Medicaid payment. The provisions for the Affordable Care Act significantly reduced DSH payments as the number of uninsured declined. However, the undocumented are not included. The transition to behavioral health and long term care reduces H+H ability to recoup UPL payments. The Executive plan includes an overall decline from both levels forecasted in last year's adoption. These include the DSH unwind, timing of the federal reductions and also the changes to the indigent care payments. The next major change is the City's services in FY 16 services increased by \$491 million due to the maintenance of DSH and UPL of \$204 million; additional cash payment of \$160 million and collective bargaining of \$83 million and Correctional Health Services (CHS) increased in 2019 by \$344 million due to DSH/UPL maintenance of \$204 in collective bargaining of \$100 million and CHS increases. Grants revenue increased in FY 17 due to anticipated Medicaid Administration grant of \$77 million. The Community Development Block grant funds for Sandy for maintenance and readiness after the storm of approximately \$30 – \$35 million. Total revenues are projected to decline from \$7.2 billion in FY 16 to \$6.3 billion by 2020 due to an \$800 million decline in Supplemental revenue. Disbursements, personal services are projected to remain flat with FTEs projected to remain flat with a 1% increase from FY 19 to 20 which is consistent with the City's budget forecast. Fringe benefits consistent with prior plans except in increased pension cost totaling \$70 million per year; 8% health insurance offset by CB savings negotiated by the City totaling \$94 million in FY 17 growing to \$123 million by FY 18. Affiliation projections were updated to reflect the new contracts approved by H+H Board for PAGNY, NYU, and Mount Sinai include collective bargaining at the City's pattern as well as the negotiated performance bonuses included in the contract. OTPS expenses remain flat over the life of the plan with a 2% growth rate due to the City payment structure for payment in FY 17 and FY 18 as discussed earlier. In total annual disbursements increase by 8% over the life of the plan, or 2% each year. However, the decline in supplemental Medicaid leaves H+H with a gap of \$579 million for FY 16 growing to \$1.7 billion in 2020. H+H over the past few months has been working on strategies for addressing the gap that resulted in \$1.1 billion in revenue initiatives with the remaining gap to be addressed through expenses initiatives that are being refined over the next few months.

Mr. Rosen asked how much the pension payments per year are. Mr. Covino stated that the total per year is \$497 million.

Ms. Youssouf asked what were the projected increases in Medicaid based on.

Dr. Raju stated that those were based on strategies put together by the Major's office. The gap closing initiatives reflect initiatives that will be put into effect to eliminate the gap by 2020, \$1.1 billion in revenues and \$700 million in expenses reductions. The reporting was concluded.

Payor Mix Reports

Ms. Krista Olson reported that there are no major changes since the second quarter report for any of the categories. There are no major changes since the second quarter report for any of the categories. The Inpatient Payor Mix compared to last fiscal year at this time, Medicaid remains a relatively stable share of the patient mix, with a slight decrease in FFS and increase in Managed Care. Medicare was .6 of a percentage point higher, also due to a shift from FFS to Managed Care. Commercial and Other remain steady, and self-pay slightly lower than last fiscal year – at 4.3%. Outpatient Adult Payor Mix, most categories have remained fairly steady, except for a noticeable increase in Commercial and a related decline in Self-Pay. Commercial payors now make up 10.4% of the Adult non-emergency visits. Outpatient Pediatric Payor Mix, pediatric visits were also showing an uptick in Commercial lines of business – driven by a shift from Medicaid and slight decline in Self-Pay. Compared to last fiscal year at this time, Medicaid remains a relatively stable share of the patient mix, with a slight decrease in FFS and increase in Managed Care. Medicare is .6 of a percentage point higher, also due to a shift from FFS to Managed Care. Commercial and Other remain steady, and self-pay slightly lower than last fiscal year – at 4.3%. Most categories have remained fairly steady, except for a noticeable increase in Commercial and a related decline in Self-Pay. Commercial payors now make up 10.4% of the Adult non-emergency visits. Pediatric visits are also showing an uptick in Commercial lines of business – driven by a shift from Medicaid and slight decline in Self-Pay.

Ms. Youssouf again raised the issue of the terminology used for uninsured and how it was being defined relative to the self-pay given that there is a difference between those patients who pay and those who do not. This issue has been raised repeatedly in the past and was to be addressed but the change in the terminology was not reflected on the report.

Ms. Olson stated that it would apply to those who have not gone through the HHC Option process for being fee-scaled. Self-pay doesn't mean that those patients do not pay but rather have not gone through the process.

Mr. Page added that self-pay as a term is misleading and the Committee has had discussions in the past regarding an appropriate term to be used and it was agreed that another term was needed.

Mr. Anantharam stated that the Committee's request would be addressed in conjunction with reviewing the data and determine what would be an appropriate terminology to use to capture the true self-pay versus no pay.

Mr. Page added that the change can be made at the beginning of the next FY 17 quarterly reporting as oppose to making a change in the current FY 16 to which the Committee agreed.

Mr. Rosen asked if HHC Option was helping with increasing revenues. Ms. Katz stated that the focus of the Options program is to get patients insured. Charity care does not only cover those who cannot pay.

Ms. Youssouf also suggested that the formatting of the report could be updated to reflect the amount of the collections for the program. Mr. Anantharam stated that the collections for Options would be shared with the Committee.

Mr. Rosen stated that in the past the report did reflect the dollars but was too congestive and was adjusted to reflect the trends.

After various discussions the Committee agreed that a change in the reporting and formatting of the reports was needed and would be made going forward in FY 17.

Information Technology Committee -- June 9, 2016
As reported by Dr. Lilliam Barrios-Paoli

Chief Information Officer Report

Mr. Guido, Senior Vice President and Chief Information Officer, presented the Chief Information Officer Report. He said that there would be two items to discuss: one Action Item and one Information Item.

Mr. Guido addressed the report's Major IT Program Status Updates on a red-yellow-green color scale: Meaningful Use (Overall yellow, Budget green, On-Time yellow); Electronic Medical Record (Overall yellow, Budget and On-Time status green); Enterprise Resource Planning (all green); Imaging (Overall yellow, Budget and On-Time status green); and Data Sciences – Analytics (all green).

Mr. Guido said that the Epic electronic medical record (EMR) is on track for deployment by the end of the year for the next two sites: Jacobi and North Central Bronx Hospitals, along with several clinics.

He then spoke to some projects in progress:

Clinical Information Systems Application Rationalization Project

Mr. Guido addressed the Clinical Information Systems Application Rationalization project. He stated that this is a consolidation of our clinical applications.

Mr. Guido said that with Epic, we will retire approximately 25% of our clinical applications. He told the IT Committee that we are doing additional consolidations, including Radiology, which will bring 11 different systems into one; and Dentrix (dental), which will bring 12 systems into one by the end of the year. He said we are looking to do more consolidations and EITS will be giving briefings to the IT Committee in the future on efficiencies and cost savings.

Enterprise IT Services (EITS) Staff Survey

Mr. Guido told the Committee that a staff survey of EITS employees will be conducted. He explained that in April 2015, we sent out our first survey and we learned we had to communicate more with our departments. We corrected this by having monthly teleconferences, quarterly town hall meetings, and getting more resources in the Networks engaged in what is going on. He said thanks to Mr. Martin and Dr. Raju, we were able to deploy telecommunications to do remote work, which will help us tremendously over the coming months.

Mr. Guido stated that another survey will be conducted to see if we are doing what we promised as well as to see what other issues there might be. He said we want to keep engaged with our EITS employees.

Action Item:

Mr. Guido presented to the Committee the following resolution for Deloitte implementation contract:

Authorizing the New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) to execute a contract with Deloitte Consulting, LLP to provide implementation services for the PeopleSoft Enterprise Resource Planning (“ERP”) System. The contract will be for a term of three (3) years with two one-year options to renew exercisable solely by NYC Health + Hospitals for an amount not to exceed \$18.2 million during the initial three-year term.

A PowerPoint presentation entitled, “Contract Award for ERP Implementation Services – Deloitte Consulting, LLP was given to the Committee members.

Approved for consideration by the full board.

Information Item:

Mr. Guido introduced Vikram Arora, Assistant Vice President and Chief Information Risk and Security Officer, who delivered a presentation on “Security & Risk Management: An Overview,” which provided the Committee members with an update on IT Security and how his team is combatting threats to NYC Health + Hospitals today.

Medical & Professional Affairs Committee – June 9, 2016
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.

Zika

As the knowledge about Zika, its risks and its transmission, are increasingly appreciated, our system-wide preparations are being stepped up. We are guided from CDC and DOHMH as to the science, screening and testing. Our initial focus was on Zika risks in pregnancy, but is now spreading to our Emergency departments and other points of entry, such as primary care. As knowledge of person to person transmission through sexual contact from male to female, then advice and testing is changing with new knowledge. Given that travel related Zika infection is much more likely than local mosquito borne disease, then our focus on travel screening and travel advice has increased. We continue to work very closely with DOHMH on the testing of patients and hopefully working toward simplified electronic access to testing and test results. As of June 3 we have tested 146 patients, with 4 positive tests.

New communication materials and strengthened travel screening are being rolled out across all of our facilities.

Patient Centered Care

- Nurse Recognition Week was a rousing success at the facilities, many outstanding staff honored and all thanked for their service. Lauren Johnston was present at many of the programs, delivering quick remarks of thanks and keynote speeches as requested. Reminder: Nursing Excellence event will take place in the fall.
- For the first time, NYSNA and H+H produced banners bearing both logos celebrating the event that were displayed in each facility. Banners are designed to be reused annually

Staff Safety:

1. Completed
 - a. PESH Review for 2015 (SH-900 Log, SH-900.1 Summary and SH-900.2 forms) to ensure compliance
 - b. Workplace Violence (WV) risk assessment walkthrough of Correctional Health Services’ facilities
 - c. WV risk assessment walkthrough of Coney Island’s Ida G. Clinic
 - d. WV risk assessment walkthrough of 199 Water Street (DRISP)
 - e. Review of 2015 WV Logs and 2829s for all facilities
 - f. 2015 AER (authorized employee representative, aka Union) Review of Coney Island, Jacobi and NCB on 5/13/16
 - g. Comparative analysis of WV data between 2014 and 2015
2. Justin Yu appointed as the new Director of Safe Patient Handling, actively networking with the facilities and Unions to design and implement a program following the legislative mandates from NYS

LiveOnNY Liaison program

NYC Health + Hospitals is partnering with LiveOnNY and will be implementing

- education and outreach programs designed for physician and nurse engagement with an advocacy for donation and transplant
- responsibility for regular recruitment and renewal of participants and ongoing evaluation of program's success
- work with LiveOnNY leadership to grow, develop and improve the program to function as an additional vital portal for donor designation decisions.
- work jointly in improving the process, communication, and education between LiveOnNY and NYC Health + Hospitals.
- inform our staff and inform the people we serve of the positives of organ and tissue donation.
- Through donation recipients and donors live on and our goal as a NYC Health + Hospital is to serve our communities and help make NY number one in lives saved through donation.

Office of Ambulatory Care Transformation (OACT)

Collaborative Care for Depression

- The work of our collaborative care teams was featured in a case study published in the New England Journal of Medicine's Catalyst site: <http://catalyst.nejm.org/collaborative-care-depression-safety-net-health-system/>
- Over the last several months, sites have been working to develop standardized workflows for retroactive and current Collaborative Care billing. As of May, all 17 facilities had billed Medicaid for Collaborative Care services.

Patient-Centered Medical Home (PCMH) Recognition:

- NYC Health + Hospitals/Gotham Health application for PCMH Recognition was evaluated by NCQA and achieved 40.62 points out of 43.50 possible points. The outcome ensures that all NYC Health + Hospitals/Gotham Health sites have a strong foundation for their forthcoming site-specific applications.
- NYC Health + Hospitals/Gouverneur application for PCMH Recognition was submitted on May 20th, 2016. NYC Health + Hospitals/NorthCentralBronx, NYC Health + Hospitals/Elmhurst, NYC Health + Hospitals/Woodhull, NYC Health + Hospitals/Coney Island are the next sites to apply, in July 2016.

High-Risk Patients

- OACT is helping lead an effort to identify and take better care of our high-risk patients: those with complex needs who are most likely to visit emergency departments and be hospitalized.
- The OACT Data Core applied a risk-scoring algorithm (modified from ACO) to Medicaid FFS patients seen in 2014 (N=123,598), and examined their utilization in 2015.
 - o >75% of the patients predicted to be high risk had a behavioral health diagnosis (substance use or a major psychiatric diagnosis).
- Data Integration for Population Health
- The offices of Ambulatory Care Transformation, Population Health, and ACO have launched a coordinated effort to produce comprehensive population health management tools for our primary care teams.
 - o M&PA currently produces several discrete population health management tools aligned with specific programs, and sites report challenges using the existing data tools to proactively manage complex patients.
 - o The joint effort within M&PA to address these needs began at the May Ambulatory Care Leadership Council Meeting, and three main focus areas have been identified: (i) Pre-visit Planning 2.0, (ii) Comprehensive Outreach Lists, and (iii) Provider Panel Management.

Pharmacy

As part of the transition to Epic and coordinated through Division of Medical & Professional Affairs, Queens and Elmhurst formularies are now composed of 43% of the same medications, which equates to 1720 of 4000 medications are standard across the two facilities. Moving forward prescribing data from Quadramed will provide the starting point for standardization for the remaining facilities. To prepare for the next Go Live in December, formulary and procurement standardization drug class reviews will be conducted.

Simplifi 797

Achieving compliance with new USP 797 and 800 standards is the subject of significant efforts. Part of that effort is implementation of software Simplifi 797 for Bellevue and Kings County Medical Center. This software application upgrade will actively establish updated policies and procedures, continuing education, and quality management reports that is centrally monitored and locally implemented. Included in Phase 2 Simplifi 797 GO Live will be implementation of the software at the remaining facilities. This upgrade in software application, along with other strategic initiatives pertaining to IV admixture units, such as upgrades in environmental controls and physical plants, will enable the NYC H+H system to fill any gaps that may exist with the new USP 797 and 800 standards.

CVS and H+H partnership

To improve adherence to medications CVS and H+H have entered into an agreement that will provide reports of CVS intervention data including (New script Outreach, First Fill Counseling, Adherence Outreach, Refill Reminder) that is provided to NYC H+H patients. During the first quarter CVS has conducted 29,078 interventions to NYC H+H patients. Additionally CVS has provided 3,043 pharmacy advisor interventions for numerous chronic conditions including (diabetes, hypertension, depression, etc.). This report is the first step of an innovative partnership toward improving outpatient medication management at NYC H+H.

Delivery System Reform Incentive Payment (DSRIP) Program

OneCity Health continues to progress with clinical project implementation and development of a final funds flow model to be used through March, 2017.

Funds Flow

The OneCity Health Executive Committee approved the parameters of the payment model through March 31, 2017 for implementation efforts in seven transformation programs, which include: Cardiovascular Disease Management, Care Transitions Intervention, ED Care Triage for At-Risk Populations, HIV Access and Retention, Integrated Delivery System, Integration of Palliative Care into the PCMH Model, and Integration of Primary Care and Behavioral Health Services. These programs will be captured in a comprehensive schedule that incorporates the funds flow model, which partners can expect in early July, 2016. All funds flow methodology will be shared with the OneCity Health network as part of the commitment to transparency and in keeping with DSRIP requirements.

The comprehensive schedule will also include partner performance metrics through March 31, 2017. OneCity Health shared initial metrics with partners in May, and accepted partner input through an 'open comment' period.

Clinical Project Implementation

For Care Transitions planning, which focuses upon hospital readmissions reduction by providing a supportive transition to the community for appropriate patients, Transition Managers are now receiving patient referrals at two NYC Health + Hospitals facilities. Eight Transition Managers have been hired, and will begin seeing patients at three more facilities soon.

For Project 11, both OneCity Health community partners and NYC Health + Hospital facilities are continuing to engage patients with the Patient Activation Measure (PAM®) surveys. OneCity Health remains cautiously optimistic about meeting all commitments made to the Department of Health for the June 30th deadline, which is the end of the first quarter of DSRIP Demonstration Year Two. In addition, OneCity Health is forming a workgroup to better understand how patients engage with primary care, as part of a larger Project 11 effort to develop a process to link uninsured New Yorkers and low- and non-utilizers of Medicaid to primary care and social services.

For palliative care integration into the PCMH, OneCity Health continues its work to provide simple advance care planning at 12 NYC Health + Hospitals neighborhood health centers and acute care facilities. OneCity Health remains cautiously optimistic about meeting all commitments made to the Department of Health for the June 30 deadline.

ED Care Triage implementation planning continues at four NYC Health + Hospitals facilities, which begins the effort to connect patients with primary care from the Emergency Department. Health Home At-Risk planning also continues at three NYC Health + Hospitals sites, in which the objective is to extend care management services equivalent to the New York State Health Home program.

The asthma home-based self-management work also continues at both select NYC Health + Hospital and community partner sites.

DSRIP Workforce Training

OneCity Health is on track to meet its June 30th deadline for completion of analyses required by the NYS DOH in order to design and execute a training roadmap to support the workforce of NYC Health + Hospitals and OneCity Health partner organizations in transformation. The roadmap will reflect the hiring, training and potential redeployment requirements to meet estimated workforce needs in year 2020 and will reflect the results of a baseline workforce survey (current state) and projections of workforce demand made through microsimulation modeling.

The Committee may recall that for these workforce requirements, OneCity Health formed a consortium with three other NYC Performing Provider Systems – those led by St. Barnabas, NYU/Lutheran and Maimonides – and contracted with consultant firm BDO in order to complete the analyses with reliable methodology on a short timeline.

Importantly, our labor partners from NYC Health + Hospitals, SUNY Downstate and other partner organizations have been engaged in these efforts since inception. The OneCity Health Workforce Subcommittee, comprising labor partners and governance committee members from our Stakeholders Committee, will meet on June 16th for a presentation from BDO and a review and discussion of current state and draft future state results.

MetroPlus Health Plan, Inc.

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee the total plan enrollment as of May 1, 2016 was 499,948. Breakdown of plan enrollment by line of business is as follows:

Medicaid	386,923
Child Health Plus	14,107
MetroPlus Gold	4,854
Partnership in Care (HIV/SNP)	4,528
Medicare	8,430
MLTC	1,125
QHP	20,369
SHOP	992
FIDA	186
HARP	8,061
Essential Plan	50,373

MetroPlus membership in the Essential Plan has increased by 66% in the last three months. Of the EP members, 57% are new, and 43% are transfers from Medicaid and QHP.

To enhance growth opportunities, we continue to concentrate our efforts on member satisfaction and thereby recruitment and retention. We are deploying several text messaging and email campaigns focusing on member engagement, including preventive health measures, lifestyle changes, as well as recertification reminders for our Medicaid population. We redesigned the entire retention program including the IVR system, member communication (texting and email programs).

MetroPlus has been working closely with H+H Central Office on identifying the most effective PCP auto-assignment logic for our members to ensure better access to care. In addition to the provider's location in relation to the member's, we will incorporate quality metrics into the logic to ensure our members (H+H patients) receive the highest quality care.

For HEDIS 2016 over 16,000 medical records were reviewed as part of the hybrid medical record review process. Supplemental data collection yielded over 8,000 hits and this year we expanded data collection to include file feeds from the facilities. Additionally, we were able to include Quest Lab data and developed a process with our provider offices to correct erroneous claims that caused incorrect member identification. We were notified that the hybrid project passed audit review and was approved to submit to NCQA and NYS DOH. We are completing our final administrative measure project (claims refresh) and will submit our final project on June 1st. Details on Star HEDIS measures include the following: one measure has exceeded last year's five Star threshold and five measures surpassed the four Star threshold. The remaining three measures have exceeded the three Star threshold. For Medicaid, over 40% of the measures reached the prior year's 90th percentile QARR rate and 25% passed the 50th percentile QARR rate. We anticipate outcomes to be similar to last year's performance.

To ensure that the State meets the goal of 80-90% of managed care spending be associated with Value Based Purchasing (VBP) arrangements by 2020, MCOs will receive a rate decrease, or penalty, for not contracting a minimum threshold of VBP arrangements. The penalty will be assessed on the previous State Fiscal Years' (SFY) VBP contracts. The parameters for the minimum number of VBP Level 1 and 2 arrangements will increase each year to reflect the requirement to move larger portions of the MCO's contracted dollars into VBP contracts. MetroPlus is working with the State Department of Health to categorize the full incentive program we have with Health + Hospitals so we can meet these requirements. We currently have a full financial risk arrangement with H + H and we work collaboratively to perform Care Management, Utilization Management, and Quality Management for our populations. MetroPlus is

currently working with the State to accept this contract as meeting criteria. In addition, we are planning value based relationships with other large systems that are in our network so that we can meet the requirement by the deadline.

ACTION ITEM:

Dr. Ross Wilson, Senior Vice President/Chief Medical Officer and Mr. Antonio Martin Executive Vice President/Chief Operating Officer presented to the committee the following resolution:

Authorizing NYC Health + Hospitals ("System") to negotiate and execute a Physician Services Agreement with the State University of New York/ Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at NYC Health + Hospitals/ Kings County ("KCHC") and NYC Health + Hospitals/ Coney Island ("CIH") for a period of four years, commencing July 1, 2016 and terminating on June 30, 2020, for an amount not to exceed \$86,659,516;

Approved for consideration of the full board.

Information Items:

Nicholas Stine, MD, Chief Medical Officer, Accountable Care Organization presented to the committee on Comprehensive Care for Joint Replacement(CJR).

He gave an overview of the Comprehensive Care for Joint Replacement program. The Key metrics to measure progress against bundled payment; NYC Health + Hospitals baseline case distribution, baseline state; hospital performance baseline and key consideration.

Strategic Planning Committee – June 8, 2016
As reported by Mr. Gordon Campbell

Action Item

FY'16 IRS Mandated Community Health Needs Assessment Update Report

Steven Fass, Assistant Vice President, Corporate Planning Services
Christopher Philippou, Assistant Director, Corporate Planning Services

Mr. Jurenko, Vice President, Intergovernmental Relations and Planning introduced Steven Fass, Assistant Vice President and Christopher Philippou, Assistant Director of Corporate Planning Services. He informed the Committee that they will give an update of the FY'16 IRS Mandated Community Health Needs Assessment. Mr. Jurenko explained that the Affordable Care Act (ACA) added requirements that 501(c) (3) tax-exempt hospitals nationwide must conduct a Community Health Needs Assessment (CHNA). The goal is to improve community health by identifying opportunities to improve health care delivery or address other community needs. He informed the Committee that the initial Community Needs Assessment Report was done in 2013. As part of the process, CHNA reports must be adopted by a governing body of the facility; made widely available to the public and upon demand; and completed or updated at least every three years. In addition, hospitals are also required to develop implementation strategies to address high priority needs identified in the CHNA. Implementation strategies must be adopted by an authorized body of the facility no later than November 15th. Mr. Jurenko noted that the ACA also added an excise tax of \$50,000 on any hospital organization that fails to meet these requirements.

Mr. Fass reported that there are five required components of the CHNA Report as listed below:

- A definition of the community served. For most hospitals we used the zip codes where 75% of patients reside and described the demographics and population health of those zip codes.
 - HJ Carter LTACH patients come from all over the City. We also made an adjustment for Bellevue who also draws from a wide area.
- A list of the most significant health needs of the community in rank order. Ranking the needs is a new requirement and was not done in the 2013 CHNA report.
- Detailed process and methodology
- A list of all community benefit organizations and city agencies
- An evaluation of programs included in the 2013 CHNA report

Mr. Fass reported the Process and Methods to Identify and Prioritize Community Health Needs as the following:

- Each hospital created a specific CHNA report, using a methodology that was developed and consistently implemented by a work group of hospital planners.
- After review of internal, state, and federal documents, the work group created a list of over 40 potential health needs.
- The list was narrowed down to 13 after receiving input from other hospital staff and testing it with hospital users.

- To rank the health needs, four sources were blended together, weighted equally: CAB members, hospital users, hospital leadership, and the prevalence of the condition.
 - Hospital user surveys were translated into 8 languages (Bambara, Bali, Bengali, simplified Chinese, French, Haitian Creole, Polish, Russian, and Spanish) and 1,700 were collected.
 - Using this methodology, the community needs were often very tightly grouped and occasionally in a tie, however one of the new 2016 requirements mandates ranking.
- Lastly, the final rankings were reviewed by hospital leadership and staff.
- The highest ranked health needs meet the IRS definition of “significant community health need”. The IRS requires that an action plan is implemented, which is to be posted in November.

Mr. Philippou reported on CHNA’s “Significant Community Health Needs” findings, listed below:

- Hypertension/high blood pressure and diabetes are significant community health needs at all hospitals
- Obesity and heart disease are significant at majority of the hospitals.
- HIV/AIDS was identified as a significant community health need at five hospitals in 2013 but none in 2015, reflecting progress in reducing HIV/AIDS diagnoses and deaths in NYC.

Significant health need and its rank (1=greatest need; 13=lowest need)	Not a significant health need and its rank (1= greatest need; 13 = lowest need)
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Need	Bell eve e	Cart er	Cone y Islan d	Elmhurs t	Harle m	Jaco bi	Kings Count y	Lincol n	M et	NCB	Quee ns	Woodh ull
Hypertensi on	1	1 (tie)	4	2	1	1	2	1	2	2 (tie)	2	1
Diabetes	5	1 (tie)	1	1	2 (tie)	3	1	3	1	2 (tie)	1	3 (tie)
Obesity	2 (tie)	4 (tie)	6	4 (tie)	9	4	6	6	3	4	5	3 (tie)
Heart Disease	2 (tie)	3	2 (tie)	4 (tie)	8	5 (tie)	4	4 (tie)	5	6	10 (tie)	5
Mental Illness	4	6 (tie)	8 (tie)	4 (tie)	6	5 (tie)	3	10 (tie)	9	5	3 (tie)	6
Substance Use	6	9	10	7	5	9	7 (tie)	2	7	9	6 (tie)	2
Asthma	8	6 (tie)	8 (tie)	12	2 (tie)	2	9	4 (tie)	4	1	13	7 (tie)
Cancer	7	10	2 (tie)	3	11	8	5	9	8	7	8 (tie)	11
Smoking	11	6 (tie)	5	8	4	7	12	7	12	8	3 (tie)	10
Violence	10	12 (tie)	11	9	10	10	10	8	6	10	6 (tie)	7 (tie)
HIV/AIDS	9	11	13	10	7	11	7 (tie)	10 (tie)	10	11	12	7 (tie)
Dementia	12	4 (tie)	7	11	12 (tie)	12	13	12	11	12	10 (tie)	12 (tie)
Perinatal	13	12 (tie)	12	13	12 (tie)	13	11	13	13	13	8 (tie)	12 (tie)

Mr. Philippou reported that the top significant health needs identified in the system’s acute care facilities’ service area in the 2016 CHNA persist from 2013. These include:

- Hypertension and Diabetes, both identified as significant needs in all 12 acute care facilities;
- Obesity and Heart Disease identified in the majority of facilities;

- Mental Illness identified in half of the acute care facilities;
- Asthma and other respiratory issues identified in five facilities.

Mr. Philippou explained that the significant needs (identified in blue highlighted cells) are the highest ranked needs after the needs identification and ranking processes from each acute care facility's perspective. In addition, the needs are sorted by system-wide ranking of the collective needs of our communities (1=greatest need, 13=lowest need). Mr. Philippou informed the Committee that the final list of significant needs is the prioritized list of needs based on the synthesis of community input, facility leader input and public health data. However, he cautioned that it does not make any statement that the other identified needs in the grid or those not present are unimportant. Contrary to this, all of the identified needs as well as the social determinants of health and risk factors to the identified chronic conditions have a need for programming and resources in our communities. The list recognizes the *top* concerns from the perspective of the acute care facility community served and leadership. Mr. Philippou stressed that while the CHNA 2016 and 2013 processes are not comparable, for reasons which are listed below, it is important to note that HIV/AIDS, which was identified as a significant need in 5 acute care facilities in 2013 was not identified in any in 2016. He noted that this is partly due to a real world decline in the HIV diagnosis rate in the communities that we serve. He added that the methodology differences, as per differing IRS requirements, otherwise drive many of the shifts in the significant needs that are identified in each respective year. Collectively, the changes led to a more coordinated and systematic 2016 CHNA process. Key methodological changes include:

- Identifying need through community input varied in methodology;
- Use of a standardized list of identified needs in 2016;
- Needs in 2016 are prioritized with community input as compared to their identification by facility leadership in 2013;
- The number of needs considered significant in each acute care facility was standardized in 2016.

Mr. Philippou noted that with respect to the December 2014 DSRIP Community Needs Assessment conducted for OneCity Health, the needs assessment findings are also not directly comparable. He added that the approach for the DSRIP needs assessment was more comprehensive and included community input of health and health-related subject matter experts and focused on groups of vulnerable populations, as well as gap analysis of needs and resources in the neighborhoods that we serve. He highlighted, however, that the needs identified in the 2016 CHNA align with the projects currently being implemented by OneCity Health, as well as system-wide clinical initiatives coordinated by Medical and Professional Affairs.

Dr. Raju inquired about those health needs that did not make the list as the top Community Health Needs Assessment. He asked if this is due to NYC Health + Hospitals' robust programs in those areas or because the need is no longer prevalent as before in those areas. Mr. Jurenko answered that it is because NYC Health + Hospitals is providing good care in those areas. In addition, because of all the work that is being done on behalf of the City and the tremendous amount of resources that are spent on this, the community health needs have dropped down. Mr. Fass commented that half of the findings are based on perception of users in the community or the CAB members and this perception is based on what they read in the paper and provided information. Mr. Mark Page, Board Member, asked whether we are driving off a dearth of care in a given community for a particular health need or if we are looking at the healthcare that the community requires. Is there a shortage of care being provided by NYC Health + Hospitals in that community or is it something else? Mr. Page specifically wanted to know what is being measured. Is it a shortfall, an H+H facility shortfall or is it just that asthma is prevalent in the community and are being treated beautifully but they show up here because asthma is important.

Mr. Steve Bussey, Senior Vice President, Ambulatory Care noted that the listed inpatient results would have been totally different for outpatient facilities. He commented that he was surprised to see that HIV/AIDS was so low particularly in some communities, but would not see much of it at the inpatient sites. Ross Wilson, MD, Senior Vice President, Corporate Chief Medical Officer, interjected that the goals are mixed. He explained that one goal is to determine how prevalent the disease is and therefore the health care need in that community and another is to determine what the people demand from the facility. For chronic illnesses, he noted, that the demands are going to be high whether the services are good or not as people are still going to need care. Dr. Wilson added that he is a little perplexed by these results, particularly as most of these conditions are ambulatory care conditions and that only the hospitals were surveyed. Dr. Wilson recommended that the D&TC's be surveyed as well and that the DOHMH maps are added into it. He explained that DOHMH have various significant maps and would like to see how these needs line-up. Sympathetically, Dr. Wilson added that we have been told to do this assessment within a set of rules and will end up with a product that may not drive what needs to be done. Dr. Wilson reiterated that the questions are real and what we are trying to do is to balance what is a requirement with its associated rules versus what we need to drive a care plan. Mr. Page commented that all these questions are extremely important and while it requires a lot of thought and resources to put the report together, it would be nice if it drops out a useful answer. The question is that how can this be done and still hit the boxes on what the Feds are requiring of us.

Mr. Philipou answered that it is important to note that there are many other needs that have not even been identified. He noted that social determinants are being considered here. He admitted that a lot of the needs that were identified by CAB members and users are not on this grid. He reminded the Committee that the IRS mandate is for the hospitals to first identify a standardized list of needs for all the communities NYC Health + Hospitals serve and then to prioritize that list. Mr. Philippou admitted that the communities face more than these 13 needs; at least 30 to 40 different types of needs. However, the purpose of the process is to highlight the most significant, the most important, or the needs that are mostly targeted by NYC Health + Hospitals' acute care facilities. Mr. Philippou informed the Committee that outpatient clinics were also surveyed but given the magnitude and the weight of the people that are thinking from an acute care prospective, it is directly correlated to have acute care facilities think of these conditions.

However, another needs assessment from the prospective of Gotham is in the works and will have different viewpoints. Mr. Philippou summed that, firstly, there was a requirement to meet the request of the IRS to identify the needs. This is an evolving process and Gotham would have a different prospective. The point is that these are the most significant needs in these communities.

Mr. Campbell interjected that while we need to adhere to IRS rules, there is a need to look at if the perceptions are close to reality. Mr. Page asked about how the priority is being identified. His understanding is that you need to identify where there are issues or shortages that need to be addressed. Mr. Philippou answered that the report is a less comprehensive report. It was not a gap analysis report where needs and resources are aligned. He reiterated that CHNA is trying to get all those different perceptions together to identify significant needs. Mr. Philippou stated that we cannot conclusively say that these are the only needs of the community and those not flagged as a significant need are not prevalent in the community. He informed the Committee that the 2013 CHNA report resulted in 90 different needs identified. He also added that due to a constraint in resources, it is not possible to have 50 different new programs to identify every need that comes around. Mr. Jurenko reiterated that the IRS mandate calls for those needs to be prioritized. Mr. Jurenko shared with the Committee that a broader approach was used to survey hospitals users, inpatients and outpatients, and Community Advisory Board members. In addition, DOHMH's community health needs assessment as well as other data sources were looked at in trying to balance the findings of the community residents, hospital users and CAB members versus NYC Health + Hospitals leadership; all of which were blended together to create that list which is prioritized as per IRS' request. Mr. Jurenko informed the Committee that identifying the community needs is the first phase of the assessment and that the next phase will be on the implementation side. The question is whether this is something unique to us or is community-wide. In reference to the asthma scores, for example, the data was analyzed to see how it ranks with other health needs; what it means for Lincoln, the downtown Bronx and Harlem where the data score is prevalent; and does that comport with what the community residents and leadership is telling us and make adjustments as necessary.

Dr. Raju commented that the first part of the report is very useful. However, while it is a mandated process, the results can be used to our advantage. He added that the Gotham needs assessment will be very useful because as clinics are being expanded in the future, we need to figure out what services are needed in those clinics depending on the community needs. Dr. Raju stated that since the identified need is a community need, perhaps there are other providers providing the same services. Therefore, is there a gap to be filled? He noted that this gap is: 1) NYC Health + Hospitals' mission, and 2) market share. He explained that if we provide those services, more people will come and use NYC Health + Hospitals' services. Dr. Raju noted that we are given an opportunity to go to the next level. Dr. Raju added that even with the inpatient services, NYC Health + Hospitals need to take a close look at the percentage of the five major needs identified (Hypertension, Diabetes, Obesity, Heart Disease and Mental Illness) from the total inpatient service. Dr. Raju noted that as a traditional health care delivery system, we continue to perpetuate those services even though there may not be enough need for it as it was 5, 10 or 20 years ago. He added that while we are taking advantage of this opportunity to transform the organization and redesign the care, there is a need to look at the market share, otherwise, we will be selling the same product. Dr. Raju stated that uniqueness is what is going to drive this organization. Therefore, the planning department should take it over and keep advising us on how to do that. The days are gone when cheap rent and location were the only factors taken into consideration in opening a clinic. Dr. Raju stressed that in the future the clinics will be based on where it is, what is the market share, who is next to us and what is the competition in the area. Mr. Jurenko agreed with Dr. Raju that this first step of the CHNA report should be expanded.

Mr. Fass reported that the implementation strategy is due on November 15, 2016. He stated that this second part of the CHNA report is a description of how the hospital plans to address the high priority community needs identified in the community health needs assessment. The implementation strategy must include:

- The anticipated impact of these actions and a plan to evaluate the impact;
- Identified programs and resources the hospital plans to commit to address each high priority health need; and
- Description of any planned collaborations with hospitals or other organizations.
- The implementation strategy must be adopted by a governing body of the facility.
- The implementation strategy must also be posted on NYC Health + Hospitals' website.

Mr. Jurenko read the resolution as follows:

Adopting in the name of the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") Board of Directors the twelve Community Health Needs Assessments ("CHNA") prepared for each of NYC Health + Hospitals' eleven acute care hospitals and for the Henry J. Carter Specialty Hospital and Rehabilitation Center ("HJC").

The resolution was approved by unanimous vote for consideration by the full Board.

Information Items:

NYC Health + Hospitals' System Scorecard FY'16 First Quarter Report
 Udai Tambar, Chief Transformation Officer

Mr. Campbell introduced Mr. Udai Tambar, Chief Transformation Officer, and invited him to present the first quarter of the System's Scorecard as presented below:

SYSTEM SCORECARD 2016 Q1

	LEAD	TARGET Q1	ACTUAL Q1		PRIOR QUARTER	PRIOR YEAR	TARGET 2020	
Anticipate & meet patient needs								
1	Out-patient satisfaction (overall mean)	COO	80%	78%	Y	78%	77%	93%
2	In-patient satisfaction (rate-the-hospital top box score)	COO	62%	59%	R	59%	60%	80%
Engage our workforce where each of us is supported & personally accountable								
3	Staff completing leadership programs	COO	242	385	G	536	239	1,200
4	Employee engagement (5 point scale)	COO	4.1	3.5	Y	3.5	NA	4.1
Provide high quality safe care in a culturally sensitive, coordinated way								
5	Hospital-acquired infections (CLABSI SIR)	CMO	1.00	1.04	R	0.86	0.95	0.50
6	DSRIP on track	OneCity CEO	90%	100%	G	100%	NA	90%
Expand access to serve more patients (market share)								
7	Access to appts (new adult patient TNAA days)	CMO	14	20	Y	22	26	14
8	Unique patients (thousand)	COO	1,200	1,226	G	1,238	1,218	2,000
9	MetroPlus members (thousand)	M+ CEO	490	493	G	482	470	675
10	Patient revenue (proportion of expense)	COO	62%	55%	R	58%	59%	70%
Increase efficiency by investing in technology & capital (organizational reform)								
11	EMR budget variance	CIO	0%	0%	G	0%	0%	0%
12	EMR implementation on track (milestones)	CIO	100%	90%	Y	90%	90%	100%
13	Contractors performance at service level	COO	100%	91%	Y	91%	NA	100%
14	FEMA projects on track	COO	100%	100%	G	92%	NA	100%
	LEAD	TARGET	ACTUAL		PRIOR QUARTER	PRIOR YEAR	TARGET 2020	

Note: Calendar year.

CLABSI data not finalized for 5 months after the reporting period; considered to be most accurate after CMS reporting deadline for the quarter.

G on target
Y trending toward target
R off target

Mr. Campbell reminded the Committee that the Scorecard is a work in progress and that their ideas and suggestions are welcomed.

Mr. Tambar stated that the scorecard's data for the first quarter is up to August 31st. He recapped that the scorecard is comprised of five main categories that are aligned with Dr. Raju's Vision 2020 listed below:

1. Patient Experience
2. Employee Engagement
3. Quality
4. Access (Market Share)
5. Efficient Support (Organizational Reform)

Mr. Tambar described the meaning of the traffic lights in context as the following:

- Green: above the quarter's target
- Yellow: below target but trending in the right direction

(Trending in the right direction: either above the quarter's target or the prior year's target)

- Red: below the target and below both the prior quarter and the prior year's target

Mr. Tambar informed the Committee that Ms. Raven Carter, Director, will be reporting on the Patient Experience section of the Scorecard. He also brought the Committee's attention to the Glossary slide comprised of the indicator definitions.

Mr. Bernard Rosen, Board Member, asked Mr. Tambar to expand on the patient revenue (proportion of expenditure) metric. Mr. Tambar answered that it is a ratio of revenues over expenses.

Dr. Raju explained further that as we are approaching the status in this country of supplemental income going down, we need to access whether we are able to pay our expenses through patients' internal income. Therefore, where we stand on that ratio is important. Dr. Raju noted that in the past that ratio used to be 60%. Dr. Raju also noted that 40% of our \$7.8 billion comes from UPL/DSH money. Therefore, there is a need to move more and more towards less than that. It is projected that in 2020, 70% of our total expenses will come from patient generated revenue.

Mr. Tambar added that it is a ratio that is fixed on a target which does not exactly mirror where our revenues and expenses go which is a little more up and down. Since it is a work in progress, there is a need to figure out the right way to measure that metric. That is the reason that it is in red even though it was green before as it reflects just the nature of how money comes in and out.

Mr. Tambar stated that the goal of the scorecard is to give a system view of what is going on. He highlighted that the employee engagement which was red last time is yellow this time. Also, the CLABSI score which was green on the last report is red, because, as explained in the footnote, CLABSI data are not finalized for 5 months after the reporting period; they are considered to be most

accurate after CMS reporting deadline for the quarter. He highlighted that FEMA projects went from yellow to green and are now on target.

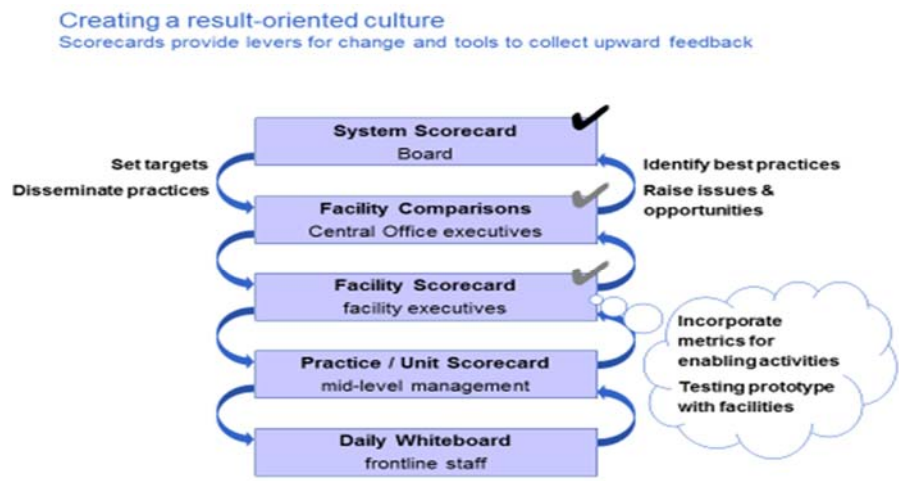
Mr. Campbell thanked Mr. Tambar for adding the glossary listed on the next slide. He commented that it is very helpful to show for each of the metrics what the variance is in terms of when they will become a target as each one of them is calibrated and calculated differently.

GLOSSARY

Anticipate & meet patient needs	
1 Out-patient satisfaction (overall mean)	roll-up average of all outpatient scores from each outpatient survey (random sample); by visit date
2 In-patient satisfaction (rate-the-hospital top box score)	% in-patients surveyed who rank hospital 9 or 10 out of 10 (random sample); by discharge date
Engage our workforce where each of us is supported & personally accountable	
3 Staff completing leadership programs	cumulative YTD employees completing supervisor, manager, leadership, and fellowship training; ~5,000 employees are eligible
4 Employee engagement (5 point scale)	survey of employees "I would recommend this organization as a good place to work"; baseline Q3 2015; actual Q1 2016; target national safety net average
Provide high quality safe care in a culturally sensitive, coordinated way	
5 Hospital-acquired infections (CLABSI SIR)	observed / expected Central Line Associated Blood Stream Infection - Standardized Infection Rate; data not finalized for 5 months after the reporting period; considered total PPS \$ awarded / total potential (up to \$1.2 B over five years); cumulative since April 2015; reported Jan & Jul
6 DSRIP on track	
Expand access to serve more patients (market share)	
7 Access to appts (new adult patient TNAA days)	average days to third next available appointment for new adult patients (primary care only)
8 Unique patients (thousand)	12-month cumulative of unique patients across entire system (not double counting patients who visit multiple sites); high estimate; actuals = 3 month cumulate
9 MetroPlus members (thousand)	active MetroPlus members across all categories at the end of the quarter
10 Patient revenue (proportion of expense)	patient-generated revenue / operating expense excluding City payments (cash receipts & disbursements YTD)
Increase efficiency by investing in technology & capital (organizational reform)	
11 EMR budget variance	EMR implementation over or under budget
12 EMR implementation on track (milestones)	estimate of milestones completed on time: Green = 100%; Yellow = missed milestones have no impact on go-live dates; Red = delays expected for go-live
13 Contractors performance at service level	% vendors compliant with Key Performance Indicators (for 11 biggest spend contracts ~45% of spend); KPIs vary by contract
14 FEMA projects on track	% milestones from monthly FEMA Program Dashboard on track (green or yellow)

G	on target
Y	trending toward target
R	off target

Mr. Tambar added that the scorecard is not just an exercise that is done for the Board, but rather data that is used to manage the organization. Therefore it is not only a governance tool but a management tool as well. In addition to the System scorecard, there is also a facility-level scorecard at the Chief Operating Officer level showing how the different facilities compare to each other so that Mr. Martin's Operations and Logistics team can use the scorecard in conversation with leadership. Mr. Tambar informed the Committee that the Transformation Office has been working with a few facilities to pilot the facility scorecard and had received some positive feedback. The idea for the facility level is to get to a unit or department level that will subsequently cascade to the front line staff, so that it is aligned with the direction we wish to go. See chart on the next page.



Mr. Tambar reported on testing prototype Facility Scorecard with Hospital Executives. The findings are listed below:

Benefits

- “True North” - Takes everything a CEO is supposed to look and gives a snapshot
- Enables everyone to "speak the same language"
- Will be useful in creating a disciplined focus on the System's priorities
- Supporting metrics begin to give a sense of how to "get ahead of the game"

Examples of current practices to monitor and drive results

- Facility CNO runs a weekly report on “Communication with Nurses” and discusses the results with the relevant units
 - Result: Surveys scores are trending up
- Facility CMO holds a weekly huddle to review Hospital-Acquired Infections and revise policies and procedures
 - Result: CLABSI is better than target
- Facility COO facilitated Rapid-Assessment Event on "respect" which led to daily discussions of it, among other actions
 - Result: Surveys showed positive trends, which should be reflected in the next Employee Pulse Check Survey

Mr. Tambar reported on the Scorecard's Next Steps as the following: **July – September 2016**
Determine Facility-level Metrics

Expand metrics & Align w/ System Scorecard
 Develop review Protocol

October-December 2016
Deploy Facility Dashboards

Refresh dashboards Frequently
 Share best practices

January 2017
Determine department and frontline metrics

Develop training

Mr. Tambar reiterated that the scorecard is a supporting tool and that the data provided will be helpful when making informed decision to improve the quality of services NYC Health + Hospitals provides. Mr. Tambar stated that there have been discussion of a timeline. There is a system-wide scorecard and for the next quarter a kind of protocol or draft for multiple facilities will be developed so that the facility-level scorecard will be finalized by the end of the year.

Mr. Campbell commented that the scorecard is creating a metric-driven culture and inculcated in that culture is sharing best practices and lessons learned. He reiterated that it is still a work in progress leading to the desired direction.

Mr. Tambar added that the scorecard is creating that common language; being objective and then framing it as not a punitive exercise.

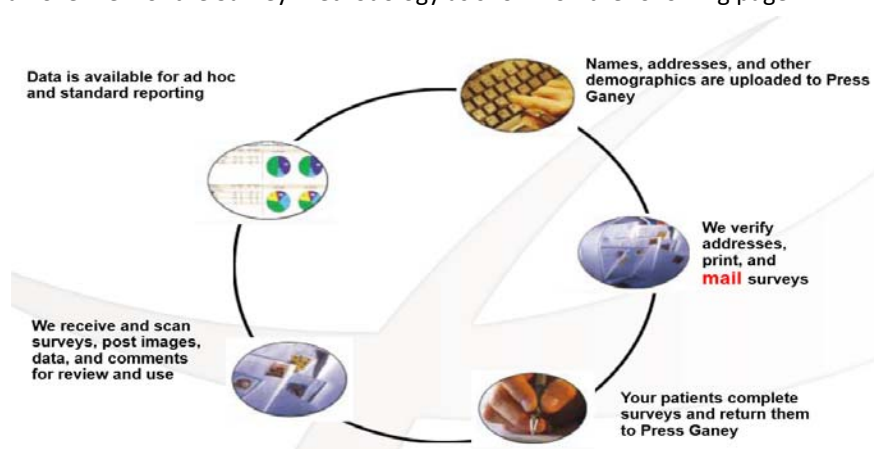
Mr. Tambar concluded his presentation stating that a draft template of the facility-level scorecard will be available on his next report. Mr. Campbell also reminded the Committee that each report will address one or two of the 14 metrics. He announced that Press Ganey will also present today and that MetroPlus Health Plan will be presenting on the following report.

Mr. Tambar turned the meeting over to Ms. Carter to present the Patient Experience Review.

Patient Experience Review

Raven Carter, MBA/FACHE, Director, Patient & Family Experience

Ms. Carter introduced Ms. Gwen Faust, Advisor, Press Ganey Associates, and invited her to join her at the table. She started her presentation with an overview of the Survey Methodology as shown on the following page:



Ms. Carter informed the Committee that most of the patients take at least four to six weeks to return the survey to Press Ganey's processing plant in South Bend, IN. Mr. Campbell asked about the rate of return for inpatient and outpatient surveys. Ms. Carter answered that each survey has its own response rate as the survey questions are a little bit different from inpatient to outpatient. Looking at inpatient facilities, just on the HCAHPS surveys, Ms. Carter stated that our response rate ranges from 12 – 17% while on the National level average is 29%. On the outpatient's side, however, our response rate ranges from 4% - 8% as opposed to 20% on the national level. Ms. Carter explained that our lesser response rate range is based on patient population. She explained that a lot of the patients have transient addresses. She added that based on her experience working with other public hospitals, some of the patients do not have a stable home address to send the survey to. Ms. Carter explained that the roadblocks encountered for getting patients to complete a survey are the same when employees are requested to complete a survey. The key is to: 1) communicate with them that "we need your feedback and we value it", and 2) using their feedback to make changes. That is really where the patient is going to connect to and will not hesitate to share feedback if they know that it will be used.

Mr. Rosen asked if it is possible to give the patient a small gift just to encourage him to do the survey. Dr. Raju answered by reminding the Committee that healthcare reimbursement has moved from ----- to value-based purchasing; therefore, it is no longer about the quality of care but the patient's perception of the care he/she received. As such, the Federal Government (CMS) prohibits this practice as it is considered as bribing to get better scores. Dr. Raju commented that New York City does not have an evaluation culture. In addition, people tend to fill out surveys only if they feel very good about it or very bad about it. Should they be neutral, they really are not interested. Therefore, the issues are not process issues but psyche of the population issues coupled with language issues.

Ms. Carter reiterated that we cannot give gifts to patients for filling out the surveys because CMS is very specific about how the survey is to be conducted including the language to be used in the survey. She stressed that communication is the best way to engage the patients in the survey process. She informed the Committee that there are other modes of surveys other than via paper survey, which is the most approved way by CMS. She stated that people feel that e-surveys are a little easier and could generate more robust responses. However, e-surveys are not an approved methodology from CMS. She informed the Committee that we survey a lot of areas not just the inpatient HCAHPS survey which is mandated by CMS either via a paper or a phone survey. She shared with the Committee that from her experience with both methodologies, the phone survey does not increase the response rate as you would think it would because people do not answer their phone nowadays.

Dr. Raju asked while we are not allowed to give the patient an incentive to fill out the survey, he would like to know if on a routine basis the discharged patient is advised that he/she will be receiving a survey at home that will serve to improve services at that facility. Ms. Carter answered that discharge phone calls are part of NYC Health + Hospitals' discharge process however, the caregiver making the call most likely had a relationship with that person who will ask them about not only the survey but also about their patient experience at the facility and any questions that need to be answered since they have been home. Ms. Carter noted that a lot of information is exchanged on the day of discharge, 75% of which goes out of the window. She reminded the Committee that one of the initiatives of Dr. Raju's 2020 vision is for the discharge procedures to include an after-visit communication in order to bridge the gap between being discharged from the hospital to the next level of care. A transformation plan is in the works to standardize that process.

Ms. Faust added that discharge information should not be given only at the point of discharge but talking about throughout the hospital experience, and so should the survey as well. She added that it is customary that during rounding, a nurse leader or a nurse manager may receive a compliment from the patient about the staff. The nurse leader should take that opportunity to tell the patient that they may be receiving a survey at home and that the hospital staff would be delighted if they filled it out. In addition, the patient should be briefed on how this information will be used without asking for a score. Dr. Page added that it is not a "might be", but "you are going to". Ms. Carter added that it is a "might be" because it is a random sample and not 100% of the patients receive the survey in the mail.

Dr. Raju asked about the method used to follow-up on the survey after sending it to the patient. Ms. Carter answered that the inpatient survey is sent to the patient within the discharge week. After 21 days, a follow-up letter is sent to them with another survey asking them to complete the survey. Ms. Carter informed the Committee that 70% of the patients receive that follow-up letter. She noted that surveys conducted for other areas do not receive that secondary follow-up letter.

Dr. Page asked if we are allowed to send the patients home with the survey. Ms. Carter answered that the first time that the patients will be able to see the questions on the survey is when they received the official document in the mail. Dr. Raju explained that according to CMS a gap is needed for the patients to be removed from the system so they may reflect back on their experience and be objective about the services they received. If the patients were to receive the survey while in the hospital, it would be perceived as if a gun is put to their head and all the hospitals would fall in the 99% percentile.

Ms. Carter added that the hand-out methodology is used in a lot of different areas such as inpatient behavioral health and nursing home residents. She explained that because of the confidentiality standpoint, that opportunity is given at discharge. In addition,

there is a whole different process involved. According to Press Ganey, there are different biases built into the mode of a survey, whether it is a hand out methodology or a paper survey. Also, there is a lot of pressure as one may feel that he/she has to answer positively. In addition, there is a mode adjustment for phone surveys. People feel that when the survey is done over the phone, one tends to rate someone higher because you hear a voice, you put a picture of that voice in your mind and feel bad saying something bad. Therefore, a paper survey gives the patients the ability to complete it in their own time, thereby giving them a chance to unbiasedly react and record how they really feel about the survey.

Ms. Maureen McClusky, Senior Vice President of Post-Acute/Long Term Care, interjected that her experience with Press Ganey has been for the survey questions to be shared with the nurses so that they can use the same terminology when addressing the patients. For example, "I am going to talk about your 'discharge planning' right now" so the patient can relate to the question on the survey stating "Did the nurse talk to you about your discharge plan?" They will be able to make the connection and answered positively. By informing the hands-on bedside staff about the survey terminology and using that terminology when addressing the patients, it would not only raise the scores but also improve the response rate. Dr. Raju interjected that it is about connecting the key words.

Mr. Richard Gannotta, Senior Vice President for Hospitals, added that research also indicates that hospitals that have surgical services like open heart surgery, create a different perception. He explained for example, if you save someone's life, even if the experience is poor, you are more likely to get a good score versus dealing with chronic conditions that may have taken a toll on the patient through the course of their lifetime. As big influence varies from hospital to hospital, it is something to think about as you may be comparing yourself to programs that have big surgical services such as saving life programs versus other programs.

Ms. Faust added that in the past, nurses were advised not to use the word pain because it was perceived that using the word would cause patients to think they were in pain. In response, today's younger nurses are cautiously not using the word pain and instead substitute it with the word "discomfort". In support to Ms. McClusky's point, Ms. Faust stated that there is a need to use the word "pain" such as, "Mr. Jones, do you have any pain? How is your pain being managed" because those are the words on the survey. She stressed that using the word pain will not in no way create pain for the patient.

Dr. Page added that while seeing results of the survey is the perfect place to land, if the patient was notified about receiving a survey in the mail and was briefed on how important it is to the facility, it may ring a bell when the patient actually receives the survey in the mail.

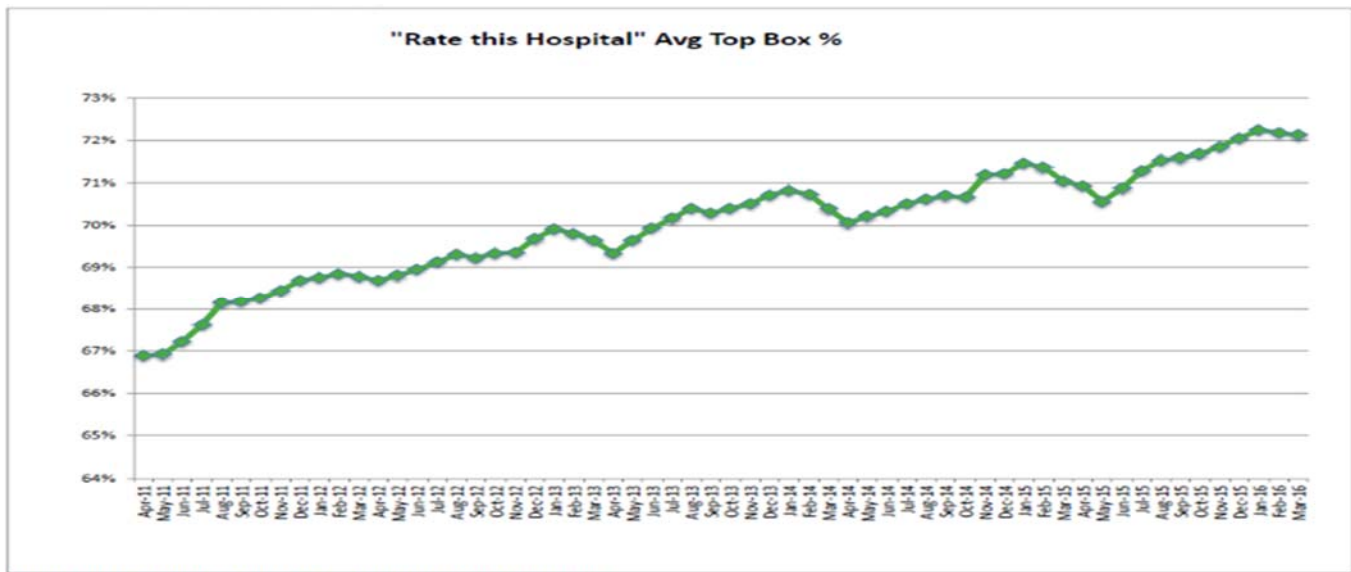
Ms. Carter reported on the different types of surveys conducted. They are listed below:**IN – Inpatient Integrated HCAHPS*****

- **MD – Outpatient Integrated Patient Visit****
- **AS – Ambulatory Surgery**
- **ER – Emergency Department**
- **PY – Inpatient Behavioral Health**
- **HH – Home Health CAHPS***
- **NH – Annual Nursing Home**
- **LTACH – Annual Long Term Care**
- **ACO – Annual Accountable Care CAHPS***
- **PCMH – Annual Patient Centered Medical Home CAHPS***

Ms. Carter reported on the various languages used for the survey as listed below:

- **CAHPS (Hospital Inpatient & Home Health)**
- **CMS approved**
 - English
 - Spanish
- **Russian**
- **Chinese**
- **Non-CAHPS**
 - English, Spanish Russian, Chinese
 - Polish
 - French
 - Arabic
 - Korean
 - Haitian-Creole
 - Hindi
 - Urdu
 - Albanian
 - Bengali

Ms. Faust reported on the Inpatient National Trends as noted on the chart below:



Ms. Faust observed that nationally, the trend is moving up slowly but steadily on a monthly basis. She pointed out that New York State is also moving up slowly and their score is about 65% which is below the national average. As a Board member of the Healthcare Association of New York State (HANYS), Dr. Raju explained that rural hospitals have the top box scores to their advantage because the people they serve know each other. They are either friends, neighbors or relatives. However, in an urban setting this connection does not exist, especially for a four-day length of stay. There is always an urban discrepancy. In addition, Emergency Department patients are more dissatisfied than the individuals that come for elective surgeries. The latter are taken directly to a room while the ED patients may have been lying down on a stretcher for nine hours waiting for a room. Because of the aforementioned reasons, the scores of some of the most populous states like California, New York, Texas and Arkansas are low as opposed to the rural states like Utah and Montana whose scores are in the 99% percentile. Dr. Raju reiterated that payments from the Federal Government are no longer based on volume but value-based purchasing, a large portion of which is based on patient experience. In other words, if we do not score high we are going to lower your reimbursement rate.

Ms. Faust agreed not only with states but also in the large cities from East to West, California and New York do not score as well as the middle of the country. She stated that for the past two quarters, NYC Health + Hospitals has been at 59% of the top box. She noted that it is a drop from the third quarter in October of 2015, which was at 62%.

Mr. Campbell emphasized the importance of the facilities' scorecard. As noted by Ms. Faust, the inpatient top box has dropped down; therefore it is important to look at each individual hospital within the system. Therefore, there is a need to disaggregate the data to see which ones are trending the wrong way versus the ones that are going up. Ms. Carter interjected that several states are at the State, if not already at the national level.

Ms. Judy Chesser, Community Advocate, added that the lack of survey responses is due to the fact that it does not work in a lot of the communities because it is a national survey and that the language used for the survey questions is not something common to their life.

Dr. Raju agreed with Ms. Chesser and confessed that he once was part of the national group that designed these surveys. He informed the Committed that psychologists, not practitioners were consulted to design the questions and agreed that some of them are not understandable. Dr. Raju noted that a large part of the reimbursement will depend on not just how good the quality of care is but also how good the people feel about it. As we are entering a new era in the healthcare industry, this metric is important in the scorecard as it can either make or break the system.

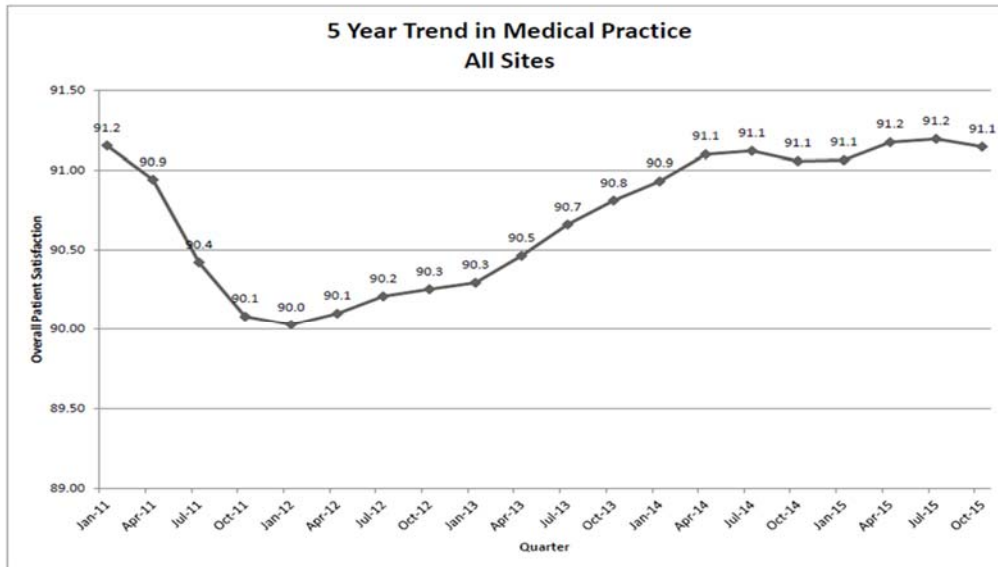
Ms. Carter informed the Committee that other types of surveys are twice as long as the inpatient's survey. Therefore, the use of surveys are not going away but are expanding.

Dr. Page asked if we really believe that hospital care is improving on a trend. Dr. Raju added that it is a perception, not the actual care. It is how the patients perceive the care. Dr. Page asked if it has to do with the art of the survey questions or their perception. Dr. Raju answered by explaining what is meant by "perception". He clarified that to some extent, perception is linked to outcome. However, he added that it also depends on other factors such as: ability to navigate the system quickly, length of time for a CAT scan during cold weather, previous experiences, cleanliness of the bathrooms, etc.

Dr. Page asked Dr. Raju if he believes that perception of the patients overall has steadily improved in US hospitals. Dr. Raju answered both positively and negatively. Positively, not because of the quality of care but because patients' needs are being addressed more than they were ten years ago. For that specific reason, some of the hospitals are adding concierge services to their plan of care just to monitor and ensure that the patients' needs are met.

Mr. Rosen gave the example of a family member who was given a small gift to compensate for the long hours of wait in the Emergency Department. Dr. Raju informed Mr. Rosen that this gesture is called "service recovery." He added that service recovery is given to patients that are not happy with the service provided. An example of a gift given during service recovery is free TV services. Dr. Raju reminded the Committee that hospitals are not only about hospital care but also hotel services.

Ms. Carter reported on the Outpatient National Trends as noted below:



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Ms. Carter stated that because hospitals are penalized for their inpatient scores, they all are working hard to try to make things better in any way they can by including concierge services, room service to their plan of care because at the end of the day they will lose money if the scores are poor.

Mr. Campbell reminded the Committee of Dr. Raju's Vision 2020 goal to reach the 90% percentile of the top box scores.

Mr. Campbell thanked Mr. Tambar and Ms. Carter for their presentations. He requested a copy of the Inpatient Survey that Ms. Carter has agreed to forward to him.

SUBSIDIARY BOARDS REPORTS

HHC Accountable Care Organization Inc. (ACO) - June 6, 2016 **As reported by Dr. Ram Raju**

The Board of Directors of HHC ACO Inc., NYC Health + Hospitals' subsidiary nonprofit Accountable Care Organization, convened on June 6, 2016 to discuss recent ACO-related activities.

Among other matters, the Board discussed the following:

- The Board welcomed its newest participant, the Community Healthcare Network (CHN), which is a network of 11 FQHCs throughout Brooklyn, the Bronx, Queens, and Manhattan. CHN is the first participant in the ACO that is not otherwise affiliated directly with NYC H+H.
- ACO Chief Medical Officer Nicholas Stine provided a presentation of the ACO's performance for Calendar Years 2013, 2014, and 2015 (partial), which demonstrates a reduction of the inpatient admission rate for its attributed population by about 20 percent,

of cost by about eight percent, and of ED visits by about eight percent. The ACO has therefore shown steady improvement in its core operational measures – the reduction of avoidable emergency department visits and hospital admission rates while improving quality.

- The Board discussed the ACO Team Fund to each ACO participant site’s population management team to acknowledge each of the site’s care team’s and practice’s contribution to the ACO’s overall success.

The ACO is undergoing its first instance of separate and discreet auditing, conducted by NYC H+H’s auditors KPMG. Note that the ACO financial statements for 2014 and 2015 have already been audited as part of NYC H+H’s auditing process. While the ACO’s original intent was to perform separate audits of 2014 and 2015 financial results, KPMG recommended to consolidate those years into a single audit. ACO management does not expect any issues of concern to be raised in this audit; the delay in finalization is due primarily to the auditor’s unfamiliarity with the ACO program.

HHC Assistance Corporation/OneCity Health Services - June 6, 2016

As reported by Dr. Ross Wilson

The meeting of the NYCHH Assistance Corporation Board of Directors, d/b/a OneCity Health Services, was held on June 6, 2016 in Room 514 located at 125 Worth Street.

Among other matters, the Board discussed the following:

- Dr. Jenkins, President and Chief Executive Officer of the Corporation presented a report discussing the role of the Centralized Services Organization (CSO) as it relates to the larger NYC H+H governance structure, namely the Audit Committee.
- Dr. Jenkins reported steps that the Performing Provider System (PPS) has taken to prepare for a potential audit from the New York State Department of Health (DOH) for implementation of the Delivery System Reform Incentive Payment (DSRIP) program. Both internal and external audits are scheduled to occur in order to ensure that the CSO and related PPS policies and procedures are intact. Further discussion regarding the role of an independent auditor to carry out the external PPS audit will ensue pending the outcome of the internal audit.
- Dr. Jenkins provided a summary of the DSRIP Year Two CSO budget. In order to align with DOH defined budget categories, the proposed budget has been updated and is formatted differently than the budget originally presented to the Board in October of 2015. In reviewing actual revenue reflected in the DSRIP Year One budget, Dr. Jenkins noted that the PPS had earned \$148.2 million, or 100% of potential earnings. CSO reporting timelines were also adjusted to align with the DOH reporting year for operational ease.
- The Board approved a subsidiary budget increase of \$5,899,411 over the amount previously approved in October of 2015 to a new total of \$26,332,061. The budget increase is due to a shift in expenditures originally accounted for within other categories of the PPS budget.

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

RAMANATHAN RAJU, MD
NYC HEALTH + HOSPITALS PRESIDENT AND CHIEF EXECUTIVE OFFICER
REPORT TO THE BOARD OF DIRECTORS
June 30, 2016

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

NYC Health + Hospitals Appoints New Leadership at NYC Health + Hospitals/Bellevue

Last month NYC Health + Hospitals appointed William Hicks as Chief Executive Officer (CEO) and Michael Rawlings as Chief Operating Officer (COO) of NYC Health + Hospitals/Bellevue. These changes at Bellevue are another step in our system wide effort to develop a new generation of facility leaders focused on financial stability, growth, greater accountability, and above all, bringing excellence to patient experience.

In their previous positions at Bellevue, Bill Hicks and Michael Rawlings developed strong track records of improving protocols and services for the benefit of staff and patients. Both are highly respected by staff and community for their leadership during Superstorm Sandy and our system's response to Ebola.

Mr. Hicks is a health care executive with more than 30 years of experience. He has been serving as acting CEO since February 2016 and served as the hospital's COO since 2013. He understands the patient care perspective and the value of keeping it at the center of his decision-making process. As COO, Mr. Hicks played a lead role in developing the team and protocols that led to the successful treatment of New York's first confirmed Ebola patient in 2014.

As the hospital's Chief Operating Officer, Mr. Rawlings will be in charge of day-to-day management, bringing more than 20 years of experience in facilities management and health care. After the hospital was damaged during Hurricane Sandy in 2012, Mr. Rawlings was among those who led the hospital as it rebuilt its infrastructure and worked closely with the Federal Emergency Management Administration (FEMA) to identify and develop mitigation plans and strategies to protect the hospital from future storms. Mr. Rawlings joined NYC Health + Hospitals/Bellevue in 2009 and most recently served as Senior Associate Executive Director of Facilities Management.

We are confident that Bill Hicks and Michael Rawlings will supply the leadership necessary to meet the changing needs of Bellevue patients. We welcome them to their new roles.

JOINT COMMISSION VISIT TO METROPOLITAN

Earlier this month, Metropolitan hosted a successful four-day survey from The Joint Commission. The surveyor's preliminary report is quite positive, complimenting Metropolitan staff on dedication to patients and families, a clear commitment to safety and quality care, and especially, teamwork. Surveyors mentioned the warm welcome they received on the units they visited. Almost all pointed out the spirit of camaraderie that staff share across departments. Congratulations to Anthony Rajkumar and everyone at Metropolitan on this effective and successful team effort.

HARLEM BEHAVIORAL HEALTH NAMI WALK

NYC Health + Hospitals Behavioral Health staff participated in the 2016 National Alliance on Mental Illness (NAMI) Walk in honor of National Mental Health Awareness Month. Program members and various staff totaling 35 individuals walked across the Brooklyn Bridge, earning \$1,500.00.

LGBTQ PRIDE MARCH

Last Sunday I was delighted to join a contingent of several hundred NYC Health + Hospitals employees, friends and family members as we walked under our "We Are An Ally" banner at New York City's annual Pride March. The event gave us a great opportunity to show solidarity with LGBTQ patients and staff, and a chance to highlight the array of specialized services we provide community members at our welcoming, non-judgmental locations across the five boroughs. I couldn't have been more pleased to see so many members of our Health + Hospitals family in attendance---as you can see from the brief slideshow.

NYC HEALTH + HOSPITALS' EXTENDS SUPPORT FOR ORLANDO

We also brought a special banner to the Pride parade --- on display here in the board room --- thanking the Orlando Regional Medical Center trauma care team for their heroic efforts after the tragic mass shooting on June 12. Many of our staff signed the banner with messages of support and solidarity, and we invite board members to sign this afternoon. We will send the

banner to ORMC next week along with a letter from our system and a token of appreciation and comfort ---New York City bagels--- for their staff.

Additionally we have posted individual group photos on social media of our ED teams with hand-held signs that say #OrlandoStrong, along with a message expressing our support of our counterparts at ORMC.

And The Fund for NYC Health + Hospitals (and its Guns Down, Life Up program) is in discussions with ORMC's trauma care leadership to offer technical assistance and help Orlando establish Guns Down Life Up and Circle of Safety hospital-based violence-reduction initiatives.

BREAKTHROUGH UPDATE

Major Service Lines/Emergency Services update

In the five facilities where Breakthrough is deployed: NYC Health + Hospitals/Bellevue, NYC Health + Hospitals/Jacobi, NYC Health + Hospitals/Kings County, NYC Health + Hospitals/Metropolitan, and NYC Health + Hospitals/ Woodhull (NYC Health + Hospitals/Queens' data is unavailable due to EPIC deployment), the average length of stay (LOS) has been decreasing and/or is below the target of a median LOS of 131 minutes for the past three months.

Major Service Lines/Behavioral Health update

At NYC Health + Hospitals/Kings County the total revenues for Adult, Child Adolescent and PHP services has increased by 16% since Breakthrough started multiple improvements to revenue capture. In addition, the number of bed days over 15 days per patient (15 days is point that Kings County Behavioral Health begins losing money) were reduced by 870 days. The total new revenues and cost savings during January-May, 2016 was \$626,635.

Earlier this month Breakthrough sponsored an informative visit by Kim Barnas, author and former CEO of ThedaCare, to Kings County Adult Primary Care, Pediatrics, ED, Behavioral Health – Primary Care Clinic. All four areas are very engaged in efforts to become continuous improvement organizations.

Leaders, managers and front line staff at Kings County Behavioral Health demonstrated the level of engagement and pride they have in the work they do to continuously improve their processes. The challenges they confront daily, and their commitment to providing patients with quality care, is the subject of an article authored by a number of Kings County clinicians in the December 2015 issue of the Journal of Family Medicine. Congratulations to Susan Whitley, MD – Director of Chemical Dependency Services at Kings County, David Estes, MD – Attending Physician and Director of the Primary Care clinic at Kings County, Michele McKenzie – Breakthrough Office, Keyvon Salimi – Behavioral Health Department at Kings County, Bassem Barada – Quality Department at Kings County; Joseph Merlino, MD – Department of Psychiatry SUNY Downstate.

DSRIP UPDATE

There is a lot of positive activity occurring in our DSRIP effort, with ongoing clinical project implementation happening across the entire OneCity Health network. I just want to highlight one item today:

In an effort to put mental health and substance abuse prevention and early identification into 100 middle and high schools throughout New York City, OneCity Health, in conjunction with three other Performing Provider Systems, announced a Request for Information to identify a Behavioral Health Agency to help implement the project.

For palliative care integration into the PCMH, we are continuing to provide simple advance care planning at 12 NYC Health + Hospitals neighborhood health centers and acute care facilities. We plan to expand the project to four additional NYC Health + Hospitals facilities in July.

Forty of our community partners and NYC Health + Hospital facilities are continuing to engage patients with Patient Activation Measure (PAM®) surveys as part of Project 11. We are also beginning to develop a care management tool, as well as design operational processes to link uninsured New Yorkers and low- and non-utilizers of Medicaid to primary care and social services.

For our work with both palliative care and Project 11, we remain cautiously optimistic about meeting all commitments made to the Department of Health for the June 30 deadline, which is the end of the first quarter of DSRIP Demonstration Year Two.

For Care Transitions planning, which focuses upon hospital readmissions reduction by providing a supportive transition to the community for appropriate patients, Transition Managers are receiving patient referrals at two NYC Health + Hospitals facilities. In total, we have hired eight Transition Managers, and pilots will begin at two more facilities soon.

We plan to begin our first Health Home At-Risk pilot in July, in which the objective is to extend care management services equivalent to the New York State Health Home program. Planning for additional pilots continues at two NYC Health + Hospitals sites.

In order to begin the Integration of Primary Care and Behavioral Health Services, we recently concluded a survey of our primary care partners to better understand their current capabilities, resource needs and potential barriers. Implementation planning has begun at two NYC Health + Hospitals facilities.

ED Care Triage implementation planning continues at four NYC Health + Hospitals facilities, which begins the effort to connect patients with primary care from the Emergency Department.

Our asthma home-based self-management work also continues at both select NYC Health + Hospitals and community partner sites.

In September, we plan to submit to the NYS DOH a training roadmap to support the workforce of NYC Health + Hospitals and OneCity Health partner organizations in transformation. The roadmap reflects the hiring, training and potential redeployment requirements to meet estimated workforce needs in year 2020 and reflects the results of a baseline workforce survey (current state) and projections of workforce demand made through microsimulation modeling. In order to review and receive input on the document with as many stakeholders as possible, we moved our internal deadline from June 30th to September 30th without sacrifice of commitments made to DOH under the DSRIP program.

To complete the survey, we formed a consortium with three other NYC Performing Provider Systems – those led by St. Barnabas, NYU/Lutheran and Maimonides – and contracted with consultant firm BDO in order to complete the analyses with reliable methodology on a short timeline. Our labor partners from NYC Health + Hospitals, SUNY Downstate and other partner organizations have been engaged in our efforts since inception.

THE FUND FOR NYC HEALTH + HOSPITALS UPDATE

2016 Guns Down, Life Up Assembly

On June 8, The Fund for NYC Health + Hospitals hosted the third annual Guns Down, Life Up™ Assembly, bringing together a packed house of violence-reduction activists, representatives from community-based organizations, advocates, survivors, and numerous stakeholders from across the city in a deep examination of violence as a public health issue. Almost 300 people representing 60 organizations participated in interactive sessions in a “world café” format, which tasked groups with working collaboratively to identify and prioritize root causes of violence in urban neighborhoods, and then to construct strategies to address the causes.

Of special note was the extensive participation of youth, many of whom came to the Assembly through their involvement with Guns Down, Life Up teams at NYC Health + Hospitals / Harlem, NYC Health + Hospitals / Kings County, or other related programs. Manhattan Borough President Gale Brewer opened the day by issuing a proclamation in observance of The Fund’s role in Gun Violence Awareness Month. The Borough President was followed by former NYC Health + Hospitals / Harlem Executive Director Dr. John Palmer who delivered a thought-provoking keynote presentation, drilling down to illuminate the realities of gun violence in NYC.

Other speakers included, NYC Health + Hospitals President and CEO Dr. Ram Raju, Cleveland City Councilman Zack Reed, who has adopted the Health + Hospitals violence reduction in his home city, Ivo Philpott, Executive Director of the Jackie Robinson Foundation, Dr. Aletha Maybank, Associate Commissioner, NYC DOHMH – Center for Health Equity, and Jackie Rowe-Adams, Executive Director of Harlem Mothers S.A.V.E., whose closing presentation drew sustained applause and support as she summoned feelings of loss and anger that follow the loss of children to violence. Adding a vivid punctuation to the day was a flash mob, along with musical performances by students who had been inspired by GDLU’s message.

According to The Fund’s Executive Director Joe Schick, the assembly was designed to create an opportunity for people who work to reduce violence to come together, network, step back, and reflect on gun violence and the importance of what they do. The interactive format offered a chance to build a discourse around their experiences and to deepen and align strategies that will push forward resolutions to bring down gun violence in our city. The mass shooting in Orlando just a few days after the assembly however, tragically reinforces the need to ensure that all communities are free from violence, and strengthening our resolve to end gun violence and its heartbreaking cost.

Art of Giving

The Art of Giving is a collaborative project between the United Federation of Teachers (UFT), Division of Elementary Schools, The Fund for Health and Hospitals and NYC Health + Hospitals sites. It was inspired by the late Sharon Coates, a UFT member and teacher at PS 156 in Brooklyn. During her hospitalization, Sharon said, "Seeing the children's artwork on the walls lifted my spirits." That first Art of Giving installation was at NYC Health + Hospitals / Carter in June 2015.

Now, The Fund looks to keep this idea alive and spread this concept throughout the enterprise. Thirteen students of PS 18 in the Bronx, under the direction of their art teacher, Zoila Cordova, created beautiful works of art. These kindergarteners' framed artwork was generously donated to Lincoln as their Art of Giving community service project. The Fund wishes to express its appreciation to UFT's Ina Babb-Henry for her support and guidance with this project.

Ruth's Dream Exhibit at Bellevue

On Thursday, June 23 The Fund for NYC Health + Hospitals, NYC Health + Hospitals / Bellevue, and Duggal Visual Solutions, presented Ruth's Dream, an exhibition of the monumental flower photography of artist Ruth Litoff.

Ms. Litoff was a patient of Bellevue's behavioral health services, whose life was marked by brilliant creativity and frequent hospitalizations for mental health issues. Years after her tragic suicide, her sister discovered her journals and undertook to fulfill one of Ruth's last wishes -- to show a collection of her photos at Bellevue, where she felt strongly she had received the most compassionate and best care for her illness. The exhibit -- an illuminated photographic field of flowers -- both honors her wish and enables Bellevue to open an inspiring conversation about art, healing, and mental illness. This installation of the exhibit and the opening event, which drew more than 200 people, was filmed for a feature documentary about Ruth's beautiful legacy. The exhibit will run through August 7.

PROGRAM OF THE MONTH CORRECTIONAL HEALTH SERVICES

A year ago the Mayor asked us to roll up our sleeves and take over responsibility for health care in the city's correctional system. This was --- and remains ---- a difficult assignment, adding patients who are among the neediest and most vulnerable in New York City.

But I am proud to say that our team stepped up and is delivering. We are extending our mission by improving the quality of care not just for the people inside the city's jails, but also for those returning to their communities.

Six months after the formal transfer of authority, and with the same resources, we have already set in motion comprehensive reforms in the way health care is delivered within the correctional system:

We are building a work force that is skilled, engaged, and absolutely committed to providing the best care for the 55,000 men and women who move through the jails each year.

We have improved our operations to:

- - Coordinate incident and complaint investigations
- - Provide prompt responses to all patient requests.
- - Set new standards for accountability, productivity and safety.
- - Establish a dedicated office for clinical quality improvement, and
- - Integrate mental health and discharge planning staffs into a unified professional psychiatric social work service.

And we are committed to developing and pursuing innovations in the services we provide.

- - We've increased continuity of care by linking with MetroPlus, Gotham Health, Health Home, Bellevue, Home Health, and our post-acute facilities.
- - We have launched a telehealth program -- the first ever in the Health + Hospitals system.
- - And last month we opened our CHS Assistance Center, a one-stop location near Rikers Island to connect our former patients and their families to services in the community.

Just this week one of our new CHS initiatives---this one concerning opioid overdose treatment--- received great notice by New York 1's Inside City Hall:

Please join me in commending our Correctional Health Services team for the necessary and vital work they are doing, and in welcoming members of the division who join us today:

Dr. Patsy Yang, Senior Vice President
Dr. Homer Venters, CMO
Patrick Alberts, Senior Director for Policy and Planning
Elizabeth Ward, Senior Director for Operations
Carlos Castellanos, Director of Operations
Levi Fishman, Associate Director of Public Affairs

PERSONS OF THE MONTH

GEORGE STRACHAN

PAUL ROBINSON

It is only fitting that this month that we honor two key employees of Correctional Health Services.

George Strachan started his career in 1985 as a corrections officer. He spent the next 19 years gaining expertise in helping inmates struggling with mental illness, HIV/AIDS, and many other health problems. His deep commitment to these patients eventually led him to a career in health services.

This year George was identified as the single best person to execute our intensive focus on patient and staff safety. As Correctional Health Services' first ever Safety Officer he has almost singlehandedly taken on the daunting challenge of building our safety and workplace violence prevention program from the ground up.

George is responsible for safety assessments in each CHS facility, and for verifying that our partners at the Department of Correction have addressed deficiencies.

He has developed strong relationships with all four health unions and with the Correctional Officers Benevolent Association. George participates in union safety meetings and has been working to strengthen and integrate our workplace violence prevention program.

While the medical and mental health staff provide patients with a community standard of care, it is George's critical work that allows clinic staff to have the same safety expectations you would find in any NYC Health + Hospitals facility.

Paul Robinson has been a champion for the rights of patients in the corrections system for 34 years, working in multiple jails across the city.

When the Department of Correction opened punitive segregation units in the late 1990's, Paul helped ensure that those in solitary confinement had their medical needs met.

His reputation as a talented communicator and problem solver led to his current assignment as the Health Services Administrator in the George R. Vierno Center, one of the most challenging jails on Rikers Island.

Paul has longstanding relationships on the local level with the Board of Correction and with the National Commission on Correctional Health Care. He excels at anticipating issues, and at developing strategies to address problems that arise quickly. He is devoted to patients and staff, constantly going above and beyond to make sure everyone has what they need to deliver high quality care to the patients within his charge.

We are grateful for the commitment, effectiveness and dedication of George Strachan and Paul Robinson. Please join me in congratulating and welcoming them both, along with their families.

RESOLUTION

Adopting in the name of the New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) Board of Directors the twelve Community Health Needs Assessments (“CHNA”) prepared for each of NYC Health + Hospitals’ eleven acute care hospitals and for the Henry J. Carter Specialty Hospital and Rehabilitation Center (“HJC”).

WHEREAS, NYC Health + Hospitals operates eleven acute care hospitals and HJC, a long term acute care hospital; and

WHEREAS, NYC Health + Hospitals has 501(c)(3) tax exempt status under the Internal Revenue Code; and

WHEREAS, The Patient Protection and Affordable Care Act, signed into law in 2010 (the “Affordable Care Act”), added to the Internal Revenue Code Section 501(r)(3) which requires that hospitals with 501(c)(3) tax status conduct a CHNA at least once every three years; and

WHEREAS, regulations adopted under the Affordable Care Act specify that a CHNA be prepared for each licensed facility operated by hospital organizations enjoying 501(c)(3) status; and

WHEREAS, on May 30, 2013 the NYC Health + Hospital’s Board of Directors approved the Implementation Strategies that are responsive to the findings of the CHNAs conducted by for the eleven acute care hospitals and HJC; and

WHEREAS, NYC Health + Hospitals has conducted CHNAs summaries of which are attached as Exhibit A; and

WHEREAS, under the Affordable Care Act, a hospital organization’s governing body or a committee authorized by the governing body must adopt the CHNA.

NOW, THEREFORE, BE IT

RESOLVED, that the New York City Health and Hospitals Corporation’s Board of Directors hereby adopts the twelve Community Health Needs Assessments prepared for each of NYC Health + Hospitals’ eleven acute care hospitals and for the Henry J. Carter Specialty Hospital and Rehabilitation Center

EXHIBIT A

COMMUNITY HEALTH NEEDS ASSESSMENT - 2016 UPDATE

EXECUTIVE SUMMARY

Purpose of the Community Health Needs Assessment

This 2016 Community Health Needs Assessment (CHNA) updates the CHNA completed in 2013 to meet the requirements of Section 9007 of the 2010 federal law, The Affordable Care Act (“ACA”). The ACA requires that any tax-exempt, IRS-designated 501(c) (3) hospital complete or update a publicly-available, comprehensive CHNA every three years in order to document the extent to which it understands the unique characteristics and needs of the local communities it serves, and responds to these needs by delivering meaningful and effective community benefit through clinical services and other programming.

Required Components

A CHNA report has five required components:

- 1) Definition of community served
- 2) A prioritized description of the significant health needs of the community
- 3) Transparency in the process and methods used to conduct the CHNA, including how it took into account input from the community served and prioritized community health needs
- 4) A description of the resources potentially available to address the identified significant prioritized community health needs
- 5) An evaluation of the impact of actions taken to address the significant health needs identified in the previous CHNA report (June 2013).

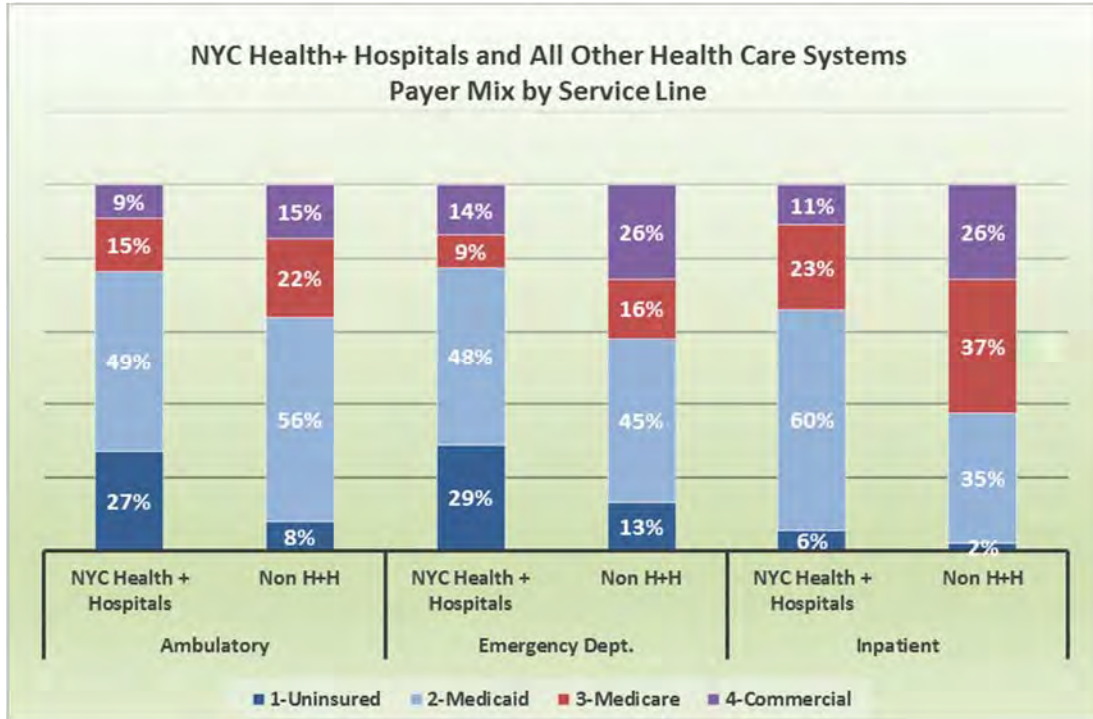
A CHNA report is considered complete when it is adopted by a governing body of the facility and made widely available to the public.

Community Served

NYC Health + Hospitals serve all New Yorkers in every neighborhood in New York City regardless of their ability to pay. Addressing disparity throughout New York City, NYC Health + Hospitals is *the* safety-net for the uninsured and underserved in New York City.

As a share of its total volume, NYC Health + Hospitals provides three times greater share of ambulatory care to the uninsured than other New York City hospitals (27% and 8%, respectively) and twice as many ED visits (29% and 13%, respectively). Medicaid and uninsured patients together account for nearly twice as many hospital stays compared to other New York City hospitals (66% and 37%, respectively) (chart 1).

Chart 1: NYC Health + Hospitals Payer Mix by Service



Sources and notes: 2014 Hospital Institutional Cost Report, 2014 DTC Cost Report for HHC using internal data, and 2013 Health Center Cost Report for all other DTCs. Includes all NYC acute, general care hospitals and related wholly owned or controlled community health centers, including HHC DTCs. Discharges exclude normal newborns. ED visits include treat and release, and visits that result in admission. Clinic visits include comprehensive care and primary care visits only.

The service area of individual hospitals in the NYC Health + Hospitals System are identified in Appendix 1. A description of these communities, including demographic characteristics identifying vulnerable populations such as disabled and residency status; and health status such as chronic disease prevalence and the rate of potentially avoidable emergency health care use, is in Appendix 2.

Process and Methods

The process and methods was designed collaboratively by a work group of facility planning directors and other representatives.

The community served by each acute care facility is defined as the geographic area in which 75% of its ambulatory care patients reside. An initial list of over 40 health needs were identified based on a review of published literature and internal analyses that have been made publically available including the 2013 CHNA and the DSRIP Community Needs Assessment. Incorporating input from other facility representatives and pilot tested with hospital users, this list was refined to 13 community health needs. Input from facility users (approximately 150 per facility were surveyed), Community Advisory Boards, facility leadership, and the prevalence of these health needs within the community were blended together to prioritize the health needs. The five highest priority community needs were considered *significant*.

Prioritized Significant Community Health Needs

All 13 identified community health needs were identified as important within the hospitals’ communities according to community input. Those considered most significant and their priority order in accordance with regulatory requirements are indicated in blue in the table below. Hypertension/high blood pressure and diabetes are significant community health needs at all hospitals; obesity and heart disease are significant at the majority of hospitals (Chart 2).

Chart 2: Community Health Need by Hospital

	Bellevue	Carter	Coney Island	Elmhurst	Harlem	Jacobi	Kings County	Lincoln	Metro-politan	NCB	Queens	Woodhull
Hypertension/ High Blood Pressure	1	1 (tie)	4	2	1	1	2	1	2	2 (tie)	2	1
Diabetes	5	1 (tie)	1	1	2 (tie)	3	1	3	1	2 (tie)	1	3 (tie)
Obesity	2 (tie)	4 (tie)	6	4 (tie)	9	4	6	6	3	4	5	3 (tie)
Heart Disease, High Cholesterol, Stroke	2 (tie)	3	2 (tie)	4 (tie)	8	5 (tie)	4	4 (tie)	5	6	10 (tie)	5
Mental Illness	4	6 (tie)	8 (tie)	4 (tie)	6	5 (tie)	3	10 (tie)	9	5	3 (tie)	6
Alcohol and/or Drug Use	6	9	10	7	5	9	7 (tie)	2	7	9	6 (tie)	2
Asthma and Other Breathing Issues	8	6 (tie)	8 (tie)	12	2 (tie)	2	9	4 (tie)	4	1	13	7 (tie)
Cancer	7	10	2 (tie)	3	11	8	5	9	8	7	8 (tie)	11
Smoking	11	6 (tie)	5	8	4	7	12	7	12	8	3 (tie)	10
Violence	10	12 (tie)	11	9	10	10	10	8	6	10	6 (tie)	7 (tie)
HIV/AIDS, Hepatitis, STDs	9	11	13	10	7	11	7 (tie)	10 (tie)	10	11	12	7 (tie)
Dementia	12	4 (tie)	7	11	12 (tie)	12	13	12	11	12	10 (tie)	12 (tie)
Premature Births, Low Birth Weight	13	12 (tie)	12	13	12 (tie)	13	11	13	13	13	8 (tie)	12 (tie)

Comparison of 2013 and 2016 Significant Community Health Needs

Most of the significant community health needs identified in 2013 were again identified in 2016. In both 2013 and 2016, a large number of hospitals identified diabetes, hypertension/high blood pressure, heart disease, obesity, mental illness and asthma as a significant community health need.

HIV/AIDS and other infectious diseases were considered a significant community health need at five hospitals in 2013, but none considered it among their most significant in 2016. A decrease in importance is consistent with the continued progress in reducing HIV/AIDS diagnoses and deaths in NYC.

Other changes in health needs between 2013 and 2016 are partly attributable to changes in federal requirements regarding methodology (see Process and Methods).

Significant Community Health Needs Identified in 2016 and 2013

	Significant Community Health Needs	
	Number of Hospitals Identified in 2016	Number of Hospitals Identified in 2013
Diabetes	12	12
Hypertension / High Blood Pressure	12	10
Heart Disease, High Cholesterol, Stroke	9	10
Obesity	8	8
Mental illness	6	10
Asthma and other Breathing Issues	5	5
Alcohol and/or Drug Use	3	9
Cancer	3	6
Smoking	3	1
Dementia	1	1
HIV/AIDS, Hepatitis, STDs	0	5
Violence	0	2
Premature Births, Low Birth Weight	0	1

Resources Potentially Available

Appendix 4 is a listing of health and social service organizations available to members of low-income, medically underserved, and other minority populations in the neighborhoods included in the primary service area of NYC Health + Hospitals,

by borough and sorted by neighborhood. These populations may experience health disparity or are at risk of not receiving medical care as a result of being uninsured or underinsured or due to geographic, language, financial, immigration status, or other barriers. Organization services provided are arranged accordingly into the following categories: Dental, Vision, Adult Day Health, Health center, Insurance enrollment, Home Health, Hospital, Nursing Home, Prescription Drug, Immigration Support, Mental Health-Inpatient, Mental Health-Ambulatory, Substance Use, Social Services, Financial Assistance, and Wellness/Prevention.

Evaluation of 2013 Implementation Plan

NYC Health + Hospitals evaluated each hospital's 2013 Implementation Plan and the impact of specific interventions that addressed identified health care needs (Appendix 3). Included in the evaluation is a list of the significant health needs identified in 2013, a description of the planned activities that addressed each of the health needs, an indication whether the planned activity was implemented, the target population and goal of the activity, and the impact or outcome of the activity.

2016 Implementation Strategy

The 2016 CHNA Implementation Strategy due in November 2016 will be designed to address the prioritized significant community health needs identified in the 2016 CHNA and must be adopted by the hospital's governing body.

The NYC Health + Hospitals Board of Directors' approval of the twelve hospitals' Community Health Needs Assessment at its June 2016 meeting will enable the hospitals in the NYC Health + Hospitals system be in compliance with the mandated deadline of June 30, 2016.

Full assessments of each facility are available at the link below:

<http://www.nychealthandhospitals.org/hhc/html/about/About-PublicInfo-CHNA.shtml>

RESOLUTION

Authorizing NYC Health + Hospitals ("System") to negotiate and execute a Physician Services Agreement with the State University of New York/ Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at NYC Health + Hospitals/ Kings County ("KCHC") and NYC Health + Hospitals/ Coney Island ("CIH") for a period of four years, commencing July 1, 2016 and terminating on June 30, 2020, for an amount not to exceed \$86,659,516;

AND

Further authorizing NYC Health + Hospitals to make adjustments to the contract amounts, providing such adjustments are consistent with the System's financial plan, professional standards of care and equal employment opportunity policy except that the System will seek approval from the Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the not to exceed amount identified in this resolution.

WHEREAS, the System has for some years entered into agreements pursuant to which various medical schools, voluntary hospitals and professional corporations provided General Care and Behavioral Health Services at System facilities; and

WHEREAS, the current Physician Services Agreement with SUNY/HSCB to provide General Care and Behavioral Health Services at KCHC shall expire on June 30, 2016; and

WHEREAS, the System, in the exercise of its powers and fulfillment of its corporate purposes, now desires that SUNY/HSCB continue to provide General Care and Behavioral Health Services at KCHC and begin to provide services at CIH; and

WHEREAS, the overall responsibility for monitoring the contract shall be under the Executive Vice President and Chief Operating Officer.

NOW, THEREFORE, BE IT

RESOLVED, that NYC Health + Hospitals ("System") is hereby authorized to negotiate and execute a Physician Services Agreement with the State University of New York/ Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at NYC Health + Hospitals/ Kings County ("KCHC") and NYC Health + Hospitals/ Coney Island ("CIH") for a period of four years, commencing July 1, 2016 and terminating on June 30, 2020, for an amount not to exceed \$86,659,516;

BE IT FURTHER RESOLVED, that NYC Health + Hospitals is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the System's financial plan, professional standards of care and equal employment opportunity policy except that the System will seek approval from the Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the not to exceed amount identified in this resolution.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) to execute a contract with Deloitte Consulting, LLP to provide implementation services for the PeopleSoft Enterprise Resource Planning (“ERP”) System. The contract will be for a term of three (3) years with two one-year options to renew exercisable solely by NYC Health + Hospitals for an amount not to exceed \$18,203,795 during the initial three-year term.

WHEREAS, NYC Health + Hospitals’ financial management applications currently in operation are over 30 years old and require upgrades, and consisting of five different software vendors and home grown systems to support NYC Health + Hospitals’ healthcare programs; and

WHEREAS, NYC Health + Hospitals’ financial management applications do not integrate with NYC Health + Hospitals’ procurement management or human resources systems; and

WHEREAS, without an ERP system joining together NYC Health + Hospitals’ disparate financial, procurement and human resource systems, NYC Health + Hospitals will be required to maintain outdated interfaces and systems; and

WHEREAS, NYC Health + Hospitals requires an ERP system to replace other independent financial systems and to integrate them with procurement and human resources functions corporate-wide; and

WHEREAS, a solicitation was issued to 27 vendors, that included 8 vendors that hold a third party contract (“TPC”) and the 19 EITS IT requirements vendors and Deloitte Consulting LLP was selected by the evaluation committee as its proposal offers NYC Health + Hospitals the best combination of technical ability, approach and price based on the evaluation factors set forth in the solicitation; and

WHEREAS, the overall responsibility for monitoring the contract shall be under the Senior Vice President of Finance, the Senior Vice President/Chief Information Officer and the Vice President Supply Chain Services.

NOW, THEREFORE, be it

RESOLVED, THAT the New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) be and hereby is authorized to execute a contract with Deloitte Consulting, LLP to provide implementation services for the PeopleSoft Enterprise Resource Planning (“ERP”) System. The contract will be for a term of three (3) years with two one-year options to renew exercisable solely by NYC Health + Hospitals for an amount not to exceed \$18,203,795 during the initial three-year term.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "Health Care System") to execute a five-year lease extension with UE Forest Plaza, LLC (the "Landlord") for 1,975 square feet of space at 2040 Forest Avenue, Borough of Staten Island to house the Mariner's Harbor Houses Family Health Center, operated by Coney Island Hospital (the "Facility") at a base rent of \$32.50 per square foot to be escalated by 3% per year and a common area maintenance charge of \$2.74 per square foot or \$5,412 per year and real estate taxes in the amount of \$6.97 per square foot or \$13,764 per year for a five year total of approximately \$436,665.

WHEREAS, in 2006, due to the poor physical condition and the unfeasibility of upgrading and expanding the Mariner's Harbor Children and Adolescents Health Center located at 142 Brabant Street, the program moved to its present location at 2040 Forest Avenue; and

WHEREAS, in May 2006 the Board of Directors authorized the President to enter a lease with the Landlord and in May 2011 a five year extension was authorized; and

Prior to the Health Care System's occupancy in 2006, Saint Vincent's Catholic Medical Center/Staten Island Division operated a clinic at 2040 Forest Avenue; and

WHEREAS, relocating the program to 2040 Forest Avenue has allowed the Facility to continue to provide needed services to the medically underserved population of Mariner's Harbor in Staten Island; and

WHEREAS, the responsibility for the clinic's operations and the proposed lease will rest with the Senior Vice President for Hospitals and the Chief of Ambulatory Care.

NOW, THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation be and hereby is authorized to execute a five-year lease extension with UE Forest Plaza, LLC for 1,975 square feet of space at 2040 Forest Avenue, Borough of Staten Island to house the Mariner's Harbor Houses Family Health Center, operated by Coney Island Hospital at a base rent of \$32.50 per square foot to be escalated by 3% per year and a common area charge of \$2.74 per square foot or \$5,412 per year and real estate taxes in the amount of \$6.97 per square foot or \$13,764 per year for a five year total of approximately \$436,665.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute a five year revocable license agreement with the American Cancer Society, Eastern Division, Inc. (the "Licensee") for its continued use and occupancy of 120 square feet of space on the campus of Queens Hospital Center and 120 square feet of space on the campus of Elmhurst Hospital Center (the "Facilities) to provide non-clinical patient support services with the occupancy fee waived.

WHEREAS, in June 2013, the Board of Directors authorized the President to enter into a license agreement with the Licensee; and

WHEREAS, the annual cancer incidence in the Borough of Queens is over 9,000 cases, and cancer is among the leading causes of death for adults aged 25 to 64 in nearly all Queens neighborhoods; and

WHEREAS, the Licensee will make its Patient Navigation Program available to patients and staff at the Facilities; and

WHEREAS, the goal of the Licensee's Patient Navigation Program is to provide access to quality educational materials, support service referrals, and other resources for the medically underserved cancer patient population and their caregivers; and

WHEREAS, the Licensee's program shall enhance the continuum of care and treatment provided by the Facilities to patients diagnosed with cancer.

NOW, THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation be, and hereby is, authorized to execute a five year revocable license agreement with the American Cancer Society, Eastern Division, Inc. (the "Licensee") for its continued use and occupancy of 120 square feet of space on the campus of Queens Hospital Center and 120 square feet of space on the campus of Elmhurst Hospital Center (the "Facilities") to provide non-clinical patient support services with the occupancy fee waived.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) to execute an agreement with The Boston Consulting Group (“BCG”) to provide consulting services to guide the structure and early operations of the NYC Health + Hospitals’ Transformation Office over a six month term for a cost not to exceed \$3.65 Million with two six-month options available exclusively to NYC Health + Hospitals for total amount not to exceed \$10.95 Million.

WHEREAS, Mayor Bill de Blasio issued a report in mid-April 2016 titled “One New York; Health Care for our Neighborhoods: Transforming Health + Hospitals (the “Report”) that identifies four high level goals to reform NYC Health + Hospitals to manage its looming fiscal crisis while meeting the critical health care needs of New Yorkers and twelve strategies that NYC Health + Hospitals should pursue to achieve the stated goals;

WHEREAS, in view of the enormity and the urgency of the reform task presented by the Report, NYC Health + Hospitals has established a Transformation Office within the Office of the President to coordinate and drive the reform agenda; and

WHEREAS, in further recognition of challenges presented by the Report and of quickly staffing and structuring the Transformation Office, NYC Health + Hospitals conducted a competitive procurement process among nationally known contractors familiar with the dynamics of urban safety net hospitals available through third party contracts (City, State or Group Purchasing contracts); and

WHEREAS, among the several firms that responded to NYC Health + Hospitals’ solicitation, BCG was selected as the one best able to meet the needs of the reform project; and

WHEREAS, the Transformation Office within the Office of the President will be responsible for managing the proposed BCG contract.

NOW THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) to execute an agreement with The Boston Consulting Group to provide consulting services to guide the structure and early operations of the NYC Health + Hospitals’ Transformation Office over a six month term for a cost not to exceed \$3.65 Million with two six-month options available exclusively to NYC Health + Hospitals for total amount not to exceed \$10.95 Million.

EXECUTIVE SUMMARY

CONSULTING AGREEMENT WITH THE BOSTON CONSULTING GROUP

- OVERVIEW:** The report titled “One New York; Health Care for our Neighborhoods: Transforming Health + Hospitals (the “Report”) issued in April 2016 identified a looming fiscal crisis for NYC Health + Hospitals and recommended that four high level goals be pursued through twelve strategies. At the same time, NYC Health + Hospitals is heavily engaged in the reform initiatives mandated and encouraged through the State DSRIP program and is also pursuing its own plan to dismantle its former Network structure in favor of one organized around a service line reporting structure. Each of these separate initiatives pose enormous challenges and integrating and coordinating them is crucial. Recognizing these challenges, NYC Health + Hospitals has established an Office of Transformation within the Office of the President to coordinate and drive the reform agenda. That office is now being staffed. Given the enormous body of work facing the Transformation Office and its nascent state, NYC Health + Hospitals engaged in a competitive procurement process to find a suitable consulting firm to assist the Transformation Office in its work. The Boston Consulting Group (“BCG”) was selected from among several highly qualified possibilities.
- PROGRAM:** The work of BCG will be to identify staffing needs, establish an internal structure for the Transformation Office, help develop conceptual work plans for its different work streams, create reporting structures and templates for the engaged divisions within NYC Health + Hospitals to report to the Transformation Office and for the Transformation Office to report to the President, the NYC Health + Hospitals Board and to the Mayor. Furthermore, as the Transformation Office begins its work, BCG will continue to provide support and advice particularly in the areas of data collection, analysis and reporting and strategic planning.
- THE OPTIONS:** While it is expected that, at the end of the initial six month term, BCG will have completed its work to stand up the Transformation Office so that it is a functioning unit engaged in the critical work with which it is tasked, it is not possible at this early juncture to predict with certainty what additional support the Transformation Office may benefit from to perform at the speed and level required by the circumstances, especially as it delves in the complex areas of program and delivery system redesign. It is prudent to give NYC Health + Hospitals the options to draw upon continued BCG services as may be appropriate. Accordingly the proposed agreement gives exclusively to NYC Health + Hospitals the right to call upon two six-month options. NYC Health + Hospitals will be under no obligation to exercise either of such options and it is expected that, if either were to be exercised, it would be based on a refinement of the scope of the services to be performed during the option term and the specific deliverables.
- PROCUREMENT:** BCG was procured as a Third Party Contract under the rules of Operating Procedure 100-5. This approach was available because BCG has current contracts with NYC EDC and with NYC HRA. The OP requires a due diligence exercise to validate the proposed contract award. The due diligence performed here consisted

in an informal request for proposals sent to five nationally recognized consulting firms with experience in the relevant field. One of the firms contacted (KPMG) opted not to submit because the proposed work would be inconsistent with its auditing function. Three firms submitted written proposals and all three made hour long presentations to a five-person Selection Committee comprised of NYC Health + Hospital employees. The Selection Committee reviewed the proposals and considered the presentation. Two finalists were identified and each, after some negotiations, submitted revised proposals. The Selection Committee, using a previously agreed upon scoring methodology, voted in favor of BCG. The proposed contract award was presented to the Contract Review Committee that voted in favor of the proposed award.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: CONSULTING AGREEMENT WITH THE BOSTON CONSULTING GROUP + NYC H+ H OFFICE OF TRANSFORMATION

Project Title & Number: _____

Project Location: CENTRAL OFFICE

Requesting Dept.: PRESIDENT'S OFFICE; OFFICE OF TRANSFORMATION OFFICE

Successful Respondent: The Boston Consulting Group
Contract Amount: \$3.65M
Contract Term: Office over a six month term for a cost not to exceed \$3.65 Million with two six-month options available to NYC Health + Hospitals for total amount not to exceed \$10.95 Million.

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

Range of Proposals: \$1.6M to \$4.9M

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

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

Method of Payment: Time and Rate
Other: explain Invoice payment, based on deliverables

EEO Analysis: Pending

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)

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

The report titled "One New York; Health Care for our Neighborhoods: Transforming Health + Hospitals (the "Report") issued in April 2016 identified a looming fiscal crisis for NYC Health + Hospitals and recommended that four high level goals be pursued through twelve strategies. At the same time, NYC Health + Hospitals is heavily engaged in the reform initiatives mandated and encouraged through the State DSRIP program and is also pursuing its own plan to dismantle its former Network structure in favor of one organized around a service line reporting structure. Each of these separate initiatives pose enormous challenges and integrating and coordinating them is crucial. Recognizing these challenges, NYC Health + Hospitals has established an Office of Transformation within the Office of the President to coordinate and drive the reform agenda. That office is now being staffed. Given the enormous body of work facing the Transformation Office and its nascent state, NYC Health + Hospitals engaged in a competitive procurement process to find a suitable consulting firm to assist the Transformation Office in its work. The Boston Consulting Group ("BCG") was selected from among several highly qualified possibilities.

The work of BCG will be to identify staffing needs, establish an internal structure for the Transformation Office, help develop conceptual work plans for its different work streams, create reporting structures and templates for the engaged divisions within NYC Health + Hospitals to report to the Transformation Office and for the Transformation Office to report to the President, the NYC Health + Hospitals Board and to the Mayor. Furthermore, as the Transformation Office begins its work, BCG will continue to provide support and advice particularly in the areas of data collection, analysis and reporting and strategic planning.

CONTRACT FACT SHEET(continued)

Contract Review Committee

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

No.

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

N/A

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):*

Selection Committee Members-

- Udai Tambar, Chief Transformation Officer
- Jeremy Berman, Deputy General Counsel
- Randall Mark, Chief of Staff to the President and CEO
- Krista Olson, AVP, Finance
- Richard Gannotta, SVP/Hospitals

List of firms responding to RFP

- McKinsey & Company
- Accenture
- The Boston Consulting Group

(note these are the 5 we sent proposal to; the first 3 responded; KPMG had to recuse themselves; no response from Booz, Allen, Hamilton)

List of firms considered

- McKinsey & Company
- Accenture
- The Boston Consulting Group
- KPMG
- Booz, Allen, Hamilton

Consulting firms with 'large scale organizational change management expertise', with 3rd party contracts, were identified. The proposal was emailed to each of the 5 identified vendors. A pre-proposal conference call was held to provide additional clarifying information. Three companies provided responses; all were invited in for 60 minute in-person presentations. Round 1 scoring was completed. The top 2 scored companies were each requested to provide updated proposals and their 'best and final offers'. Both companies provided updated proposals. Round 2 scoring was completed. Boston Consulting Group (BCG) was the highest scored company. BCG reduced their fee from \$4.9M to \$3.65M. The other company submitted an original fee of \$3.45M and held firm with their pricing.

The selection criteria is as follows:

1. Plan responsiveness to:
 - a. Structure the office
 - b. Develop implementation processes
 - c. Determine measurement metrics
 - d. Develop progress templates
2. Depth and Technical Expertise of Staff
3. Cost
4. Demonstrated knowledge of healthcare industry and the challenges of urban, safety net healthcare systems
5. References supporting successful engagements for similarly complex projects

CONTRACT FACT SHEET_(continued)

Scope of work and timetable:

The work of BCG will be to identify staffing needs, establish an internal structure for the Transformation Office, help develop conceptual work plans for its different work streams, create reporting structures and templates for the engaged divisions within NYC Health + Hospitals to report to the Transformation Office and for the Transformation Office to report to the President, the NYC Health + Hospitals Board and to the Mayor. Furthermore, as the Transformation Office begins its work, BCG will continue to provide support and advice particularly in the areas of data collection, analysis and reporting and strategic planning.

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

The potential benefits of the successful deployment of the transformation plan that ties to the strategies outlined in the One New York: Healthcare for our Neighborhood report, is practically incalculable as it could yield millions of dollars in additional revenue over many years and produce substantial savings. If this additional revenue and cost savings are realized, they would dwarf the cost of the contract.

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

N/A No previous history, first contract

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

Given the enormous body of work facing the Transformation Office and its nascent state, NYC Health + Hospitals engaged in a competitive procurement process to find a suitable consulting firm to assist the Transformation Office in its work. The Boston Consulting Group ("BCG") was selected from among several highly qualified possibilities.

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 FACT SHEET (continued)

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

- Antonio Martin, Executive Vice President/COO
-

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. 6/23/16
Date

Analysis Completed By E.E.O. In Process
Date

Keith Tallbe
Name

Office of Transformation Proposed Agreement with The Boston Consulting Group (BCG)

Presentation to Board of Directors

Dr. Ross Wilson
Chief Transformation Officer

Thursday, July 28, 2016



NYC HEALTH+ HOSPITALS Office of Transformation

OoT will ensure goals of Vision 2020 align with strategies in “One New York; Health Care for our Neighborhoods: Transforming Health + Hospitals” as well as ongoing reforms (e.g., DSRIP)

The specific objectives include:

- ✓ Enhance **patient experience** through care coordination and addressing the social determinants of health
- ✓ Expand **access and provide sustainable coverage** through new MetroPlus members, new unique patients, and new funding streams for the uninsured and uninsurable
- ✓ Engage the **workforce to match inpatient capacity** to demand and expand community-based care
- ✓ Achieve **operational excellence** to drive savings and new revenue streams and make NYC H+H a high-performing health system
- ✓ Build **partnerships to support health outcomes** of communities



NYC HEALTH+ HOSPITALS Scope of Contract

BCG was selected through a competitive process to launch the Office of Transformation

Phase 1 (26 weeks)

- Structure the office and identify staffing needs
- Establish an internal structure for the Office of Transformation
- Staff critical functions on an interim basis to ensure overall program management
- Develop work plans for its different work streams
- Determine measurement metrics
- Create reporting structures and templates to report to the NYC Health + Hospitals Board and President, and the Office of the Mayor
- Provide support and advice particularly in the areas of data collection and analysis

(Decision point to refine scope and deliverables)

Phase 2 (24 weeks)

(Decision point to refine scope and deliverables)

Phase 3 (24 weeks)



NYC
HEALTH+
HOSPITALS **Contract Summary**

Project Plan: Transformation Plan
Term of contract: 6 Month term
With two six-month options available to NYC Health + Hospitals for total amount not to exceed \$10.95 Million

Projected Expenses

- FY2017: \$3.65 Million
- FY2017: Optional \$3.65 Million
- FY2018: Optional \$3.65 Million
- **TOTAL: \$10.95 Million**

Proposed Funding Source: Central budget



RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "System") to negotiate and execute a five-year contract (the "Contract") with Canon Solutions America to provide System-wide Managed Print Services with two, one year options to renew solely exercisable by New York City Health and Hospitals Corporation, in an amount not to exceed \$74.3 million for seven years.

WHEREAS, New York City Health and Hospitals Corporation does not currently have a System-wide management program of its print devices creating inefficiencies and excess costs;

WHEREAS, a Request for Proposals to address this concern was issued on April 6, 2015 and Canon Solutions America was chosen by the selection committee based on the scoring criteria set forth in the Request for Proposals; and

WHEREAS, estimated savings from the contract are \$3.5 million over the initial term, and \$2.9 million for the two, one year options for an estimated total of \$6.4 million; and

WHEREAS, the Senior Vice President/Corporate Chief Information Officer shall be responsible for overall management and monitoring of the Contract.

NOW, THEREFORE, BE IT

RESOLVED, that the New York City Health and Hospitals Corporation be and is hereby authorized to negotiate and execute a five-year contract (the "Contract") with Canon Solutions America to provide System-wide Managed Print Services with two, one year options to renew solely exercisable by New York City Health and Hospitals Corporation, in an amount not to exceed \$74.3 million for seven years.

Executive Summary

Proposed Contract Canon Solutions America for Managed Print Services

Objective:

The NYC Health + Hospitals (Health + Hospitals) developed and conducted a Request for Proposal to evaluate the opportunity to move towards a Managed Print Services (“MPS”) environment for printers and multi-functional devices (“MFD”) across the entire organization. The objective is to work with a single supplier who will be responsible to provide hardware service on all desktop printers and MFDs while also providing new MFD hardware when necessary. Further, the MPS Vendor will provide consultative services that will assist in reducing the total number of pages printed over time while also reducing total cost through the process of redirecting print to lower cost machines and migrating from color pages to black and white. The MPS Vendor will also recommend ways to repurpose existing devices across the entire organization which will result in a reduction of new printer hardware purchases.

Current State:

Health + Hospitals utilizes Multi-Functional Devices (“MFDs” to include high-speed print shop devices) and Desktop Printers to support the majority of Health + Hospitals’ printing needs.

There are 2,434 MFDs currently in use at Health + Hospitals. Health + Hospitals utilizes 1,050 (43%) Canon devices, 1,056 (43%) Xerox devices, 312 (13%) Ricoh devices, 15 (<1%) Konica Minolta devices, and 1 (<1%) HP device. Regarding device ownership; 1,200 (49%) devices are rented, 600 (25%) devices are leased, and 634 (26%) devices are owned. 2,385 (98%) of the devices are serviced by the original equipment manufacturers, while 49 (2%) of the devices are serviced by a third party. This service includes the parts, labor, maintenance, and toner to ensure the devices are operating correctly. Health + Hospitals prints roughly 225M black and white pages and 15M color pages from MFD’s. Click volumes for these print shop devices are included in the MFD click volume totals listed above.

There are approximately 22,356 networked and local printers (Single Function Printers / SFP’s) currently utilized at Health + Hospitals. There is currently no model standardization at Health + Hospitals; there are several hundred different printer models currently in use. Health + Hospitals prints roughly 207M black and white pages and 33M color pages for a total of 240M pages per year from printers.

Health + Hospitals has a combined volume from MFD’s and Printers (SFP’s) of about 480M pages.

Health + Hospitals spends of \$11.5M annually on its current state non-standardized managed print services.

Award Recommendation:

After evaluating proposals submitted by multiple interested parties, the NYC Health + Hospitals Evaluation Committee is recommending for Canon to be awarded the Managed Print Services contract. Canon agrees to support all Service Level Agreements required by Health + Hospitals (to include aggressive response time and up-time requirements) by offering 30 (thirty) full-time employees for use across the organization. These service levels will greatly improve the existing services being performed

Executive Summary

Proposed Contract Canon Solutions America for Managed Print Services

by multiple incumbents. Canon will service 2,434 MFD devices and 22,356 printers throughout the term of the 5 year agreement. Canon has agreed to absorb nearly \$2.6M in competitor's early termination costs to ensure that Canon will be capable to service the entire fleet of MFDs within NYC Health + Hospitals.

Projected Savings:

The estimated savings from the contract are \$3.5 million over the initial five year term, and \$2.9 million for the two, one year options for an estimated total of \$6.4 million.

The projected additional savings based on printer reductions is \$110K over the initial five year term, and \$470K for the two, one year options for an estimated total of \$580K.

Canon Service Offering:

Canon will provide right-sizing services by strategically reducing the number of printers and recommending an appropriate MFD inventory based on print volume and staff requirements. Canon will track, monitor and manage all hardcopy output equipment and their associated supplies for Health + Hospitals' local and networked printers, multi-functional devices, copiers, scanners and facsimile devices supporting all Health + Hospitals facilities.

The enterprise MPS program will include break/fix/parts/labor maintenance service support for current and future equipment along with delivering timely, comprehensive and highly detailed usage reports while providing leading technology, multi-functional devices ("MFDs"), continuous education and best practice protocol to achieve print avoidance. Print avoidance will be achieved through a variety of technical and cultural changes recommended by Canon and approved by Health + Hospitals. For example, user tracking results in increased visibility to who prints what and why, creating a sense of ownership and accountability of print related costs. Working with Health + Hospitals Senior Leadership, Canon will help develop policies and assist in educating staff on proper printing procedures (what should be printed versus what shouldn't). Health + Hospitals and Canon will mutually agree to annual print reduction targets that will be achieved through the adoption of various technologies and educational programs.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: MANAGED PRINT SERVICES
Project Title & Number: MANAGED PRINT SERVICES
Project Location: CORPORATE WIDE
Requesting Dept.: ENTERPRISE INFORMATION TECHNOLOGY SERVICES/ Supply Chain Services

Successful Respondent: CANON SOLUTIONS AMERICA
Contract Amount: \$74,334,132 for 7 years
Contract Term: 5 Years with 2, 1-Year Options to Renew

Number of Respondents: 7
(If Sole Source, explain in Background section)

Range of Proposals: \$56,707,025 - \$61,890,764 for a 5-year contract (5-yr proposals submitted)

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

Funding Source: Grant: explain _____ General Care Capital
 Other: Cost Center by Facility

Method of Payment: _____ Time and Rate
Other: Health + Hospitals will be invoiced monthly for repair/parts/labor maintenance service support for current and future equipment

EEO Analysis: Conditional Approval Received on 5/19/16

Compliance with Health + Hospital's McBride Principles? Yes No

Vendex Clearance Yes No N/A (Pending Approval)

(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):

NYC Health + Hospitals currently utilizes Multi-Functional Devices (“MFDs” to include high-speed print shop devices) and Desktop Printers to support the majority of NYC Health + Hospitals’ printing needs.

There are 2,434 MFDs currently in use at Health + Hospitals. Health + Hospitals utilizes 1,050 (43%) Canon devices, 1,056 (43%) Xerox devices, 312 (13%) Ricoh devices, 15 (<1%) Konica Minolta devices, and 1 (<1%) HP device. Regarding device ownership; 1,200 (49%) devices are rented, 600 (25%) devices are leased, and 634 (26%) devices are owned. 2,385 (98%) of the devices are serviced by the original equipment manufacturers, while 49 (2%) of the devices are serviced by a third party. This service includes the parts, labor, maintenance, and toner to ensure the devices are operating correctly. Health + Hospitals prints roughly 225M black and white pages and 15M color pages from MFD’s. Click volumes for these print shop devices are included in the MFD click volume totals listed above.

There are approximately 22,356 networked and local printers (Single Function Printers / SFP’s) currently utilized at Health + Hospitals. There is currently no model standardization at Health + Hospitals; there are several hundred different printer models currently in use. Health + Hospitals prints roughly 207M black and white pages and 33M color pages for a total of 240M pages per year from printers.

Health + Hospitals has a combined volume from MFD’s and Printers (SFP’s) of about 480M pages.

NYC Health + Hospitals spends a total of \$11.5M annually on its current state non-standardized managed print service. With the Manage Print Service initiative, Health + Hospitals sees an opportunity to consolidate its supplier base and drive standardization and operational efficiencies across the organization. In centralizing the contracting process and leveraging the volume of the entire organization, Health + Hospitals expects to realize cost savings through a comprehensive, well thought-out, print management program, while maintaining or improving the current levels of quality and service/support.

Contract Review Committee

Was the proposed contract presented at the Contract Review Committee (CRC)? (include date):
Yes. The contract award was presented on April 27, 2016.

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:

Not applicable

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):

Selection Committee Members

1. Jim Gomez – Former Assistant Vice President, EITS
2. Craig Franklin – Network Chief Information Officer
3. Eli Tarlow –Network Chief Information Officer
4. George Bonanno – Associate Director, Supply Chain *Management*
5. Gil Vega – (withdrew committee membership after the voting process was finalized)

CONTRACT FACT SHEET(continued)

- 6. James Linhart – Deputy Comptroller
- 7. Jerry Childs – Coordinating Manager A, Coney Island Hospital
- 8. Michael Cosmi – Director, Information Services, Network Services
- 9. Richard Plaza – Assistant Director, Desktop Technologies

Firms Submitted Proposal

- 1. Canon – considered and selected finalist
- 2. HP
- 3. Lexmark
- 4. Pitney Bowes – considered
- 5. Xerox - considered
- 6. Auxilio
- 7. Ricoh

Canon is currently a supplier of products and services to NYC Health + Hospitals. In addition, other incumbents who provide similar services to NYC Health + Hospitals also participated in the RFP process. As collectively decided by the Selection Committee, Canon’s current performance was the most beneficial amongst all incumbents providing Manage Print Services to NYC Health + Hospitals today. Reference checks with other Hospital systems similar in size to NYC Health + Hospitals were conducted amongst the RFP finalists; Canons references resulted in the most complimentary out of all finalists. Canon was the only finalist to offer a reference of comparable size and scope to NYC Health + Hospitals. During the evaluation phase of this process, Canon received the highest scores when compared with the other 2 finalists.

Scope of work and timetable:

Health + Hospitals selected Canon to provide a comprehensive and innovative enterprise managed print services program (MPS) including an initial fleet replacement where necessary, tracking of print volumes across departments and facilities, recommendations based on tracking to re-direct printing to Multi-Functional Devices (MFDs) while reducing color printing.

The selected supplier will provide right-sizing services by strategically reducing the number of printers and recommending an appropriate MFD inventory based on print volume and staff requirements. Health + Hospitals expects that the selected Supplier will track, monitor and manage all hardcopy output equipment and their associated supplies for Health + Hospitals’ local and networked printers, multi-functional devices, copiers, scanners and facsimile devices supporting all Health + Hospitals facilities.

The enterprise MPS program will include break/fix/parts/labor maintenance service support for current and future equipment along with delivering timely, comprehensive and highly detailed usage reports while providing leading technology, multi-functional devices ("MFDs"), continuous education and best practice protocol to achieve print avoidance. Print avoidance can be achieved through a variety of technical and cultural changes recommended by the Supplier. User tracking results in increased visibility to who prints what and why, creating a sense of ownership and accountability of print related costs.

Working with NYC Health + Hospitals Senior Leadership, selected Supplier will help develop policies and assist in educating staff on proper printing procedures (what should be printed versus what shouldn’t). NYC Health + Hospitals and the Supplier will mutually agree to annual print reduction targets that will be achieved through the adoption of various technologies and educational programs.

CONTRACT FACT SHEET(continued)

Further, the selected Supplier will be responsible for managing the acquisition (and removal) of the physical devices as well as providing the necessary service and support for all hardcopy output equipment.

NYC Health + Hospitals’ owned MFDs will be serviced by the selected Supplier until the device reaches end of life. At that point, the device will be replaced by the selected Supplier’s proposed technology (contingent of an approval by Health + Hospitals).

NYC Health + Hospitals’ rented and leased devices will either be serviced by the selected Supplier or replaced with selected Supplier’s proposed technology (which Supplier will then service).

All existing contracts and current service providers will be replaced by the selected Supplier through a mutually agreed upon transition plan between NYC Health + Hospitals and selected Supplier. The networked and local printers are owned by Health + Hospitals and will be serviced by the selected Supplier throughout the contract. Health + Hospitals is also open to Supplier proposed solutions based on Supplier’s experience in implementing a managed print services program at similar organization to Health + Hospitals.

Below is a timetable which will take 84 days to cover all sites.

Project Initiation and Planning
Review project plan for all locations
Kick off meeting for program
Identify H+H escorts for 4 PDS Teams across Regions
Confirm Server and Monitoring requirements
Complete IT Security requirements for VPN
Review process changes - Managing printers, MFP, Fax, Ticketing procedures
Confirm toner logistics per facility
Create transition communication & Confirmation Meeting with Each Facility
Pre Rollout Tasks
Finalize project plan
Finalize resources and logistics
Team conference call - review project plan
Service launch prep meeting - Ticketing mgmt, Hot swaps, Dispatching, end user follow ups
Pre Rollout Meeting - all locations
Technical / Process Set up Tasks
Set up Device Monitoring - FM Audit
Set up Help Desk Processes - Remedy Configuration
Set up Device SLA Configurations
Testing - ticketing procedures
Set up Portal / user accounts

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

CONTRACT FACT SHEET(continued)

	Printer Reduction Year Over Year	Projected Savings	Projected Additional Savings	Projected Total Savings
Year 1	6%	\$ (94,987)	\$ 28,198	\$ (66,789)
Year 2	7%	\$ 337,311	\$ 31,646	\$ 368,957
Year 3	8%	\$ 736,982	\$ 27,244	\$ 764,227
Year 4	8%	\$ 1,104,867	\$ 8,596	\$ 1,113,463
Year 5	9%	\$ 1,441,772	\$ 12,878	\$ 1,454,650
Year 6	5%	\$ 1,441,772	\$ 140,414	\$ 1,582,186
Year 7	5%	\$ 1,441,772	\$ 333,563	\$ 1,775,335
Total		\$ 6,409,491	\$ 582,539	\$ 6,992,029

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

Spend Type	Annual Spend
MFD Device and Service Costs	\$ 7,483,163.92
Printer Toner Spend	\$ 3,816,891.24
Additional Printer Supply Spend	\$ 77,628.54
Outsourced Printer Service Spend	\$ 157,119.53
Total	\$ 11,534,803.23

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

The current products and services cannot be provided by the Corporation's staff because Health + Hospitals is not a distributor or a manufacturer of printers and other equipment required for a Managed Print Services program. NYC Health + Hospitals' staff also does not have expertise to repair and maintenance the type of equipment required for a Managed Print Service program.

Canon has been selected as they are able to provide adequate staffing to support all Clinical areas on a 24/7 basis, and maintain an inventory of all critical parts to complete any repair within the required time frames. Further, on-site staffing will be provided for each facility to support the response time requirements, up-time requirements, and overall goals of NYC Health + Hospitals.

Canon will also provide a dedicated technical support by providing their personnel to proactively monitor devices, clear paper jams, swap out consumables when toner is low, prior to an NYC Health + Hospitals employee making a request to the Enterprise Service Desk

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 FACT SHEET(*continued*)

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

Eli Tarlow, Assistant Vice President, Enterprise IT Services

Sal Guido, Senior Vice President, Corporate CIO, Enterprise IT Services

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.: *May 19, 2016*

Analysis Completed By E.E.O.: *Conditionally Approved*

32051

TO: April Monegas, Assistant Director
Supply Chain Services
Division of Materials Management

FROM: *for* Keith Tallbe *Keith Tallbe*

DATE: May 19, 2016

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

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

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): _____

Contract Number: _____

Project: Managed Print Services

Submitted by: Division of Materials Management

EEO STATUS:

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

COMMENTS:

KT:srf

Managed Print Services Contract with Canon Solutions America

Paul Albertson, Vice President, Supply Chain Services

Sal Guido, Senior Vice President, Corporate CIO



Managed Print Services – Benefits and Plan

- Current Annual spend is \$11.5 million
- Canon experience: healthcare facilities using EPIC as their EMR system
- Single vendor with 43 full-time, dedicated service staff
- Projected savings of \$6.4 million over 7 years
- Additional annual savings based on reduction in print volumes
 - Remove an average 1250 Single Function Printers each year over life of contract; a reduction of approximately 40% of the current printer fleet
- Potential additional savings of \$7 million to \$9 million over 7 years from reduction in paper costs and external printing
- Reduction plans:
 - EPIC rollout – replaces paper-based medical records
 - E-prescribing – replaces paper prescriptions
 - ERP rollout – automated work flows and electronic approvals
 - Reducing number of copiers and desk top units
 - Closing/reducing scopes of print shops



Projected Savings

	Printer Reduction Year Over Year	Projected Savings	Projected Additional Savings	Projected Total Savings
Year 1	6%	\$ (94,987)	\$ 28,198	\$ (66,789)
Year 2	7%	\$ 337,311	\$ 31,646	\$ 368,957
Year 3	8%	\$ 736,982	\$ 27,244	\$ 764,227
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Year 6	5%	\$ 1,441,772	\$ 140,414	\$ 1,582,186
Year 7	5%	\$ 1,441,772	\$ 333,563	\$ 1,775,335
Total		\$ 6,409,491	\$ 582,539	\$ 6,992,029

- Potential additional savings of \$7 million to \$9 million over 7 years from reduction in paper costs and external printing
- Total contract is five years with two, one (1) year options to renew for a total not to exceed of \$74.3 million over the seven year period.



Governance/Procurement Methodology

- Governance Structure
 - Each facility will have a three person governance to review metrics, including print volumes, equipment reduction program
 - facility leader, Canon leader, and the facility-based EITS leader
 - Monthly Corporate-wide Business Reviews for first year; then quarterly for remainder of contract term
- Solicitation/Evaluation
 - RFP posted in the City Records
 - 7 vendors submitted proposals
 - 3 vendors deemed responsive
 - Canon was highest rated by selection committee members



RESOLUTION

Amending the Resolution adopted February 25, 2016 regarding the revision of the previously approved Draper Hall lease to authorize the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute an amendment of the December 24, 2014 sublease with Draper Homes Housing Development Fund as nominee for Draper Hall Apartments LLC ("Tenant I") to provide for the return to NYC Health + Hospitals of approximately 15,150 square feet included in such lease (the "Draper II Site") on the campus of Metropolitan Hospital Center and to simultaneously execute a sublease with Draper Family Housing Development Fund Corporation or such other housing development fund company as shall be approved by both NYC Health + Hospitals and the New York City Department of Housing Preservation and Development ("HPD") (the "HDFC") as nominee for Gilbert on First LLC (in such capacities being referred to together with the HDFC as "Tenant II") of the Draper II Site for a term of 99 years, inclusive of Tenant II options for the development of a 16 story structure on the Draper II Site with approximately 153 apartments for low and moderate income individuals and families at a rent payable to NYC Health + Hospitals of not less than \$87,606 per year.

WHEREAS, the NYC Health + Hospitals' Board of Directors approved a resolution to authorize the modification of the Draper Hall lease previously approved to separate out the Draper II site to permit its separate lease to Tenant II; and

WHEREAS, the previous resolution authorized the construction of a new 14 story structure containing 131 apartments; and

WHEREAS, subsequently, Tenant II has determined that it will be possible to build a structure with two additional floors and approximately 22 additional apartments; and

WHEREAS, in view of the acute need for affordable apartments in the City it is desirable to take advantage of this increased development opportunity to construct additional apartments as part of the previously approved plan; and

WHEREAS, consistent with the increased number of units, it is appropriate that the rent payable to NYC Health + Hospitals commensurately.

NOW THEREFOR, be it

RESOLVED, that the New York City Health and Hospitals Corporation be authorized to ("NYC Health + Hospitals") to execute an amendment of the December 24, 2014 sublease with Draper Homes Housing Development Fund as nominee for Draper Hall Apartments LLC ("Tenant I") to provide for the return to NYC Health + Hospitals of approximately 15,150 square feet included in such lease (the "Draper II Site") on the campus of Metropolitan Hospital Center and to simultaneously execute a sublease with Draper Family Housing Development Fund Corporation or such other housing development fund company as shall be approved by both NYC Health + Hospitals and the New York City Department of Housing Preservation and Development ("HPD") (the "HDFC") as nominee for Gilbert on First LLC (in such capacities being referred to together with the HDFC as "Tenant II") of the Draper II Site for a term of 99 years, inclusive of Tenant II options for the development of a 16 story structure on the Draper II Site with approximately 153 apartments for low and moderate income individuals and families at a rent payable to NYC Health + Hospitals of not less than \$87,606 per year.

EXECUTIVE SUMMARY

OVERVIEW: In December 2014 New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) leased Draper Hall to Draper Homes Housing Development Fund as nominee for Draper Hall Apartments LLC for the development of low income housing. Subsequently, it was determined that an additional building could be constructed on the parcel of land included in the original Draper Hall lease. Accordingly, in February 2016 the NYC Health + Hospitals authorized a restructuring of the Draper Hall lease such that a parcel of approximately 15,150 square feet be returned to NYC Health + Hospitals and freshly leased to Draper Family Housing Development Fund Corporation as nominee for Gilbert on First LLC (“Tenant II”) to permit the construction of a new 14 story structure with 131 apartments. In yet a further development, Tenant II has now determined that the proposed new structure can be increased by two additional stories with approximately 22 additional apartments. This is a welcome development as it makes possible the housing of approximately 22 additional low income New York individuals or families. Under this proposal, the rent payable by Tenant II will increase from \$75,000 per year to \$87,606 based on an annual rent per apartment of about \$573 per apartment.

PROGRAM: As originally approved in February, 2016, the project will be financed, in part, through the “Mix and Match Program” which is a joint financing program for the creation of mixed income housing of New York City Housing Development Corporation and HPD. In keeping with Mix and Match requirements 50% of the units in the new project will be affordable to households that qualify the project to receive Federal Low Income Housing Tax Credits. In Draper II, 25% of the units will be set aside for families earning less than 50% of Area Median Income and another 25% of the units will be set aside for families earning between 50% and 60% of AMI. Mix and Match requires that the remaining 50% of the units be set aside for moderate and middle income families with maximum rents set to be affordable to households earning 130% of AMI. As a result, in Draper II, 10% of the units will have rents affordable by families earning 80% of AMI, 20% by families earning 100% of AMI and 20% by families earning 130% of AMI.

TENANT: As originally approved in February, 2016, the principals of the managing member of the LLC are principals of SKA Marin. SKA Marin is an experienced developer of low income housing for seniors and disabled tenants. SKA is the principal in the development of Draper Hall. SKA was also the principal in Metro East 99th Street, a 176 unit building, across from Metropolitan Hospital Center. Metro East 99th is the first Medicaid Redesign Project in New York State and serves elderly and non-elderly tenants who can live independently but have previously been patients in NYC Health + Hospitals long-term care or who are under care at NYC Health + Hospitals facilities for chronic conditions. SKA Marin has also been a principal in the successful development of Kings County Senior Residence on the Kings County Hospital Center campus pursuant to a sublease with the Corporation approximately ten years ago.

**Page Two – Executive Summary
Amendment – Draper Hall**

Because of the HPD loan requirements, the lease will be made in the name of the HDFC but the LLC will have all of the rights of the Tenant to enforce the lease terms, to perform the Tenant's obligations and to be recognized as the "beneficial tenant." The LLC will be responsible for the performance of the Tenant's obligations.

FINANCING: As originally approved in February, 2016, the Draper II project will be financed with low income tax credits, a loan made by the Housing Development Corporation in conjunction with additional funding by the New York City Department of Housing Preservation and Development ("NYCHPD") NYS HCR State tax credits and the City Council. Section 8 vouchers will NOT be issued for this project.

TERMS: As originally approved in February, 2016, NYC Health + Hospitals will enter into a sublease with Tenant II with a term of ninety-nine years, inclusive of Tenant II options. The term of the sublease shall commence upon sublease execution. Whereas the original resolution had called for a rent of \$75,000 per year, with the increased size of the building, the rent will be increased to \$87,606.

Tenant II will be responsible for all costs associated with the development and operation of its housing program. Upon sublease execution construction shall commence. All plans and specifications of the project shall be subject to the prior approval of HPD and NYC Health + Hospitals which approval shall not be unreasonably withheld.

Any further subletting by Tenant II of space within the new building will be subject to the consent of NYC Health + Hospitals.

The cost for all utilities provided to the project will be the responsibility of the Tenant provided Tenant may pass the cost of utilities to the building residents. Tenant II will also be responsible for all structural and nonstructural interior and exterior, maintenance of, and repairs to, the property.

Tenant II will indemnify NYC Health + Hospitals and the City of New York and will provide adequate insurance against all liability arising from its use and occupancy of the property, naming the Corporation and the City of New York as additional insured parties.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") to execute an extension of the existing agreements with Arcadis U.S., Inc. ("Arcadis") and with Parsons Brinckerhoff, Inc. ("Parsons") for a term of twelve months for an amount not to exceed \$2,366,826.50 for both of such contractors drawing on funds left unused from the prior contract.

WHEREAS, Bellevue Hospital Center, Coler Specialty Hospital and Rehabilitation Center, Metropolitan Hospital Center and Coney Island hospitals were all damaged by Hurricane Sandy; and

WHEREAS, in February 2013 NYC Health + Hospitals issued a Request for Proposals (the "RFP") to secure the services of architects and engineers to help to plan the necessary repair, restoration and hazard mitigation work; and

WHEREAS, Arcadis and Parsons were awarded contracts pursuant to the RFP which expired September 30, 2015; and

WHEREAS, on March 26, 2015, the NYC Health + Hospitals' Board of Directors approved an extension of the Parsons and Arcadis contracts for an amount not to exceed \$5 Million and for a term of one year expiring September 30, 2016; and

WHEREAS, of the \$5 Million approved for the Arcadis and Parsons' contracts, only \$2,633,173.50 has been spent; and

WHEREAS, work remains to be done to develop the over-all strategy and priority to further the repair, restoration and hazard mitigation work at the damaged NYC Health + Hospitals' facilities and to present the same to the Federal Emergency Management Agency; and

WHEREAS, NYC Health + Hospitals wishes to continue to use the services of Arcadis and Parson and to allow them to continue on-going work; and

WHEREAS, the Vice President for Corporate Operations shall be responsible for the administration of these contracts.

NOW THEREFORE, be it

RESOLVED that the New York City Health and Hospitals Corporation be authorized to execute an extension of the existing agreements with Arcadis U.S., Inc. and with Parsons Brinckerhoff, Inc. for a term of twelve months for an amount not to exceed \$2,366,826.50 for both of such contractors drawing on funds left unused from the prior contract

EXECUTIVE SUMMARY

CONTRACT EXTENSIONS WITH ARCADIS U.S., INC. AND PARSONS BRINCKERHOFF, INC.

OVERVIEW:

Following Hurricane Sandy, NYC Health + Hospitals awarded contracts to Arcadis U.S., Inc. ("Arcadis") and Parsons Brinckerhoff, Inc. ("Parsons") in the combined total of \$16 Million including all option terms. These contractors performed valuable services helping to design, price and present to the Federal Emergency Management Agency ("FEMA") plans for the repair, restoration and hazard mitigation of the facilities damaged by Sandy. In March 26, 2015, the NYC Health + Hospitals' Board of Directors approved an extension of the Parsons and Arcadis contracts for an amount not to exceed \$5 Million and for a term of one year expiring September 30, 2016. NYC Health + Hospitals is now moving beyond the initial planning of the Sandy projects and their preliminary presentation to FEMA and is starting the actual work on the damaged facilities. As the actual work on each facility is started, project architects and engineers are being hired using competitive procurement processes managed by the NYC Economic Development Corporation ("EDC"). Arcadis and/or Parsons may choose to submit proposals for such work and they may be awarded contracts to perform such work. That work would be performed under separate contracts from that proposed here and with separate funding a cost limits. The proposed contract merely extends the term of the existing contracts for a year using only the funds initially earmarked for these contractors in order that they can continue to perform the remaining work with EDC and the NYC Health + Hospitals' team to present the repair, restoration and hazard mitigation plans to FEMA and other governmental bodies and to formulate the over-all strategies being pursued in the projects.

31667B

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: David Larish, Director
Office of Procurement Systems and Operations

FROM: Manasses C. Williams

DATE: February 13, 2015

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

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

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: _____

Project: Professional Services

Submitted by: Office of Procurement Systems and Operations

EEO STATUS:

1. Approved
2. Approved with follow-up review and monitoring
3. Not approved
4. Board Conditional

COMMENTS:

MCW:srf

31647

TO: David Larish, Director
Office of Procurement Systems and Operations

FROM: Manasses C. Williams *r.f^\.C .JJ. .*

DATE: November 10, 2015

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

Manasses C. Williams
Senior Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

The proposed contractor/consultant, Arcadis U.S., Inc. has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): corporate-wide

Contract Number: _____

Project: Requirements Contract for Professional Engineering and Architectural Services

Submitted by: Office of Procurement Systems and Operations

EEO STATUS:

1. Approved
2. Conditionally Approved with follow-up review and monitoring
3. Not approved
4. EEO Board Conditional Approval

COMMENTS:

MCW:srf

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "NYC Health + Hospitals") to execute a sub-sublease with the Howard Hughes Corporation for about two years and approximately 18,740 square feet of space on the 31st floor at 199 Water Street, New York, to house HHC Assistance Corporation d/b/a OneCity Health Services at a rent of \$33/square foot or \$463,815/year after factoring three months of free rent for the first year and \$33.66/square foot or \$630,788.40 for the second year for a two year total of approximately \$1,094,603.40 plus the cost of sub-metered electricity.

WHEREAS, the NYC Health + Hospitals participates in the New York State Delivery System Reform Incentive Payment ("DSRIP") program and leads the largest Performing Provider System in the City consisting of approximately 280 health care providers and other entities (the "PPS"); and

WHEREAS, HHC Assistance Corporation d/b/a OneCity Health Services, acts on behalf of NYC Health + Hospitals as the "Central Service Organization" for the PPS; and

WHEREAS, pursuant to resolution adopted in February 2015 by the NYC Health + Hospitals' Board of Directors, NYC Health + Hospitals entered into a sub-sublease with Health Care Finance Group LLC for half of the 31st floor of 199 Water Street in Manhattan consisting of 16,880 square feet, which is occupied by OneCity Health Services; and

WHEREAS, OneCity Health Services needs additional space to accommodate its expanded staff working on the DSRIP program; and

WHEREAS, the proposed sub-sublease will permit OneCity Health Services to occupy the other half of the 31st floor of 199 Water Street consisting of 18,740 square feet, fully furnished, under agreement with the Howard Hughes Corporation; and

WHEREAS, the rental costs of such occupancy will be funded through DSRIP planning grant and performance payments; and

WHEREAS, NYC Health + Hospitals' Senior Vice President and Chief Medical Officer and the Chief Executive Officer of OneCity Health Services will be responsible for the proposed sub-sublease.

NOW, THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation be and hereby is authorized to execute a sub-sublease agreement with the Howard Hughes Corporation for about two years and approximately 18,740 square feet of space on the 31st floor at 199 Water Street, New York, to house HHC Assistance Corporation d/b/a OneCity Health Services at a rent of \$33/square foot or \$463,815 per year after factoring three months of free rent and \$33.66/square foot or \$630,788.40 for the second year for a two year total of \$1,094,603.40 plus the cost of sub-metered electricity.

EXECUTIVE SUMMARY

ONE CITY HEALTH SERVICES 199 WATER STREET BOROUGH OF MANHATTAN

- OVERVIEW:** The New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) seeks authorization from its Board of Directors to execute a sub-sublease of approximately two years’ duration with the Howard Hughes Corporation (“Howard Hughes”) for approximately half of the 31st floor on the 31st floor at 199 Water Street in Manhattan consisting of approximately 18,740 square feet to house HHC Assistance Corporation d/b/a OneCity Health Services.
- NEED/
PROGRAM:** NYC Health + Hospitals participates in the New York State Delivery System Reform Incentive Payment (“DSRIP”) program and leads the largest Performing Provider System in the City consisting of approximately 280 health care providers and other entities (the “PPS”). OneCity Health Services currently occupies half of the 31st floor at 199 Water Street consisting of 16,880 square and, through the proposed sub-sublease, OneCity Health Services will occupy the balance of the 31st floor. The additional space is required to accommodate the needs of employees and consultants engaged in projects aimed at creating an integrated delivery system of health and social service providers which will close gaps in the continuum of care. The space is located on the 31st floor of a 1.1 million square-foot building known as One Seaport Plaza. The proposed additional sub-sublease space is configured as office space with twenty-five work stations and twenty-one offices. The space comes fully furnished and in virtually move-in condition.
- TERMS:** OneCity Health Services will occupy the balance of the 31st floor consisting of approximately 18,740 square feet of space. The subtenant is the Howard Hughes Corporation and the over-tenant is AON. The owner of the building is the Resnick Organization. The sub-sub lease will contain a term of approximately two years. The base rent is \$33/square foot or \$618,420 per year for the first year of the agreement. The first three months of the term are rent free which reduces the first year cost to \$463,815. With the free included, the net effective rent for the first year is \$24.75 per square foot. The base rent for the second year will be \$33.66 per square foot, or \$630,788.40. The base rent for the two year term totals \$1,094,603.40. OneCity is also responsible for payment of sub-metered electricity.
- FUNDING:** The rental cost will be funded through DSRIP planning grant and performance payments.

SUMMARY OF ECONOMIC TERMS

SITE:	Part of 31 st Floor 199 Water Street New York, New York
LANDLORD:	Resnick Seaport LLC
TENANT:	AON Service Corporation
SUB-TENANT:	Howard Hughes Corporation
TERM:	Approximately two years
FLOOR AREA:	18,740 square feet
RENEWAL OPTIONS:	None
BASE RENT:	\$33 per square foot
ESCALATION:	2.0% per year
FREE RENT:	Three months
UTILITIES:	Tenant will pay separately metered electricity
OPERATING EXPENSES:	Tenant not responsible for any payments for operating expenses
REAL ESTATE TAXES:	Tenant not responsible for any payments for real estate taxes
FUNDING:	DSRIP planning grant and performance payments

199 Water St.

New Lease - 18,740 sf

	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>	<u>9</u>	<u>10</u>	<u>11</u>	<u>12</u>	<u>Avg. Rent PSF (12 mos.)</u>	<u>Avg. Rent PSF (24 mos.)</u>
Year 1	0.00	0.00	0.00	51,535.00	51,535.00	51,535.00	51,535.00	51,535.00	51,535.00	51,535.00	51,535.00	51,535.00	463,815.00	24.75
Year 2	52,565.70	52,565.70	52,565.70	52,565.70	52,565.70	52,565.70	52,565.70	52,565.70	52,565.70	52,565.70	52,565.70	52,565.70	<u>630,788.40</u>	33.66
												total	1,094,603.40	29.20

Existing Lease - 16,880 sf

Year 1	39,288.00	39,288.00	39,288.00	39,288.00	39,288.00	39,288.00	39,288.00	40,258.00	40,258.00	40,258.00	40,258.00	40,258.00	476,306.00	28.22
Year 2	40,258.00	40,258.00	40,258.00	40,258.00	40,258.00	40,258.00	40,258.00	41,271.00	41,271.00	41,271.00	41,271.00	41,271.00	<u>488,161.00</u>	28.92
												total	964,467.00	28.57

Note: Sept 1, 2016 to Aug 31, 2018 time period

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (NYC Health + Hospitals) to approve a Capital Project for an amount not to exceed \$28,349,000 for the design, construction and outfitting of a new Diagnostic and Treatment Center at 155 Vanderbilt Avenue, Staten Island, operated by NYC Health +Hospitals (the "system").

WHEREAS, the Vanderbilt Health service area is located in and serves the St. George area of Staten Island, which has been designated as a Primary Care Health Professional Storage Area (HPSA) and a Special Population (Medicaid) Dental Care HPSA. There is a critical need for comprehensive primary, preventive and supplemental health care services in the proposed service area, as evidenced by low rates of preventative screening services, high rates of chronic conditions in both the general and Medicaid enrollee populations and high rates of emergency department and inpatient utilization for ACSC among Medicaid enrollee residents; and

WHEREAS, the NYC Health +Hospitals primary care expansion initiative which includes the Vanderbilt site, is responding to the identified health, health care and social needs of the community by providing high quality, patient-centered, comprehensive, and coordinated care; and

WHEREAS, the proposed project will include construction of a two-story modular structure at 155 Vanderbilt Avenue, Staten Island; and

WHEREAS, the Diagnostic and Treatment Center will offer primary care and specialty services; and

WHEREAS, bids for the construction of the Center have been received, and a budget for the cost of construction and outfitting has been developed; and

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

WHEREAS, the proposed total project budget, inclusive of all contingencies, is estimated to be \$28.4 million; and

WHEREAS, the overall management of the project will be under the direction of the Office of Facilities Development.

NOW THEREFORE, be it

RESOLVED, the NYC Health + Hospitals (NYC H+H) be and hereby is authorized to proceed with the design, construction and outfitting necessary for completion of a new Diagnostic and Treatment Center at 155 Vanderbilt Avenue, for an amount not-to-exceed \$28,349,000.

EXECUTIVE SUMMARY

NEW DIAGNOSTIC AND TREATMENT CENTER 155 VANDERBILT AVENUE, STATEN ISLAND, NY

OVERVIEW: NYC Health +Hospitals is seeking to construct a new Diagnostic and Treatment Center located at 155 Vanderbilt Avenue in Staten Island, New York. The center will be approximately 18,340 square feet and estimated to cost \$28,349,000. The project will be designed and bid in accordance with the NYC Health + Hospitals' Operating Procedure 100-5.

The new center will offer primary care and specialty services including adult medicine, pediatrics, obstetrics/gynecology, social work, general surgery, orthopedics, urology, ENT, vascular, endocrinology, gastroenterology, cardiology, pulmonology, rheumatology, infectious disease, neurology, dermatology, podiatry and ophthalmology. The clinic will be open 6 days a week as follows: Monday 8am to 8pm; Tuesday 8am to 6pm; Wednesday 8am to 8pm; Thursday 8am to 8pm; Friday 8am to 6pm and Saturday 9am to 5pm.

NEED: The development of this center is part of an initiative to expand the presence of NYC H+H throughout Staten Island.

SCOPE: Construct a Diagnostic and Treatment Center on an off-campus site located at 155 Vanderbilt Avenue in Staten Island, New York. Total square footage of this project is 18,340 square feet. Presently, there is an existing vacant one-story building with no basement on site. The project scope includes existing building demolition, site construction, including an interior parking area as well as new utility connections and services to the new building. The site construction will also include a new foundation to support the modular building. The design will include site development and accessory parking on-site. The two-story modular building will be constructed off-site by a modular manufacturer specializing in the construction of fully equipped modules with interior partitions, finishes and MEP systems ready to be joined on-site.

COSTS: \$28,349,000. The budget allocation, based on actual costs and planned costs, is as follows:

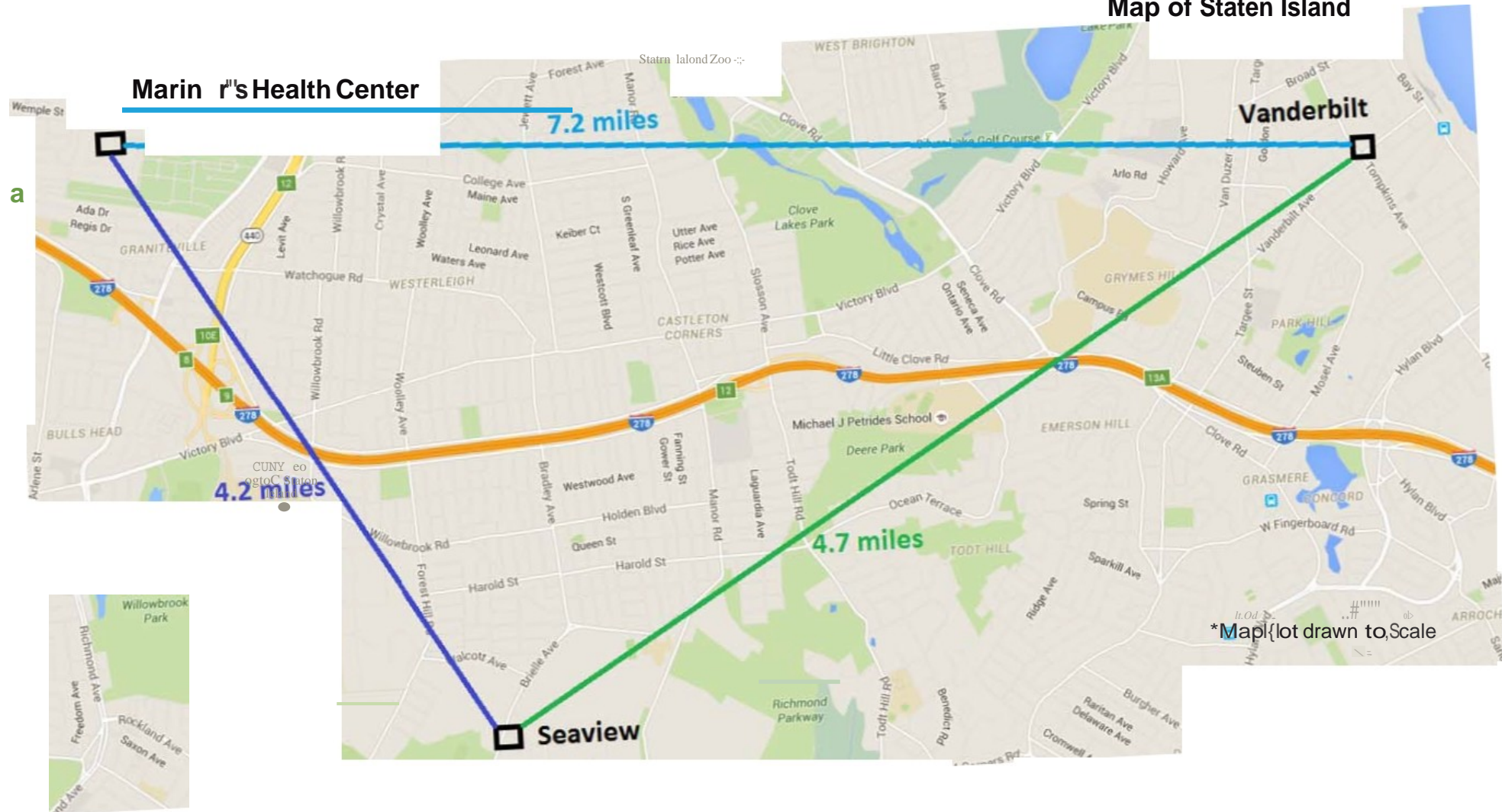
Planning/CON	1,089,614
Design	2,396,133
Construction	19,514,501
FF&E	1,815,060
Telecommunications	1,240,237
Contingency	2,293,062
TOTAL	\$28,348,607

FINANCING:	City General Obligation Bonds - City Council	\$8,052,000
	City General Obligation Bonds - Mayoral	\$20,000,000
	DOHMH Capital Funds	\$87,000
	Health + Hospitals 2010 Bonds	\$209,607

Page Two – Executive Summary
Project Approval – 155 Vanderbilt Avenue

SCHEDULE: The project is scheduled for completion by Fall 2017. The Certificate of Need (CON) application has been submitted to the New York State Department of Health (DOH) and approval is pending.

Map of Staten Island



a

*Map (not drawn to scale)

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "NYC Health and Hospitals") to execute a revocable license agreement with the Volunteer Heart Resuscitation Unit and Ambulance Corporation of Staten Island (the "Licensee") for its continued use and occupancy of 4,284 square feet of space in the Surgical Pavilion to house the administrative functions of an ambulance service and 500 square feet of space for parking on the campus of Sea View Hospital Rehabilitation Center and Home (the "Facility") at an occupancy fee rate of \$7,757 per year for a five year total amount of \$38,785.

WHEREAS, in July 2011, the Board of Directors authorized the President to enter into a license agreement with the Licensee; and

WHEREAS, the Licensee provides emergency medical services to the Staten Island community and has operated out of space on the Facility's campus since 1997; and

WHEREAS, the Facility continues to have space available on its campus to accommodate the Licensee's requirements; and

NOW, THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation (the "NYC Health and Hospitals") be and hereby is authorized to execute a revocable license agreement with the Volunteer Heart Resuscitation Unit and Ambulance Corporation of Staten Island (the "Licensee") for its continued use and occupancy of space in the Surgical Pavilion to house administrative functions of an ambulance service and 500 square feet of space for parking on the campus of Sea View Hospital Rehabilitation Center and Home (the "Facility") at an occupancy fee rate of \$7,757 per year for a five year total amount of \$38,785.

EXECUTIVE SUMMARY

LICENSE AGREEMENT VOLUNTEER HEART RESUSCITATION UNIT AND AMBULANCE CORPORATION OF STATEN ISLAND

SEA VIEW HOSPITAL REHABILITATION CENTER AND HOME

The New York City Health and Hospitals Corporation ("NYC Health + Hospitals") seeks authorization from the Board of Directors of the Corporation to execute a revocable license agreement with the Volunteer Heart Resuscitation Unit and Ambulance Corporation of Staten Island ("Volunteer Heart") for its continued use and occupancy of space to house administrative functions for an ambulance service at Sea View Hospital Rehabilitation Center and Home ("Sea View").

The Volunteer Heart Resuscitation Unit and Ambulance Corporation of Staten Island will continue to use space on the grounds of Sea View as their base of operations. They have been operating from Sea View since 1997. Volunteer Heart is a not-for-profit organization made up of 50 dedicated Staten Islanders, who are concerned about the quality of healthcare on Staten Island. They serve the community by providing emergency medical coverage, at no cost, to many organizations, sports events, health fairs and community parades. The organization operates from 7:00 p.m. until midnight, seven days a week.

Volunteer Heart will have use and occupancy of approximately 4,284 square feet of space on the second floor the Surgical Pavilion and 500 square feet for parking four vehicles across from the great lawn. In 2014, Volunteer Heart moved from the Administration Building into their current location. The Surgical Pavilion space they now occupy was vacant and in poor physical condition. Volunteer Heart made approximately \$300,000 worth of renovations to the second floor. Volunteer Heart will pay an occupancy fee of \$7,757 per year. Volunteer Heart will also provide free medical coverage for Sea View's events as requested. Volunteer Heart will provide interior maintenance and housekeeping to the licensed space.

Volunteer Heart will be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of the use of the licensed space and shall provide appropriate insurance naming the Corporation and the City of New York as additional insured parties.

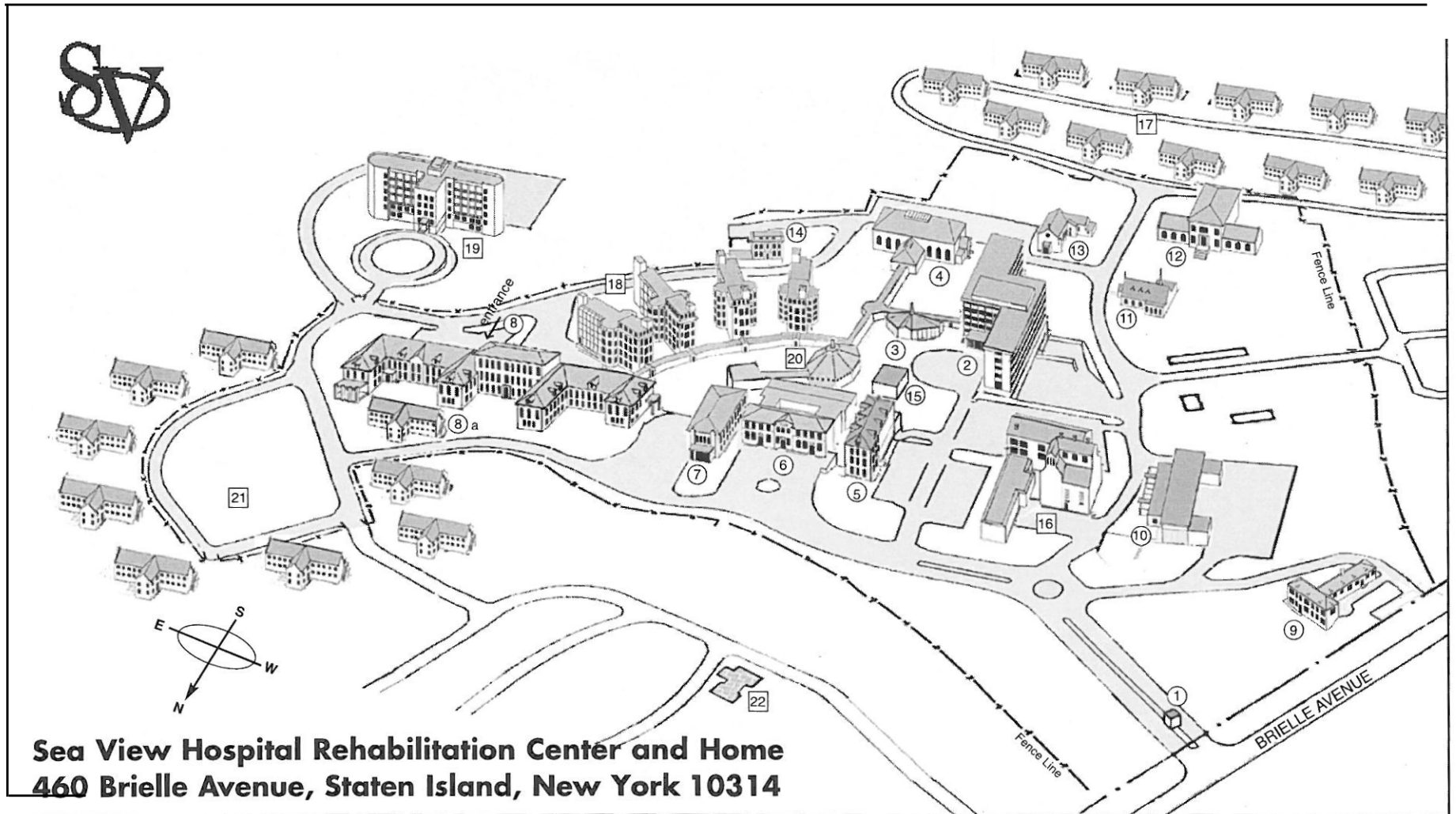
The license agreement shall not exceed a term of five (5) years without further authorization by the Board of Directors of the Corporation and shall be revocable by either party on sixty (60) days prior notice.

RATE CHART

Prior Term	Year 1 – 2011	Year 2 – 2012	Year 3 – 2013	Year 4 – 2014	Year 5 – 2016*	TOTAL
Total Fee	6,078	6,382	6,701	7,036	7,388	\$33,585
Per Sq. Ft.	1.27	1.33	1.40	1.47	1.54	

New Term	Year 1 – 2016*	Year 2 – 2017	Year 3 – 2018	Year 4 – 2019	Year 5 – 2020	TOTAL
Total Fee	7,757	7,757	7,757	7,757	7,757	\$38,785
Per Sq. Ft.	1.62	1.62	1.62	1.62	1.62	

*Agreement expires on August 31, 2016. New agreement will commence September 1, 2016.



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

Occupied Buildings: O

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

Unoccupied Buildings: D

- 10. FDNY / EMS / OCME
- 11. Sea View Playwrights Theatre
- 12. Camelot
- 13. Community Board# 2
- 14. Staten Island Ballet Offices and Studios
- 15. Power Plant Building
- 16. Old Power Plant & Laundry Building
- 17. Men's Tuberculosis Dormitories
- 18. Women's Open Air Pavilions
- 19. Children's Hospital
- 20. Kitchen Building
- 21. Women's Tuberculosis Dormitories
- 22. Ruin of the Director's House

Sea View Hospital Rehabilitation Center & Home

Surgical Pavilion and Parking Lot

Improvements made by
Volunteer Heart Resuscitation Unit & Ambulance
Corporation of Staten Island

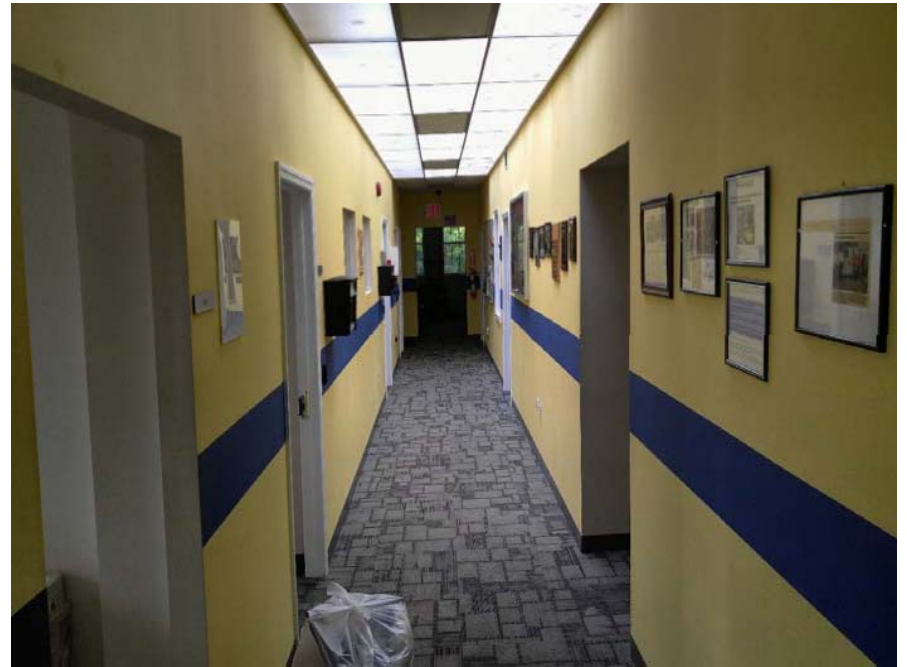
Built in 1913



Main Hallway



Main Hallway Shot # 2



Conference and Training Room

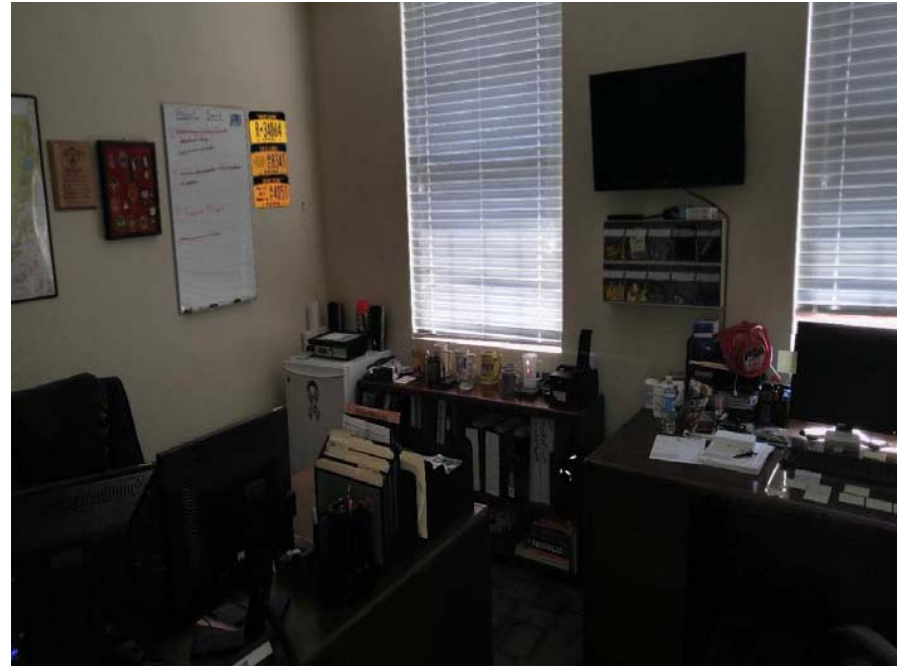
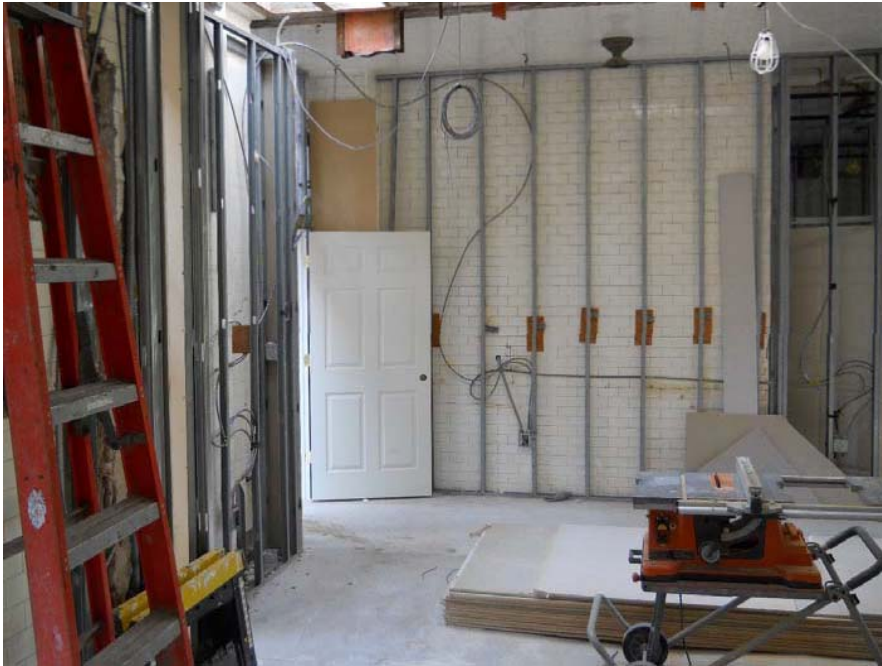


Two new restrooms
were added.

One as shown and a
second one not
pictured with the
original shower
from original
construction



Office Space



Office Space # 2



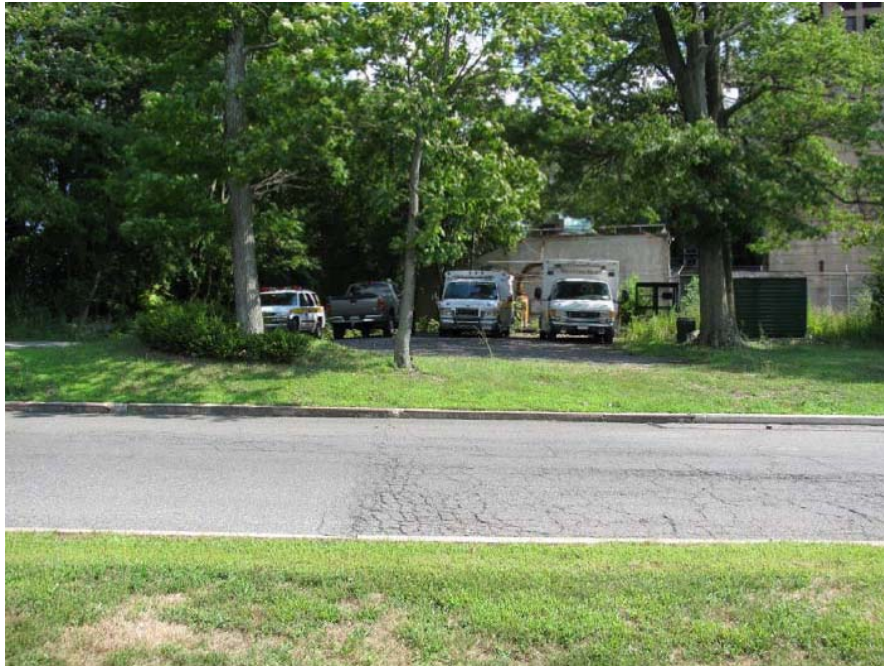
Prior to the office rebuild
Volunteer heart Ambulance did
a rehabilitation to our parking
area.

New driveway, leveling of area, gravel, lights and canopy were installed to help us safely protect our ambulances and allow for proper drainage in the parking lot. Prior to this our ambulances were getting ruined by tree sap and sunlight.

Parking Lot View # 1



Parking Lot View # 2



After completion of the office construction Volunteer Heart Ambulance cleaned out the back section of our parking lot. This area contained much debris and weeds. This allowed us to extend our parking and storage area and created a clean area behind our vehicle parking.

Lower Parking area View # 1



Lower Parking Area View # 2



RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "NYC Health + Hospitals") to execute a license agreement with the New York City Human Resources Administration ("HRA") permitting HRA's continued occupancy of approximately 325 square feet of space in Lincoln Medical and Mental Health Center ("Lincoln") through June 30, 2017 with two one-year renewals for the operation of the New York City Identification Card Program ("NYCID Program") with the occupancy fee waived but with HRA responsible for supplying its own security guard and paying the cost of the additional cleaning required in the amount of \$294/month such amount to increase by 2% annually.

WHEREAS, on July 10, 2014, Mayor Bill de Blasio signed Local Law No. 35 of 2014, establishing the NYCID Program; and

WHEREAS, Mayor de Blasio issued Executive Order No. 6 of 2014 designating HRA as the administering agency of the NYCID Program; and

WHEREAS, the NYCID Program provides an identification card to many New York City residents who have difficulty acquiring alternative forms of identification, thereby helping all residents receive benefits from City services; and

WHEREAS, Local Law No. 35 requires the administering agency of the NYCID Program to designate at least one access site in each of the five boroughs and HRA desires to ensure that the Program reaches as many New York City residents as possible; and

WHEREAS, by exercise of his authority to deviate from NYC Health + Hospitals' contracting and procurement rules, President Ramanathan Raju, MD, executed a license agreement, subsequently reported to the NYC Health + Hospitals' Board of Directors permitting HRA to establish the Bronx site for the NYCID program at Lincoln in time for the launch of the NYCID Program; and

WHEREAS, NYC Health + Hospitals desires to continue to participate in and support the IDNYC Program by allowing the NYCID Program to continue to operate from and engage with applicants at the Hospital; and

WHEREAS, the Senior Vice President for Hospitals and the Executive Director of Lincoln shall be responsible for the administration of the proposed license agreement.

NOW THEREFOR, be it

RESOLVED, that the New York City Health and Hospitals Corporation is authorized to execute a license agreement with the New York City Human Resources Administration ("HRA") permitting HRA's continued occupancy of approximately 325 square feet of space in Lincoln Medical and Mental Health Center through June 30, 2017 with two one-year renewals for the operation of the New York City Identification Card Program with the occupancy fee waived but with HRA responsible for supplying its own security guard and paying the cost of the additional cleaning required in the amount of \$294/month such amount to increase by 2% annually.

EXECUTIVE SUMMARY

LICENSE OF SPACE AT LINCOLN MEDICAL AND MENTAL HEALTH CENTER TO NEW YORK CITY HUMAN RESOURCES ADMINISTRATION FOR OPERATION OF THE NYCID PROGRAM

- Overview:** In July 2014 Mayor de Blasio launched the NYCID Program to make Identification Cards available to New Yorkers who have difficulty obtaining Identification Cards. An NYCID office was established in every borough and, to meet the scheduled launch of the NYCID Program President Ramanathan Raju approved an Exception to Policy to authorize the execution of a license agreement with the New York City Human Resources Administration (“HRA”) which operates the NYCID program for space at Lincoln Medical and Mental Health Center (“Lincoln”) in time for the launch of the NYCID Program. HRA wishes to continue to operate the NYCID Program at Lincoln although in smaller space.
- Need/
Program:** Mayor de Blasio determined that large numbers of New Yorkers could not obtain identification card and were therefor impeded from obtaining City benefits and participating fully in various other activities. The NYCID Program provides identification cards to such New Yorkers and has satisfied a substantial need. When the NYCID Program launched there were a great many New Yorkers who sought the identification cards provided. While many New Yorkers continue to request identification cards from the NYCID Program, the demand has leveled off and, accordingly, HRA is able to meet the need in much smaller space. Accordingly, 325 square feet of space has been identified to be made available to HRA in the Lincoln 1st floor lobby at the Morris Avenue entrance.
- Terms:** HRA will not be responsible for any occupancy fee. But HRA pays for all costs of the NYCID Program at Lincoln. HRA supplies a security guard for the NYCID Program at its cost and HRA reimburses Lincoln for the cleaning costs associated with the licensed space in the amount of \$294/month subject to an annual 2% increase. HRA is responsible for the cost of any alterations it requires and for restoring the licensed space to its prior condition upon the end of the license agreement. HRA indemnifies and holds harmless NYC Health + Hospitals for any costs, claims or damages that are incurred, brought or suffered as a result of the operation of the NYCID Program at Lincoln. The term of the license will run through June 30, 2017 and will renew for two one-year periods thereafter upon the consent of the parties.

RESOLUTION

Authorizing the Executive Director of MetroPlus Health Plan, Inc. to negotiate and execute a contract with Finity, Inc. (“Finity”) to provide education, engagement and rewards services for a term of three (3) years with three 1-year options to renew, solely exercisable by MetroPlus, for an amount not to exceed \$11.5 million per year

WHEREAS, MetroPlus Health Plan, Inc. (“MetroPlus” or the “Plan”), a subsidiary corporation of the New York City Health and Hospitals Corporation (“NYC Health + Hospitals”), seeks education, engagement and rewards services; and

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, consistent enrollment in health insurance is a critical component of maintaining good health; and

WHEREAS, for those with chronic conditions it is critical to their health that they adhere to their clinically prescribed program; and

WHEREAS, MetroPlus seeks to improve the customer experience of all its members, increasing the likelihood they will remain with MetroPlus; and

WHEREAS, an RFP for education, engagement and rewards services was issued in compliance with the MetroPlus’ contracting policies and procedures; and

WHEREAS, Finity has been selected as the vendor with the demonstrated ability to provide these services; and

WHEREAS, the Certificate of Incorporation of MetroPlus reserves to NYC Health + Hospitals the sole power with respect to MetroPlus entering into contracts, other than with NYC Health + Hospitals or a health care service provider, with an annual value in excess of \$3,000,000; and

WHEREAS, the Board of Directors of MetroPlus has duly considered and approved the proposed contract between MetroPlus and Finity.

NOW THEREFORE, be it

RESOLVED, that the Executive Director of MetroPlus is hereby authorized to negotiate and execute a contract with Finity to provide education, rewards, engagement and rewards services for a term of three (3) years with three 1-year options to renew, solely exercisable by MetroPlus, for an amount not to exceed \$11.5 million per year.

EXECUTIVE SUMMARY
Authorization to Negotiate and Execute a Contract with
Finity, Inc.

The Executive Director of MetroPlus Health Plan, Inc. (“MetroPlus” or the “Plan”) seeks to negotiate and execute a contract with Finity, Inc. to provide education, engagement and reward services for an amount not to exceed \$11.5 million annually for a three year term with three options to renew for one year each.

Finity has been selected as a result of a Request for Proposal procurement process, RFP No. 100912R129, to provide these services directly to MetroPlus. The purpose of the RFP was to select a vendor to provide education, engagement and reward services for MetroPlus.

As part of the Health and Hospitals System 20/20 vision, MetroPlus is aggressively seeking to grow its membership. To accomplish this goal, additional members need to be enrolled and the significant number of existing members who disenroll from MetroPlus each month must be reduced. One key to reducing this loss of membership is improving the member experience.

MetroPlus released a solicitation asking for a vendor to assist with improving the member experience by providing education, engagement and rewards services. These services would seek to provide health information to individuals in an interactive way that give members more of a connection to MetroPlus. Further MetroPlus sought proposals for a program to reward members who achieved certain health objectives. These objectives would include broad based objectives open to large segments of the MetroPlus membership including having a physical, having your child vaccinated and completing an initial health assessment. For those with certain chronic conditions the objectives would be specific to those conditions and might include medication adherence and reducing blood sugar levels. For the rewards program to be successful, the vendor would need a strategy to engage members, explain the program to them and keep members interested and excited about participating and ensure they are actually rewarded according to program rules.

The not-to-exceed amount will be for a combination off fees such as initial set-up and analytics. In addition, MetroPlus will be billed for the cost of the actual rewards redeemed and the cost to print and mail member engagement communications. Finally, Finity has proposed putting its licensing fee at risk, only to be received if there is improvement in certain clinical scores.

Background of Finity

Finity is a leader in the field currently providing these services to all Medicaid recipients in the state of New Mexico. They have also done similar work for a plan primarily serving Medicaid recipients in Philadelphia.

Finity offers a tested, customizable platform to assist MetroPlus in its customer experience work. Finity's website is easy to use and provides a wealth of health information for MetroPlus members. The health objectives that are incentivized will be targeted to the needs of MetroPlus and its members.

Finity uses a strong outreach campaign including a variety of methods to initially explain the program and engage members. The website also gives members the ability to track the points they earn by achieving the selected health objectives. A robust call center staff, with broad language abilities, will continue to engage members and answer questions.

Finity also offers a robust suite of reports that will allow close tracking of the program and give MetroPlus excellent information of the health habits of those enrolled. This information can be used to target individuals for services and to help improve quality measures.

The vendor contract is for a three year term with three 1-year options to renew. The projected start date is January 2017.

32062

Keith Tallbe
Associate Counsel, Director of Procurement
Legal Affairs, Supply Chain Services

METROPLUS HEALTH PLAN
CORPORATE AFFAIRS DEPARTMENT

2016 JUL 22 P 12: 25

TO: Kathleen Nolan, Assistant Director
for Corporate Affairs
MetroPlus Health Plan

FROM: Keith Tallbe *KT*

DATE: July 19, 2016

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

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

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): MetroPlus Health Plan

Contract Number: _____

Project: Medicaid Education, Engagement, and Member Incentive Program

Submitted by: MetroPlus Health Plan

EEO STATUS:

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

COMMENTS:

KT/srf



Education, Engagement and Member Rewards Program

Why

- Member engagement is key to positive health outcomes and plan growth
- Opportunities for improvement:
 - High turnover rate, member disenrollment
 - Need to improve quality/HEDIS scores
- RFP done to provide member engagement/rewards program to improve member loyalty and encourage health care activities that will increase quality scores

What will be accomplished

- Finity was selected out of four responders
- Selected vendor will provide a comprehensive education, engagement and rewards program
- Key elements of program:
 - Relentless outreach using different methods (print, phone, texting, email) to connect with members
 - Accessible and engaging web and smartphone platforms to provide educational content
- Reward program to incentivize healthy behavior:
 - Points given to members who achieve specified health objectives such as annual physical, getting vaccinated, completing health risk assessment
 - Rewards for member addressing selected conditions; for example diabetes or asthma (i.e. improved diabetic control)
 - Points can be redeemed for prizes and gift cards

Why Finity

- Finity programs have shown success in improving member health using CMS established methodologies:
 - For asthma up to 44% increase in medication adherence, up to 30% reduction in ER visits and inpatient admissions
 - For perinatal care, 16% increase in postpartum visits, reduction of 7% in low birth weight babies, 5% increase in well baby visits
 - For behavioral health, 13% to 19% fewer inpatient admissions, 140% increase in medication compliance
- Finity was also the most cost effective vendor

Budget

- Budget is \$11.5 million annually for all services including outreach, member rewards, and member portal
- Outreach expenses are highest in year 1 but will decline over time
- Rewards expenses start low but will increase over time as more members engage
- MetroPlus will evaluate at years two and three to determine value to continue program

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (“NYC Health + Hospitals”) to execute an agreement with COPE Health Solutions (“COPE”) to provide consulting services to help structure the partners (the “Partners”) in the NYC Health + Hospitals-Led Participating Provider System (the “PPS”) under the Delivery System Reform Incentive Payment (“DSRIP”) program to yield a network obtaining 90% of its patient service revenue from value-based payments including structuring the method for making DSRIP payments to lead to such a state over a term of one year with two, one-year options to renew solely exercisable by the Corporation for total amount not to exceed \$6,810,000 in initial 12-month period, \$6,810,000 in the first renewal terms and \$5,450,000 in the second renewal term for a total not-to-exceed amount for the three-year period of \$19,070,000.

WHEREAS, the NY State Department of Health (“DOH”) accepted NYC Health + Hospitals’ application to participate in the DSRIP program under which it has established the PPS with Partners consisting of health care providers, governmental bodies, community organizations and other entities;

WHEREAS, among the key goals of the DSRIP program is to encourage health care providers to structure their payment models as value-based; and

WHEREAS, an additional and interrelated key goal of the DSRIP program and the NYC Health + Hospitals-Led PPS is the establishment of a sustainable integrated delivery system; and

WHEREAS, the PPS is challenged to structure DSRIP payments to its Partners to incentivize value-based billing and, over the long term, structure a sustainable value-based billing model; and

WHEREAS, NYC Health + Hospitals conducted a request for proposals (the “RFP”) competitive process to select a consultant to assist in meeting such challenges; and

WHEREAS, out of the five firms that responded to the RFP, the NYC Health + Hospitals’ Selection Committee selected COPE as the consultant in NYC Health + Hospitals’ best interest; and

WHEREAS, COPE has substantial experience working with other Participating Provider Systems operating under DSRIP programs across the country; and

WHEREAS, the Vice President heading the NYC Health + Hospitals’ DSRIP program will be responsible for managing the proposed COPE contract.

NOW THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation is authorized to execute an agreement with COPE Health Solutions to provide consulting services to help structure the partners in the NYC Health + Hospitals-Led Participating Provider System under the Delivery System Reform Incentive Payment (“DSRIP”) program to yield a network obtaining 90% of its patient service revenue from value-based payments including structuring the method for making DSRIP payments to lead to such a state over a term of one year with two, one-year options to renew solely exercisable by the Corporation for total amount not to exceed \$6,810,000 in initial 12-month period, \$6,810,000 in the first renewal terms and \$5,450,000 in the second renewal term for a total not-to-exceed amount for the three-year period of \$19,070,000.

EXECUTIVE SUMMARY

Proposed Contract with COPE Health Solutions Consultant Services for DSRIP Program

- Overview:** NYC Health + Hospitals seeks approval for an agreement with COPE Health Solutions (“COPE”) to provide consulting services to assist in meeting Delivery System Reform Incentive Payment (“DSRIP”) program goals for developing a Value-based Payment (“VBP”) structure.
- Term:** One year with two, one-year options.
- Need/
Program:** A key goal of the DSRIP program is to push health care providers towards using a VBP structure. DSRIP establishes various deadlines for achieving measured progress towards the ultimate goal of 90% VBPs. In DSRIP Year 2 (April 1st, 2016 – April 1st, 2017) the NYC Health + Hospitals’ led Participating Provider System (the “PPS”) is to submit a growth plan outlining its path towards 90% VBP. Growth plans will be weighed in terms of ambition level (speed of implementation, level of risk, total dollars at risk, opting for a differentiated approach rather than total cost of care for total population). By April 1st, 2018, at least 10% of total managed care organization expenditures within the PPS are to be VBPs. Each year through the end of the DSRIP program in 2020 the PPS is required to show documented progress in substantially increasing the share of revenues that are VBP. Along the way, the PPS is to develop and present to State DOH a reporting structure for PPS-wide performance reporting and communication. The PPS’s success in earning DSRIP payments will depend, in part, on its ability to demonstrate progress as required. NYC Health + Hospitals does not have the internal resources or expertise to design a program to achieve the required goals and consequently has sought the support of an experienced consultant.
- Cost:** The total cost of the contract, including the two option terms, will not exceed \$6,810,000 in initial 12-month period, \$6,810,000 in the first renewal terms and \$5,450,000 in the second renewal term for a total not-to-exceed limit of \$19,070,000.
- Procurement:** To identify potential vendors qualified to do this work, a Request for Proposal (“RFP”) was released on May 27, 2016. Five firms responded. The Selection Committee reviewed each proposer’s proposal and each had a chance to present to the Committee. After meeting with the five proposers and engaging with the two finalists, COPE was selected as the highest rated proposer to provide the requested services.

CONTRACT FACT SHEET
NYC Health + Hospitals

Contract Title: **CONTRACTING and FUNDS FLOW PLANNING SUPPORT FOR ONECITY HEALTH SERVICES**

Project Title & Number: **CONTRACTING and FUNDS FLOW PLANNING SUPPORT FOR ONECITY HEALTH SERVICES**

Project Location: Various _____

Successful Respondent: COPE HEALTH SOLUTIONS

Contract Amount: \$6,810,000 (initial 12-month period)

Contract Term: \$6,810,000 in the first renewal terms, and \$5,450,000 in the second renewal term; for a total not-to-exceed amount for the three-year period of \$19,070,000.

Requesting Dept.: OneCity Health Services

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

Range of Proposals: \$677,050 to \$6,810,000 for year 1

Minority Business Enterprise Invited: **Yes**

Funding Source: Operating Budget

Method of Payment: Time and Rate

EEO Analysis: Approved

Compliance with HHC's McBride Principles? Approved

Vendex Clearance Pending Review

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):

NYC Health + Hospitals sought a contractor to strategically develop budgets, funds flow methodologies and contracting arrangements for the HHC-Led DSRIP PPS to achieve its objectives in collaboration with its partners, and that positions the PPS to meet its value-based payment arrangements by March 2019 in accordance with New York State Department of Health (NYS DOH) requirements. This includes creating a financial plan, a contracting methodology and network development strategy aligned with the New York State Roadmap to Value Based Payments.

NYC Health + Hospitals is responsible for implementing a DSRIP Project Plan that was submitted and approved by NYS DOH in December, 2014. The plan includes baseline descriptions of how the entirety of the partnership will approach and execute required clinical project and organizational transformation efforts.

The NYC Health + Hospitals-Led-PPS is not a legal entity; its structure exists only through executed contracts with its PPS Partners to implement the DSRIP program. The partner network is comprised of over 220 organizations from throughout the healthcare and social services continuum, including hospitals, Health Homes, skilled nursing facilities, clinics/federally qualified health centers (FQHCs), behavioral health providers, home care agencies, hospice providers, community-based organizations and others.

Under DSRIP, performance must be measured at the total state, PPS, and individual partner level in order to monitor progress toward achieving program requirements. From the PPS perspective, to improve the likelihood of sustainability, contracting methodologies for partner organizations must be designed and implemented to promote value-based purchasing and alternative payment models.

Among the requirements set forth by the NYS DOH are the following:

- Develop detailed baseline assessment of revenue linked to value-based payment, preferred compensation modalities for different provider types and functions, and managed care organization strategy by 9/30/2016.
- Complete funds flow budget and distribution plan and communicate with the PPS network.
- Establish reporting structure for PPS-wide performance reporting and communication.
- Finalize a plan towards achieving 80%-90% value-based payments across the network by year 5 of DSRIP at the latest in line with the New York State DSRIP VBP timeline:
 - In DY 2 (April 1st, 2016 – April 1st, 2017), PPSs will be requested to submit a growth plan outlining the path of their network towards 90% value-based payments. All growth plans will be weighed in terms of ambition level (speed of implementation, level of risk, total dollars at risk, opting for a differentiated approach rather than total cost of care for total population).
 - End of DY 3 (April 1st, 2018), at least 10% dollars of total MCO expenditure are captured in Level 1 or above.

- End of DY 4 (April 1st, 2019), at least 50% of total MCO expenditure will be contracted through Level 1 VBPs or above. At least 15% of total payments contracted through Level 2 VBPs or higher (full capitation plans only).
- End of DY 5 (April 1st, 2020), 80-90% of total MCO expenditure (in terms of total dollars) will have to be captured in at least Level 1 VBPs. At least 35% of total payments contracted through Level 2 VBPs or higher for fully capitated plans and 15% contracted in Level 2 or higher for not fully capitated plans.

COPE Health Solutions will work with NYC Health + Hospitals to identify the most feasible approach to establish a sustainable Integrated Delivery System and Value-Based Payment structure.

CONTRACT FACT SHEET(continued)

Contract Review Committee

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

The contract will be presented at the CRC on July 22, 2016

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

N/A

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):

Evaluation Committee Members:

1. Dr. Christina Jenkins, CEO, OneCity Health Services
2. Laura Free, AVP, Health +Hospitals Managed Care and Finance
3. Lauren Johnston, Sr. Asst. Vice President
4. Richard Miller, CFO, University Hospital, SUNY Downstate Medical CTR.
5. Linda DeHart, AVP, Corporate Reimbursement
6. Tatyana Seta, CFO, OneCity Health Services

List of Firms Responding to RFP:

COPE Health Solutions
McKinsey & Company
Premier Healthcare Solutions
Health Management Associates
USA Staffing & General Contractor Corp.

Evaluation Criteria:

- 1) Demonstrated Understanding of Work Requested **(30%)**
- 2) Overall engagement design and approach to work-streams **(10%)**
- 3) Prior experience and demonstrated performance with Medicaid managed care programs, Accountable Care Organizations (ACOs) and/or value-based payment arrangements at comparable scale (>500K lives) **(20%)**
- 4) Available resources for engagement **(10%)**
- 5) Client references, including validation of past performance on projects as defined in #3 **(15%)**
- 6) Cost proposal **(15%)**

The Evaluation Committee selected COPE Health Solutions and McKinsey & Company as the highest rated proposers in terms of the evaluation criteria stated in the RFP. These firms were invited to interview with the Evaluation Committee to clarify their proposals on Wednesday, July 6, 2016. The in-person interviews confirmed the Committee's position to select COPE Health Solutions, as they are the highest rated proposer per the evaluation criteria and performed best during the interview, including COPE Health Solutions references with New York State Performing Provider Systems and with other states as to work on Medicaid waivers implementation of the Delivery System Reform Incentive Program.

CONTRACT FACT SHEET(continued)

Scope of work

COPE Health Solutions' goal is to partner with NYC Health + Hospitals' OneCity Health Services to design a feasible, scalable strategy to develop an integrated delivery system capable of financial sustainability in a market requiring capitation at the health plan level. Such strategy will focus on creating a financial plan, developing a flexible contracting methodology, implementing a network development strategy and anticipating and addressing potential challenges throughout the transformation process. To achieve this long-term goal, NYC Health + Hospitals will have to undergo a cultural transformation to be able to effectively engage community providers in development of the network that will be essential to the viability of the VBP model.

To achieve this goal, COPE Health Solutions will establish internal alignment and common business processes, and support NYC Health + Hospitals through the planning and execution of the core workstreams.

To execute the workstreams, COPE Health Solutions proposes to establish an executive advisory group composed of clinical and non-clinical champions representing MetroPlus, NYC Health + Hospitals, the H+H ACO and key external partners to shape the work and course correct as appropriate. Consistent with their client engagement philosophy, COPE Health Solutions envisions leading the development of work products and advising on strategy with a locally-based team who will ingrain themselves in the operations of NYC Health + Hospitals. In addition to the assigned team, COPE Health Solutions brings a host of additional team members deeply engaged with five other New York State PPSs and large integrated delivery systems across the country, providing the opportunity to leverage shared experiences, knowledge, local and national best practices and community partner perspectives.

H+H Contracting and Funds Flow Planning Support Workstreams

Workstreams	Description
1. Payment Models for Project Implementation in Outcomes Based Environment	Leverage our demonstrated experience and existing innovative payment models to best leverage DSRIP dollars for network refinement and shared services development
2. Integrated Delivery System Design	Identify strategies for creating an integrated delivery system that includes external network partners to improve the health of our members by addressing social determinants of health and helping them navigate the health care system to receive coordinated and efficient health care services. This will include defining clear roles across MetroPlus, ACO and NYC Health + Hospitals to optimize resources, build required capabilities, and fill expected gaps (e.g., primary care).
3. Financial Sustainability Under Global Capitation	Identify strategies for NYC Health + Hospitals' PPS to become financially sustainable in a market where payment is predominantly value based, including a global capitation model.
4. Roadmap to Align Services	Create and execute a roadmap to align services and contracting methodology between H+H's Medicare ACO, and H+H's Managed Care Organization (MCO), MetroPlus, and advise upon the formation of one or more contracting entities (e.g., Medicaid ACO, IPAs) from within the NYC Health + Hospitals PPS

Timetable for Workstreams

Phase 1 (Months 1-3)
Planning and Preparation - Prepare a strategic plan for Value-based Payment (VBP) models and Integrated Delivery System (IDS) across H+H and OneCity Health; identify partner and network engagement opportunities and roadblocks; conduct Stakeholder Interviews with key PPS partners; Inventory current services
Phase 2 (Months 4-9)
Design and Execution of DSRIP Year 3 and Contracting Strategy - Design VBP and IDS models; Test payment models for DSRIP project implementation; develop phase two partner contracts Implement a phased financial model approach for sustainability under global capitation Align services and organization structure with OneCity Health and Health + Hospitals
Phase 3 Months 10-12
Follow-up, Design, and Execute Contracting for DY4 - Conduct follow-up and long-term detailed design; Deliver VBP principles and a 4-year gap closure plan
Implement the IDS

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

NYC Health + Hospitals is one of the largest PPSs in NYS and will be challenged over the short-term to structure DSRIP payments to its partners and to establish a value-based payment structure. Since payments to the DSRIP Performing Provider Systems will become increasingly dependent on the achievement of milestones, considerable funds will be tied to meeting the value-based payment milestones in the short run. In the long run it is also critical to position H+H for long-term sustainability. It will be cost effective to achieve long term sustainability and success in implementing value-based payments through an effective integrated delivery system and value-based payment structure.

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.

NYC Health + Hospitals does not possess the technical resources and/or expertise to perform the requirements of the contract.

*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?*

N/A

CONTRACT FACT SHEET (continued)

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

Dr. Christina Jenkins, CEO of OneCity Health Services

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: Submitted to EEO on July 8, 2016

Analysis Completed By E.E.O: July 21, 2018

Keith Tallbe, Associate Counsel, Legal Affairs

32063

TO: David Larish
Supply Chain Services
Division of Materials Management

FROM: Keith Tallbe *KT*

DATE: July 20, 2016

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, COPE Healthcare Consulting, Inc., dba COPE Health Solutions, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): OneCity Health

Contract Number: _____

Project: Contracting and Funds Flow
Planning Support for OneCity Health
Services

Submitted by: Division of Materials Management

EEO STATUS:

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

COMMENTS:

KT:srf



Contracting and Funds Flow Planning Support for NYC Health + Hospitals-Led DSRIP Performing Provider System

NYC Health + Hospitals
Board of Directors
July 28, 2016

Christina Jenkins, MD
Vice President, NYC Health + Hospitals
CEO, OneCity Health Services



Summary

- NYC H+H wishes to engage consultant COPE Health Solutions to support ~250 partner organizations in fulfilling DSRIP requirements in building an integrated delivery system
- DSRIP program requirements include
 - Partner funds flow (contracting)
 - Readying DSRIP partners to engage in value-based payment (VBP) arrangements (VBP)
- This engagement is undertaken on behalf of the OneCity Health PPS and is funded through the DSRIP budget
- We seek Board approval to contract with COPE Health Solutions for one year, with up to two additional one-year options to renew, and a total not-to-exceed (NTE) amount for the three-year period of \$19,070,000.
 - Year 1 – NTE = \$6,810,000
 - Year 2 – NTE = \$6,810,000
 - Year 3 – NTE = \$5,450,000

Total Three Year NTE = \$19,070,000



Procurement Process + Background of COPE Health Solutions

- COPE was selected through a formal RFP process
 - Evaluation committee comprised NYC H+H finance, clinical, and DSRIP leadership
 - Unanimous choice of evaluation committee
 - Highest-scoring in both initial review and finalist presentations/interviews
 - Reference checks excellent

- The proposed engagement was also reviewed and approved by
 - NYC H+H Contract Review Committee (CRC) - scheduled July 22, 2016
 - NYC H+H Centralized Services Organization (“CSO”) Board – scheduled July 25, 2016

- COPE team has many relevant attributes for the engagement, including
 - Knowledge of NYC H+H
 - Detailed understanding of DSRIP
 - Track record of working with other New York State PPSs
 - National experience working on value-based payments and population health management for health systems



Engagement Overview

- Engagement deliverables include:
 - Identifying strategies for NYC H+H and partners to become financially sustainable under value- based payments, including global capitation
 - Designing an integrated delivery system (IDS) with external partners that addresses social determinants of health and delivers coordinated, high-quality, cost-effective care
 - Applying knowledge gained from current and prior national delivery system transformation efforts, including innovative payment/incentive models, so that this partnership:
 - Earns maximum DSRIP performance dollars
 - Deploys those dollars to strengthen the PPS, build capabilities, and help partners prepare for value-based payments



Engagement Design

- Four overarching workstreams
 - Payment models for project implementation in outcomes based environment
 - Integrated delivery system design
 - Financial sustainability under global capitation
 - Roadmap to align services

- Initial 12-month engagement is divided into three phases, each with sub-steps and specific deliverables:
 - Phase 1 (months 1-3) Planning and preparation
 - Phase 2* (months 4-9) Design and execution of DSRIP Year 3 (DY3) contracting strategy (12-month contracting beginning April 1, 2017) and alignment for DY4
 - Phase 3* (months 10-12) DY3 follow up, design and execution of contracting for DY4 and beyond

* Phases 2 and 3 will be further specified during Phase 1

