

BOARD OF DIRECTORS MEETING
THURSDAY, APRIL 24, 2014
A-G-E-N-D-A

<p>Call to Order - 4 pm</p>	<p>Rev. Lacey</p>
<p>1. Adoption of Minutes: March 20, 2014</p>	
<p><u>Acting Chair's Report</u></p>	<p>Rev. Lacey</p>
<p><u>President's Report</u></p>	<p>Dr. Raju</p>
<p>>>Action Items<<</p>	
<p><u>Corporate</u></p>	
<p>2. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with Petrone Associates LLC to provide Hospital Medical Physicist Consulting Services to all Corporation facilities on an "as needed" requirements basis. The Hospital Medical Physicist Consulting Services contract will be for a term of three years with two, one year options to renew, exercisable solely at the discretion of the Corporation, for a total cost not to exceed \$5,117,004. The contract amount includes a 12% contingency reserve of \$537,460 for additional physicist services that may be required. <i>(Med & Professional Affairs / IT Committee – 04/10/2014)</i> EEO / VENDEX: Approved</p>	<p>Dr. Calamia</p>
<p>3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute an agreement with KPMG LLP to provide the Corporation with auditing services and other directly related services including debt issuance related services, debt compliance letter, tax services, and certification/attestation for cost reports for a term of four (4) years, for an amount not to exceed \$3,487,000 plus a 10% contingency reserve of \$340,000. <i>(Audit Committee – 4/10/2014)</i> EEO: Conditional / VENDEX: Pending</p>	<p>Ms. Youssef</p>
<p>4. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute requirements contracts with four firms; Environmental Planning & Management, Inc.; LiRo Engineers, Inc.; Warren & Panzer Engineers, PC and Woodard and Curran to provide environmental services on an as-needed basis at various facilities throughout the Corporation. The contracts shall be for a term of one year with two (2) one-year options for renewal, solely exercisable by the Corporation, for a cumulative amount not to exceed \$3,000,000 for services provided by these consultants. <i>(Capital Committee – 4/10/2014)</i> EEO: Approved / VENDEX: Pending</p>	<p>Ms. Youssef</p>
<p><u>Committee Reports</u></p>	
<ul style="list-style-type: none"> ➤Capital ➤Equal Employment Opportunity ➤Finance ➤Medical & Professional Affairs / Information Technology ➤Strategic Planning 	<p>Ms. Youssef Rev. Lacey Mr. Rosen Dr. Calamia Mrs. Bolus</p>
<p style="text-align: right;"><i>(over)</i></p>	



BOARD OF DIRECTORS MEETING
THURSDAY, APRIL 24, 2014 ~ AGENDA ~ PAGE 2

<p><u>Facility Governing Body / Executive Session</u></p> <ul style="list-style-type: none">➤ Metropolitan Hospital Center <p>Diagnostic & Treatment Center Annual Quality Assurance Plan / Evaluation 2013 (Written Submission Only)</p> <ul style="list-style-type: none">➤ Segundo Ruiz Belvis Diagnostic & Treatment Center <p>Semi-Annual Report (Written Submission Only)</p> <ul style="list-style-type: none">➤ Coney Island Hospital➤ Sea View Hospital Rehabilitation Center and Home <p>>>Old Business<< >>New Business<<</p> <p>Adjournment</p>	<p>Rev. Lacey</p>
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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 20th of March 2014 at 4:00 P.M. pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Reverend Diane E. Lacey
Mr. Alan D. Aviles
Dr. Mary T. Bassett
Josephine Bolus, R.N.
Dr. Jo Ivey Boufford
Dr. Herbert F. Gretz, III
Ms. Anna Kril
Dr. Hillary Kunins
Mr. Robert F. Nolan
Mr. Mark Page
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Linda Hacker was in attendance representing Acting Commissioner Kathleen Carlson in a voting capacity. Reverend Lacey 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 February 27, 2014 were presented to the Board. Then, on motion made by Reverend Lacey and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on February 27, 2014, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

Reverend Lacey received the Board's approval to convene in Executive Session to discuss matters of quality assurance.

Reverend Lacey announced the appointments of and welcomed HHC's newest Board Members, Dr. Mary Bassett, Commissioner of the Department of Health and Mental Hygiene; Dr. Hillary Kunins, Director of Community Mental Health Services and Acting Executive Deputy Commissioner, Division of Mental Hygiene, at the Department of Health and Mental Hygiene; and Mr. Steven Banks, Commissioner of the Human Resources Administration, whose start date is April 1, 2014.

Reverend Lacey received the Board's approval of the following committee appointments: Dr. Vincent Calamia to serve as Chairman of Medical and Professional Affairs and Information Technology; Dr. Mary Bassett to serve as a member of the Quality Assurance and Medical and Professional Affairs and Information Technology Committees; Deputy Mayor Lilliam Barrios-Paoli to serve as a member of the Finance, Strategic Planning, and Executive Committees; Mark Page to serve as a member of the Capital Committee; and Dr. Hillary Kunins to serve as a member of the Quality Assurance and Medical and Professional Affairs and Information Technology Committees.

Reverend Lacey stated that the Joint Commission is conducting triennial surveys at Queens Hospital Center and Bellevue Hospital Center. Mr. Rosen represented the Board at the leadership interview at Queens Hospital and noted the surveyors' appreciation for the hospital and its staff. It is expected that Bellevue will perform equally as well once the survey is completed.

Reverend Lacey updated the Board on approved and pending Vendex.

On behalf of the Board of Directors, Reverend Lacey announced that President Alan Aviles is retiring from HHC after 17 years of service to the Corporation. She stated that he has been a compassionate and tireless leader who has devoted his time to helping HHC become better prepared to meet the challenges facing healthcare in today's world. She commended him on his commitment and support to HHC for the past 17 years.

PRESIDENT'S REPORT

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

Mr. Aviles also expressed his gratitude to the Board for their support over the past nine years while serving as the President of HHC.

ACTION ITEMS

RESOLUTION

2. Authorizing the President of the New York City Health and Hospitals Corporation to execute a 99-year **sublease** with **CAMBA Housing Ventures, Inc.** or a not-for-profit housing development fund corporation in which CHV is the sole member, or a limited partnership or limited liability company in which the general partner or managing member, as applicable, is an affiliate of CHV for the development of low-income housing, and housing for the formerly homeless on the site of the "G Building," a **parcel of land on the campus of Kings County Hospital Center** of approximately 97,000 square-feet at a fair market value rent established by appraisal which is currently anticipated to be not more than \$2.5 million in total.

Joanne Oplustil, President and CEO of CAMBA Housing Ventures, Inc. presented an overview to the Board of CAMBA's goals for the development of housing for the homeless on a parcel of land on the campus of Kings County Hospital Center.

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

BOARD COMMITTEE AND SUBSIDIARY BOARD REPORTS

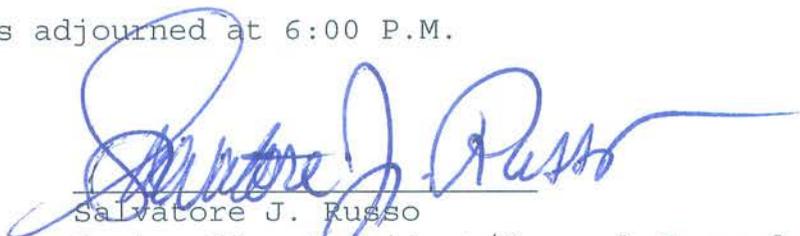
Attached hereto is a compilation of reports of the HHC Board Committees that have been convened since the last meeting of the Board of Directors. The reports were received by the Chairman at the Board meeting.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Reverend Lacey reported that the Board of Directors as the governing body of Woodhull Medical and Mental Health Center reviewed, discussed and adopted the facility report presented; and reviewed and accepted the semi-annual written reports for Coler Goldwater Specialty Hospital and Nursing Facility.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:00 P.M.



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

COMMITTEE REPORTS

Audit Committee – February 13, 2014 As reported by Ms. Emily Youssouf

Ms. Youssouf directed Mr. Christopher Telano, Chief Internal Auditor to begin his presentation.

Mr. Telano saluted everyone and stated that he will begin his briefing by stating that pages three, four and five summarize the four audits currently being conducted by the New York City Comptroller's Office. The first one is the Emergency Room wait time – after the auditors visited the Emergency Department for a second time, they sent an email dated January 24, 2014 stating that based on their review thus far they found insufficient evidence that many of the efforts made to reduce the wait time were formally evaluated. The last paragraph in my briefing refutes that, stating that based on my observation and the monthly and daily information that is evaluated, that this is an incorrect conclusion. We are going to be reaching out to the Comptroller's Office to discuss this point further. On page four is the Navigant audit, the last line indicates that we have not heard from them since September 2013. At this point we do not know the status of that audit. Regarding the ongoing active audits of Lincoln Affiliation and the Patient Revenue, they are meeting with individuals and obtaining information.

Mr. Telano continued by stating that page six lists the audit reports that we are going to review. The first one relates to our review of the art work inventory management. Mr. Telano said that before he calls the representatives to the table, he wants to state that the HHC art web site has a quote that states that the art collection is owned by the City of New York and HHC solely serves as its curator. He then asked the representatives to come to the table and they introduced themselves as follows: Mr. Joe Schick, Executive Director of the Fund for HHC and the President's Office of Special Projects, which oversees the HHC art collection; Fred Leak, Senior Director of the President's Office of Special Projects and Gregory Mink, Arts Administrator.

Mr. Telano proceeded by stating that he will quickly review the findings. The HHC art department maintains a database listing the pieces of art Corporate-wide. We looked for 260 items at 10 facilities, but could not locate 70 percent of those items. We also found that the database was incomplete, and that items we found at the site were not on the database. The other issue is regarding Operating Procedure 10-23 and the inadequacies of that procedure. First, it is dated 1996 and it just does not address the current situation. Our last comment is related to the move of Goldwater to the Carter facility and the lack of control over the artwork being moved.

Ms. Youssouf asked Mr. Schick if he is going to discuss the plans to remedy this and if that is part of the presentation?

Mr. Schick responded that it is and stated that he thought it would be useful for the Committee to hear a brief history of the art work collection and our engagement with them over the years. He stated that it is unusual for a Board Committee to be considering art when they are so many other things that often come up that are appropriate. To which Ms. Youssouf responded that this is one of her favorite topics and it is a lot better than some of the other things we considered.

Mr. Schick began his presentation by stating that the HHC art collection has its origins in the 1930s when some of the works that has been collected in the then City Hospitals were deemed worthy of preservation. The first art work is a mural at Queens Hospital Center, done by an artist named William Palmer in 1936, under the Federal Works Progress Administration rubric, which is responsible for a great many art works that are here both within our system and at other places within the City. In the 1970s, HHC was very active in the acquisition of art works, adding to the collection with the preeminent reason that they were putting art work in the facilities. It was shortly after the formal establishment of HHC as a public benefit corporation. We were using public works to beautify our facilities, which is still, one of the kinds of core missions of what it is that we do.

Ms. Youssouf asked if where it states buyer, does that mean HHC purchased the item.

To which Mr. Schick answered that in some cases, it means that there were purchases of art. In other cases, there were donations and other cases, works that had been at the facilities without governance and in that way became part of the collection. In the 1980s, there was a lot of construction on the HHC hospitals. The percent of design and construction budgets to be dedicated to the purchase of art works was instituted and we followed that by purchasing art works and the collection grew. Over the years, oversight over HHC art has resided in many places within the Corporation, depending on who wanted it, and what the budget was for its oversight. For the last approximately year and a half, it transferred from the oversight of the Facilities Development Office to my office where it resides at this time.

Mr. Schick continued with the next slide with the work by Ansel Adams – we have a number of works by Mr. Adams and by other very prominent artists. HHC art is the largest public art collection in New York City, and has been and remains committed to preserving it, making them accessible to the public, largely through their placement in our facilities. It can be a complicated mission because it often involves preservation as facilities change, as renovations take place and modernization occurs. The art works are sometimes the last thing to be thought of in the initial planning, so it is our job to hopefully, in a timely way, intercede. That has not always been the case, but it is by and large the mission of our

organization. Today we maintain an electronic database of more than 6,000 works of art, the first public agency to develop an art collection database. Some of the works can be seen on the art web site.

Ms. Youssouf asked if the 6,100 was all of the art. Mr. Schick said that it is all of the art that we have. Then she asked if the issue was that not all the pieces could be located? Mr. Telano answered that that is right, we looked for 260 of those pieces, and we could not locate 70 percent of those. Then we did find other items that were not on the database--therefore, the number of pieces in our database may not be reflected 100 percent accurately. Mr. Schick said that part of the disparity, he thinks, is attributable to the fact that the definition of art is something of a fluid one with regard to the works that are on the wall or not on the wall of our facilities. For example, a poster purchased for \$18, and there are many of them that are used to beautify patient areas, may not be listed on the database. They are purchased at the facility level, and the communication has not always been fluid on that – so they could have bought 30 posters to fill in a facility.

Ms. Youssouf stated that if they bought them in 1930, they could be worth a lot now. To which Mr. Schick responded that they could be. In that case, he thinks, most of them have probably made it into the database. The database was periodically, although irregularly, updated over the years. Between Mr. Mink's knowledge of art and the cues that we occasionally get from the facility, we would have found that 1930 poster, identified it and valued it.

Mrs. Bolus stated that last year, the Federal Government was supposed to be claiming all of the works done by the WPA (Works Progress Administration). They felt that since the Federal Government had paid for this art work to be done, that it was theirs. Mrs. Bolus then asked if we had any of that.

Mr. Schick responded that we have works that were commissioned by the WPA in the 1930s when then President Roosevelt used the monies that were paid to artists who had stimulated the economy. He said he had not heard, but perhaps through the New York City Department of Cultural Affairs or the Mayor's Office, which took an active role in the dialogue around art. He said he would pursue the information. Many of them are in our facilities, and would be extremely complicated to remove. Of the 6,100 works, the audit team did identify some works that were not there, and some that would not have been within our database, because they fall below the threshold of identification. Works are intended to be on display at HHC facilities. What he discover in the past year, he did not feel that it was in the best interest of either the art or the facilities to have works that were not in display for the benefit of patients or visitors within the facility. Mr. Mink has been systematically recapturing those works and bringing them back to a safe, secure controlled storage at 346 Broadway. In 2013, we captured about 850 works of art; we have identified about 650 additional works of art that we are bringing back gradually from the facilities. We expect to have all of those within our control by the fall of this year.

Ms. Youssouf asked if everything will be accounted by then. Mr. Schick answered that he thinks a lot will be accounted for. Some things, he believes over the years, it could be decades, are irretrievably lost. We appreciate the comments by the audit team about this; we do see ourselves as the monuments men in some sense about all of this. We think our goal is to preserve, it is not always easy.

Ms. Youssouf asked Mr. Schick if he is actually going out to each facility and going from top to bottom? Mr. Schick said yes, earlier this week we went to one facility where we did not find everything. It may be that some things were stored and fell prey to Sandy. A lot of things had been moved from their distant location. About five years ago, there was an instance where a theft was underway; a piece of a large mural at one of our hospitals that was no longer in a visible public location had been cut from the wall. We found out about it and pursued leads, and determined that a temporary worker in the facility had begun the systematic removal of an extremely valuable work of art. We believe he was arrested. There is a certain amount of vigilance, we will not discover every piece of art work in the full course of a new survey, but we will do a few other things that have preventive value. Notably, we are going to start to create bar coding tags that we will put on every piece which will disclose the location and some descriptive aspects of it. The database already has most items, if not all, which are photographed so now we will be able to attach a far more specific geography. The price of doing all that has come down – at one point, the price was prohibited.

Ms. Youssouf asked if the facilities will keep a record of what they have and will they have instructions to let you know if they have to move it.

Mr. Schick responded that this refers to Operating Policy 10-23 which in its establishment, created an obligation on the part of the facilities from the most senior level, to maintain and keep track of and oversee the works of art in their custodianship. Over the years, people have changed, rules have changed – OP 10-23 was always likely to be a pretty obscure piece of arcana in our system. It has really sort of fallen off the radar for a lot of people at the facilities. We plan to do a complete overhaul of it, the audit team correctly identified the need for that and we have already undertaking some exploration of the aspects of that. By March 21st we are going to present an initial outline, we will work with Mr. Russo and his office and will work with facility representation as well. Ultimately a new OP 10-23 will emerge with the obligation of my office to communicate with facilities management and to make them aware of it and to enhance the nature of their responsibility for the pieces within their direct custodian control. As we update the database, we also hold sort of in-service dialogues with the people who have more hands on responsibility.

Ms. Youssouf asked if some of this art work is being appraised, will they be insured and is this something that can be put on the balance sheet -- perhaps this is a question for Finance. She asked Mr. Jay Weinman, Corporate Comptroller to approach the table.

Mr. Weinman stated that he did not really know who owns the art work – that was one of the discussions he recently had with the Office of Legal Affairs, who really owns it and whether it actually belongs on our books as an asset or not. That question has to be answered first and he is not exactly sure yet, but if it is an asset, then yes, it will have to be put on our books with a specific value.

Ms. Youssouf asked that if it is not an asset for us, then is it an asset for the City. Mr. Schick responded that his understanding is that the asset is wholly owned by the City. If we, by virtue of the 1973 City Charter, have a curatorial responsibility for it, we are not the asset holder. From the perspective of having to be responsible for the valuation of it, we are not asked to do that by the Public Design Commission, which is part of the Department of Cultural Affairs.

Mrs. Bolus asked if we are not the holder, how then could we be responsible for the preservation. To which Mr. Schick responded that because that is the responsibility bestowed upon us as the curators of the work to maintain it and to safeguard it.

Mr. Russo added that we also get the benefit of the beautiful art work in our facilities.

Mrs. Bolus added that it seems odd that we cannot take it as asset, but we can take it off as an expense. It is kind of hard.

Mr. Schick said that given the value of it to our facilities, those 6,000 works that there is kind of quid pro quo in there. It does not cost a lot of money to oversee the collection, although we will have to spend some more money in the year to come to just make sure that we are following the suggestions of the audit team.

Ms. Youssouf said that she is not 100 percent sure that if we are curating it and it is still in our facilities, that it is still not an asset somehow for us, from an accounting vantage point.

Mr. Weinman added that from the accounting perspective, we are going to have to make sure who actually has title. While the City may own some of them, we just have to make sure that everything is on the books. If we are curating, solely curating and it is really not owned by us, then it would not go on our books.

Mr. Russo said that as part of our agreement, we do not own the property even if they are in our facilities. For that one dollar a year with the City, we have the benefit of having them, but they did not surrender title to us. There may be some differences of something that has been specifically donated to HHC; we would have to look on an individual basis. In those cases, we would still have to have the relationship with the Public Design Commission.

Ms. Youssouf said that once you figure that out, if they could report back to this Committee. It is a lot to sort out, but she is sure the City would like to know how much they have in art work and where it is. It is an asset to the City and since we are a component part of the City budget anyway, it all ends up flowing to the same place. To which Mr. Schick added that they probably do a kind of umbrella evaluation of all the art that exists within the City under their domain. That would include architecture and all manner of art and we are one of the components of it.

Mr. Russo asked Mr. Weinman if the facilities we have are listed on the City's asset list. To which Mr. Weinman responded that the buildings are on our asset list.

Mr. Martin added that he is very happy that Mr. Telano did the audit, because to a great extent, a lot of what has come forth, we would not have known. Ms. Youssouf said that she agreed.

Mr. Schick said that we are addressing the database issues and completely recapping OP 10-23. Some of the points that are being made this morning will be incorporated and answered in an updated version of the policy; essentially all of these things are action steps for us. The works of art that we are recapturing from facilities or already have within storage in our offices are intended in many cases to be returned to facility view. We are giving Carter 47 works of art, totaling about \$700,000 and the insurance for those is substantially above that figure.

That includes one work by the artist Romare Bearden which is valued at \$500,000. Collectively, and then another work valued at \$45,000. Collectively, all of the other works have a value of somewhere in the neighborhood of \$175,000.

Mr. Schick continued and said that rather than having the facilities spend many hundreds of thousands of dollars to essentially buy art work to beautify their facility, we are doing it for them. We are working with the architects, the designers and our facility representatives to introduce a far higher standard of art to the facilities than would otherwise be purchased. We are saving the money, and we are giving them better art. We are doing the same thing for Gouverneur and we will do the same thing for 55 Water Street.

Ms. Youssouf said that she thinks it is great, and that is the purpose of us having this art.

Mrs. Bolus asked if they are being protected by placing under glass or plastic. Mr. Schick responded that when they are displayed, they will be put under Plexiglas.

Mrs. Bolus asked if there will be a sign somewhere that says the penalty for tampering with it. Mr. Schick answered yes, perhaps a one piece of signage that would identify that the works are HHC, that they are protected by HHC and that they should not be tampered with in any way.

Ms. Youssouf thanked Mr. Schick and said she appreciate it and wished him good luck. She then turned to Mr. Telano to continue with his briefing.

Mr. Telano stated that on page eight of the briefing, they did a real estate rental properties audit, which is space utilized by outside tenants at HHC facilities. He asked if the representatives could approach the table.

Ms. Youssouf asked them to introduce themselves, they did as follows: Jeremy Berman, Deputy Counsel, Office of Legal Affairs; Ms. Denise Soares, Senior Vice President, Generations Plus Network; Caswell Samms, Network CFO and Leithland Tulloch, Deputy CFO, Harlem Hospital Center.

Mr. Telano continued and said that the first issue we came across was regarding an HHC building located at 1727 Amsterdam Avenue. We found that there is a tenant there, Jackson Ophthalmology, who we could not determine if they were paying rent. There are no documents, there is no lease, there are no canceled checks regarding this tenant. Apparently, there is a history related to the building that I believe Mr. Berman can fill us in more regarding this issue.

Mr. Berman said that the history of this building has actually been discussed before the Capital Committee when a resolution was adopted to authorize one of the occupants to receive a license. This is a building which is owned by the City of New York and was built in the early 1970s and for the purpose of housing DOH programs of a community-based health care provider which has since split into two parts and now constitutes the two main occupants of the building, both over a couple of decades. The operation of these DOH programs has shifted back and forth between HHC and DOH, as different administrations come and go. In the course of that evolution and under circumstances perhaps 20 years ago, the building came to be assigned to HHC to operate. That is actually the pattern of the real estate relationship between the City of New York and HHC, that properties are given to HHC to manage, and then conversely surrendered by HHC back to the City without necessarily clear documentation. So it was not evident that this property was totally under our jurisdiction until really rather recently.

Ms. Youssouf asked if the history of the building was known when they approved the lease with the other parties. Mr. Berman responded yes, it had become known. In fact, this other party, Heritage Health stimulated this evolution because Heritage Health was very anxious to take over some space in the building that had recently been vacated by DOH. For a period of more than a year, Heritage Health had been agitating through various channels that they should receive the right to occupy this space that had been vacated by DOH. The original impulse had been to say this is a City matter, this is a City building, and the City had put DOH in place. It was not clear to us that we had the authority to enter into this relationship with Heritage Health. There had been a number of efforts by HHC, dating back to the 1980s to get the City to assert its control and jurisdiction over this building, unsuccessfully, apparently the City will not take the building back, and we should then say we will step up. We will be the administrators of this building. In doing so, we inherited a situation which is very unorthodox. Mr. Telano says that there are no documents to justify Jackson's occupancy. In fact there is no document to indicate the basis of anybody's occupancy there.

Ms. Youssouf asked who Heritage has been paying rent to. Mr. Berman answered Harlem Hospital, Heritage and the other main occupant, Upper Manhattan Mental Health has been paying on a fairly regular basis to Harlem Hospital which has been receiving the money and has been treating this as a regular income stream that they monitor. However the ophthalmologist does not appear to pay anything to Harlem Hospital.

Ms. Youssouf asked if they have contacted Heritage and the other entity to see if they sublease out the space to the ophthalmologist. Mr. Berman said that we have spoken to Heritage, only because Heritage pressured us. We have been hesitant to broach this whole subject with Upper Manhattan because we wanted to understand better what the community support for the programs was and the political support for the programs, before we started pressuring them to regularize their occupancy. This is something we would like to have done months ago, but we think that the reason the City has not taken this building back from us is because it is kind of a hot potato, in that the occupants of the building have kind of a proprietary sense about it, which is not based upon anything legal. Rather than stir up a hornet's nest, we wanted to proceed carefully. In fact, we thought it would probably be prudent to wait until after the election, so there was a new elected official in the Council representing that district, with which we could consult and approach this in a kind of diplomatic way. It is our goal and our obligation to get Heritage and Upper Manhattan on a lease or a license approved by this Committee at fair market value. It is not consistent with our charter to be providing space to a private ophthalmologist, that occupancy would have to be set forth.

Ms. Youssouf asked if Harlem Hospital has anything buried away anywhere, a lease or some kind of agreement. Ms. Soares answered no, we have searched and we have not found anything.

Ms. Youssouf asked if anyone at Harlem has any contact with the ophthalmologist. Mr. Tulloch responded yes, we have sent him several letters to see if we can obtain a copy of his lease, but we have not been successful. We have been in contact with his attorney, to see if they could identify if a lease exists.

Ms. Youssouf asked if they were aware that the ophthalmologist has not been paying rent to Heritage. Mr. Tulloch said correct.

Mr. Berman stated that they have a meeting scheduled with Laray Brown and Mr. Wilson and Heritage next week. To which Ms. Youssouf said that Heritage is not the problem. Mr. Berman said that everything about Heritage is a problem.

Mr. Berman said that he thought they had a clear arrangement with Heritage that was embodied in the resolution that was adopted by the Committee. Since then, for reasons that are not clear, Heritage has been unhappy with that arrangement and has complained to various elected officials that there is something not fair about the way in which they are being treated. We need to deal with these other matters, but since they are complaining and asserting themselves, we want to meet with them and understand their point of view.

Ms. Youssouf asked if they should be meeting with the others. Mr. Berman answered yes, we should. Then Ms. Youssouf said, forget the ophthalmologist – you have another big tenant there. Ms. Youssouf stated that it would make a lot of sense to have those meetings as soon as possible. Mr. Berman agreed.

Mr. Russo agreed as well and stated that Mr. Berman will work with Ms. Brown to set up a meeting with them, and then ascertain whether in fact they have been getting the rent from the ophthalmologist.

Ms. Youssouf asked if Harlem Hospital has any information about how long they have been receiving rent from these entities, and if the rent has been at the same level from day one through now. Mr. Samms stated that we have documentation to show that we have been receiving rent. Ever since Heritage and Upper Manhattan branched off from the original lessee, we have been collecting on a monthly basis \$30,000 from Upper Manhattan and over \$7,500 from Heritage. Then Ms. Youssouf asked since when. To which Mr. Samms responded that they had broken off in the 1980s.

Mr. Berman added that there was a litigation brought by HHC against Upper Manhattan for non-payment of rent. There was a court stipulation that required that certain repairs be done by HHC through Harlem Hospital and required Upper Manhattan to resume paying rent. Ms. Youssouf stated that there must have been a lease then, because how could a court decide in our favor if we had nothing indicating we owned the property, or we had a lease agreement with them. Mr. Berman commented that that is a very logical conclusion, but still in all, we do not have that lease or license and neither do they.

Mr. Russo added that it could be stipulated by the parties so that it would not be an issue, and there would be no question – so that the court would not have to see such document.

Mrs. Bolus asked what year was this. To which Mr. Berman responded that he is guessing but he would say 1990. Mrs. Bolus then asked if they have been paying rent since then. Mr. Berman said yes. Ms. Youssouf asked if it's the same rent. Ms. Soares said yes.

Ms. Youssouf asked if the rent has not increased since 1990. Mr. Berman responded that that is right, and his speculation is that the rent has not increased since 1974. Mr. Russo stated that these organizations have a lot of community support and they provide a very important community service. To which Ms. Youssouf added that nobody is questioning the organizations. What we are questioning is that this is just not appropriate business practice. We support them, but it is our obligation to maintain those properties and buildings so they are in good standing physically which is why we get rent. If people have not noticed, HHC needs to collect as much money as possible. It is not about them, what we care about is that we get leases in place that we are protected legally, and that we have everybody paying who is in our buildings.

Ms. Youssouf stated that she would like Mr. Berman to report back and let to the Committee know what happens. To which Mr. Berman responded that it would give him great pleasure to be able to come back and report that all this has been arranged -- he had taken the first step by dealing with Heritage and now he finds this very disturbing. Ms. Youssouf added that she is disturbed because we approved the lease, and they signed it.

Mr. Berman stated that not only did the Committee approve the resolution, not only did the head of Heritage sit right in this seat before you, but we also prepared a letter of intent to map out what was going to happen when they signed. It is very disturbing and also although they are a very respected organization, it kind of makes you wonder how reliable a business partner they are.

Ms. Youssouf stated that she would urge him to please have a meeting with the other party as quickly as possible, and then the ophthalmologist.

Mrs. Bolus asked if Mr. Berman has spoken to the legislators. Mr. Berman responded that Ms. Brown has been in touch with both the new elected Council member from the District and with City Hall. She made it clear to them that we have an obligation both as custodians of the property and further as a healthcare provider.

Mr. Martin added that we have to be consistent also, because we have other entities that are in our facilities that are paying rent and are doing the right thing.

Mr. Telano continued with his briefing by stating that he has a couple of other issues related to Generations Plus and Harlem and Lincoln and asked if Ms. Youssouf wants to go over them. Ms. Youssouf responded sure.

Mr. Telano stated that the first area is regarding the receipt of rent payments. We found that a check for \$80,000 from Sprint was originally sent to our facility in January of 2012, but was not deposited until February 2013. Apparently a check was sent, and after six months, it became void and then they sent a second check which also became void. Then the third check was finally cashed, it is hard to track where this check went, but I was informed that it originally went to the Lincoln facility, and then it was forward to the Central Office. We do not know who at Central Office, and obviously they did not deposit it in Central Office.

Ms. Youssouf asked if there was someone present to help with this finding. Mr. Weinman approached the table and stated that they did not have a record of receiving the check. He knows that it was not deposited and was not cashed. He then said that the policies they have in his office is when they receive a check it would be deposited right away.

Ms. Youssouf asked if Sprint had any instruction where to send the check and to whom? Mr. Telano responded that they looked at the contract and there is no remittance address in there. The amendment from 2011 states that they do have a licensor address that states New York City Health & Hospitals Corporation with the Lincoln address.

Ms. Youssouf asked what the best course is – is it to do an addendum to the lease. Mr. Berman answered that because of this finding by our internal auditors, we amended our formal license agreement to include a direction that payments be made to the facility in which the space is located, to the attention of the Chief Financial Officer of the Corporation. Under the operating procedure, it is the obligation of the Chief Financial Officer of the facility to make contact with all licenses and tenants and to collect the money. He does not believe that there is any other instance, including any other instance with Sprint, with whom we have our licenses, where they have not managed to figure out the importance of zoning and we managed to direct them to make payment to the facility. But it does raise a good point; he said he would be happy to provide her with a new copy of our licensing agreement that does contain this language.

Ms. Youssouf said that she thinks that he should provide it, because that is definitely information to the Committee.

Mrs. Bolus asked if it would help to provide a self-addressed envelope. To which Mr. Berman responded that this is not a function assigned to the Office of Legal Affairs. We do not collect the money, the facilities are responsible and their chief financial officers are responsible for collecting this money.

Ms. Youssouf added that there are two other instances – maybe Harlem Hospital or the network is the one to really address it, because there was a failure to collect increased rent totaling another \$36,000. This one, I am very concerned about because we approved this agreement with the American Academy of Funeral Services, and they did not pay rent – what is the plan to try to fix all of this.

Mr. Samms said that we can start back with the Sprint lease. Sprint believed that the place of business was 125 Worth Street therefore the check was being mailed to Central Office. Going forward, we are in direct communication with Sprint with regards to rent payment. We are also going to improve communication with the Corporate Comptroller's Office to make sure all rents are deposited. Also, keeping copies of all posted checks as well as the posting, so we have a record. With regard to the institutional cost report issue, that predates to a lot of senior management changes here in the Finance Department. There was no Chief Financial Officer at that point in time, and there was no Comptroller in Harlem's office either. He said he started in December and a new Controller was hired in January – so we actually put a tracking mechanism in place to make sure that we are monitoring the controls as well as updating across the board and updating the bills and receipts that we send to the tenants on a timely basis.

Ms. Youssouf asked if you are comfortable that now you know all the tenants, you know the terms of the leases, any bills that are due and that you have put on an automatic schedule to send the bills out and have a tickler system in place that tells you when the lease is up, etc. and are all these safety features in place now.

Ms. Soares responded yes, when we got the audit report, we looked at all of the people in the network who have tenants. I asked Mr. Samms to really follow up with that and mentioned that we had put a plan in place as to how we would collect the rent, how we have the tickler and just to make sure that everything was on par. So we are comfortable now with that.

Ms. Youssouf stated that there is one more. Mr. Telano then continued by stating that there is an inconsistency regarding the Towers Café lease. The contract requires that they send register receipts or a computerized report documenting the amount of sales, because the rent is based on the percentage of sales – this was not being done. We also found inconsistency that Jacobi does not have that clause specifically, and I know there is a boiler plate that does not apply verbatim to the Jacobi lease as it relates to updating on a monthly basis regarding the receipts – it was close.

Mr. Russo added that it was close enough. He believes it said "and cash register receipts". Mr. Telano commented that that was the boiler plate. Mr. Russo said yes. Then Mr. Telano said that Jacobi did not specifically state that it was required, whereas the other lease said that it was

required. Mr. Russo added that he did not recall off hand, he will dig up the email where it says that it was in the Jacobi as cash. Ms. Youssef commented yes, manually reported – so the question is how is this being fix and who the person is to respond.

Mr. Telano said that perhaps Mr. Samms could address that. Mr. Samms said that the previous process that Finance was using at Lincoln was to obtain copies of the actual Bates statement to do the reconciliation. We are now in the process of actually collecting all of the cash register receipts, as well as known samples of the cash register receipts to make sure they reconcile with the bank statements. We already did the first two quarters of Fiscal Year 2014, and we have identified no issues at this point in time, this will also be managed by the Controller's office and Finance and those reconciliations will continue.

Ms. Youssef asked if they meant at the network level. Mr. Samms and Ms. Soares answered yes, at the network level. Mr. Russo added that in addition to putting in our standard agreement cash register receipts, and any other electronic recording receipt, we have used this as an opportunity to even further improve our documents.

Ms. Youssef asked what about Jacobi. To which Mr. Telano stated that Jacobi was going to make the necessary changes to their contract.

Mrs. Bolus asked how many Towers Cafes we have. Mr. Martin answered that he thinks there are two others and that they are one of our primary vendors.

Mrs. Bolus asked if we have instituted the same procedure with them to make sure that we get this straight. Mr. Martin responded yes, that he did an analysis of all of our facilities in terms of art work, real estate and two other issues that are coming up. I can assure you that we are investigating and we are taking corrective action. Mr. Martin handed out the report to the Committee.

Ms. Youssef thanked him and said that she appreciates it. Then asked, if we are ready to move on to Queens. Mr. Telano said yes and stated that on page 10 of the briefing, we did an audit of patient property and valuables at Queens Hospital. First, we found some control weaknesses related to the safeguarding of the valuables. They were being transported throughout the hospital without the Hospital Police. We found that they were kept in unsecured areas in the Psychiatric Emergency Department. Sometimes they were kept in the rooms for an excessive period of time. Section D is related to unclaimed patient property not being recorded by the Patient Property Office. They were holding it for an excessive period of time and not contacting relatives within a legitimate time period. Section C is related to the discharge of deceased relatives, which we are not confirming the individual who is collecting their items. On page 11, we found that weapons being confiscated from patients are being kept for an excessive period of time instead of being destroyed. Mr. Telano asked for the Queens representative to be called.

Ms. Youssef asked them to introduce themselves and then talk about how you are addressing this issue. They introduced themselves as follows: Robert Rossdale, Deputy Executive Director; Michael Milinic, Network Controller; Michael Valentino, Senior Associate Director.

Mr. Rossdale stated that as an overview, we certainly have had a fragmented system. The Emergency Department, the Comprehensive Psychiatric Emergency Program (CPEP), Inpatient Units, various people doing different things, not in a uniform way and that is what the audit picked up. We have corrected many of the items that were listed by the audit, for example, safeguarding transports around the hospital. The Hospital Police are accompanying people with any patient property and valuables into the property office – that was not the case before. As far as unsecured areas, the safe in CPEP was not in a secure area. Hospital Police, under Mr. Valentino has taken responsibility for all security aspects of patient property. They have a new safe for CPEP, which we expected to be delivered in January, but delivery was delayed by the manufacturer. As soon as it arrives, it is going to be placed in a secure location in CPEP. As far as unclaimed patient property, and in terms of notifying relatives, processes have been changed in the Property Office on many aspects – they are now notifying within the time frame. As far as the weapons being there for excessive periods of time, that has also been corrected. We have been using the Breakthrough process to bring all parties together -- Emergency Department, CPEP, Property Office, Patient Relations, Administration and Hospital Police -- to come up with a unified policy and we expect by the end of the month to have that in place. So far we have had six or seven meetings both with the actual people, front line people who are doing the work collecting the patient property, doing the vouchering, as well as with the higher level administrator. We are not happy with the audit not because of the auditors, they were very fair, but because they brought out some things we discussed back and forth. Almost always, they were right and we found a way to address it.

Mr. Rossdale continued by stating that Mr. Telano's staff has done audits that have been very good for Queens Hospital Center.

Ms. Youssef commented that the gun item concerns her and asked if there is a unified procedure in HHC about what you do when you get a patient with gun. Mr. Russo answered that it has to be turned over to the police. Mrs. Bolus added within 30 days.

Mr. Valentino stated that the weapon was not a firearm. Anything like that would immediately be vouchered and brought to the police department for proper handling. The items discussed with the auditors were more like if a patient came in with maybe a steak knife or something like that. It was inappropriate, obviously, to bring it to the floor, so it would be confiscated by Hospital Police, vouchered, a Hospital Police HHC 587 form filed, and put into the safe. The issue found was that it was kept in the safe for an extended period of time, and we were not disposing of it properly. Now we sweep the safe on a 30-day rotation and we dispose of the items properly – it was a good catch by the auditors.

Mrs. Bolus asked what he meant by properly. To which Mr. Valentino answered that it gets photographed and then it goes into the compactor. It gets witnessed by Hospital Police and an administrator and documented on the Hospital Police Form.

Ms. Youssouf asked when you say it is returned, that is only if and when the weapon is not really a weapon. Mr. Valentino responded exactly, sometimes someone comes in with a folding knife that may have some value to them; maybe it is a family item. It is still not appropriate to bring it into CPEP or into another area of the hospital. We do confiscate it and hold it, and as appropriate, we do return it to the patient upon discharge and document that on the Hospital Police report and the person signs for the property in our property log book.

Mr. Russo added that if you have any questions, you can always call our office as to whether this constitutes an appropriate item to return back to the patient. Mr. Valentino stated absolutely and thanked Mr. Russo.

Ms. Youssouf thanked them for the thorough response and stated that next time they will be here in person.

Mr. Telano moved on with his briefing report by stating that on page 12, we did a surprise audit, an inventory count of the medical surgical supplies at Bellevue, and we revealed that 60 percent of the items that we counted did not agree with the computer system. We also noted that there was inventory for the Dialysis Department that was not contained within the inventory system. We noted that the area in which the inventory was maintained was very accessible during business hours. The gates were left open, and there were some security issues. We also noted that when the items were being forwarded to the patient care unit, there was a lack of control over the number of items being sent and that they were not being signed off for.

Ms. Youssouf asked the representatives of Bellevue to introduce themselves and how they are going to address these issues. They introduced themselves as follows: Steve Alexander, Executive Director; Neal Agovino, AVP and William Hicks, Chief Operating Officer.

Mr. Alexander stated that he will give you an overview and then Mr. Agovino will give some more details. On the first issue with the inventory counts, we had not been doing periodic cycling of inventory, which we needed to do to correct the imbalances in the system and the imbalance on the shelf – we have instituted that. The recent cycle count that was done showed only four items out of 80, or 5 percent that were inaccurate. The documentation was made in eCommerce to reconcile that, as well as an investigation to find out why it was off. The dialysis items that were not carried as inventory items in eCommerce have been corrected. There were a few items that were not part of that formal electronic inventory that were added.

Ms. Youssouf asked how it could not be part of the inventory. To which Mr. Alexander responded that it is a little bit of a legacy. When the dialysis items used to be inventoried by that department, they were not kept by central. When we made the transition to a vendor for dialysis services, these were kind of left off to the side. There were just a few items, so we had to add those. They had not historically been on the formal med/surg inventory.

Ms. Youssouf asked if it is different at every facility. Mr. Alexander said that he believes it is and it should be more unified.

Mr. Martin added that in the document he gave you, the Executive Directors looked at their own respective facilities to make sure they had controls in place so that they could manage this. Mr. Martin does not know if the controls are the same everywhere, but they gave him a level of confidence that they have control over it.

Mrs. Bolus asked Mr. Alexander how much of the equipment are we keeping, since we have sent the dialysis to another department. Mr. Alexander responded that the equipment was all purchased by the vendor and that was a couple of years ago. This is actually Dialysis Solutions that are used by inpatients, which are the only ones that we manage.

Ms. Youssouf asked that having the cage open is obviously an issue – have you put on new locks. Mr. Alexander said there are locks on the doors, but when people are inside there, they were leaving the doors open, which as pointed out, is a vulnerable situation – it has been corrected. We are installing card access readers, which will also address the issue of knowing the individuals who access at any point in time. Some of that had been in place but was lost during Sandy, and we did not put back the systems quickly enough – that is being corrected.

Mrs. Bolus asked if we know for a fact that nothing was tampered with when the doors were open and the equipment was there. Mr. Alexander said that they are open when the department is in operation. There is staff inside, it is just that somebody could walk in and somebody could be in the back. We do not know in effect, but we are doing a more effective job now of managing the inventory counts.

Ms. Youssouf added that you did not have an inventory count, so something could have gone missing in the past, but you fixed that; is that what you are saying. Mr. Alexander answered that we had the count, the count was not always timely and accurate, it what is being reflected out here. What was in the system did not accurately reflect necessarily what was on the shelf. Without the intermittent and periodic regular cycle counts, we do not have the opportunity to reconcile the discrepancies in the balances – that is what is being fixed. On the last item, med/surg works regularly with the nursing staff to identify what should be the appropriate par levels for different items that are stocked on the floor. We are going through the process of updating all of those par levels for that part of it. We are also reinforcing and reeducating to make sure that the unit staff will

receive stock by signing off, and we are randomly inspecting, as was recommended, selected issues, and then recounting all of those to make sure that items that are leaving the store room are in fact accurately documented as we go forward.

Ms. Youssouf thanked them and asked the Committee if there was anything else. Mrs. Bolus responded not at this time.

Mr. Telano continued by stating that a surprise inventory audit of the Pharmacy at North Central Bronx was conducted and wanted to acknowledge that the report came out excellent.

Ms. Youssouf asked if there is anybody here from North Central Bronx – we just want to say congratulations. Then Mr. Telano stated that concludes his presentation.

Ms. Youssouf said that now we go on to Compliance.

Mr. McNulty saluted the Committee and introduced himself as Wayne McNulty, Chief Corporate Compliance Officer. Mr. McNulty started on page 3 of the Corporate Compliance Report, Section IA. Mr. McNulty discussed the Compliance training efforts and provided an update to the Committee on the same. He informed the Committee that the training period started on January 1, 2012 and ended on January 3, 2014. He further informed the Committee that the training period had realized very positive results. Mr. McNulty stated that during the training period, a total of 21,686 HHC staff members and workforce members were trained, which is 94.5 percent of the total number of workforce members that were designated for training. He stated that the process of updating the three compliance modules - the physicians' module, the health care professionals' module, which includes all licensed personnel, licensed under Title 8 of the Education Law, and the module that covers all Group 11 employees/managers – was underway. Mr. McNulty informed the Committee that the Board of Directors' module was in the process of being updated also. Mr. McNulty explained that every module update would include the education of HHC staff regarding HHC's policies that prohibit the use of personal or other non HHC-issued E-Mail accounts to transmit confidential, privileged, protected and/or sensitive patient, employee or Corporate information and records in the course of conducting HHC business, or to transmit official Corporate records in the course of conducting HHC business.

Mr. McNulty continued by reviewing the Compliance training results for the three different modules. He reviewed Section A of page four of the report, which provided that as of January 3rd, 93 percent of the physicians' corporate-wide were trained. He went over Section B of the report, which stated that as of January 3rd, 94 percent of the health care professionals' were trained corporate-wide. He closed with reviewing Section C on page 5 of the report, which concerned the training of Group 11 managers. Mr. McNulty closed the discussion of the training results by revealing that 98.7 percent of the Group 11 managers were trained Corporate-wide.

Ms. Youssouf stated that is outstanding.

Mr. McNulty thanked all HHC staff members who took time out of their busy schedules to complete the training, adding that the training took about an hour to complete.

Mrs. Bolus asked what his goal was. To which Mr. McNulty responded that their goal was to be around 95 percent corporate-wide. He said they exceeded that in some regards. With respect to the personnel who did complete the training, he stated, in summary, that efforts would be made during the new training period to ensure that all of these individuals would be first to complete training. Mr. McNulty continued by stating that the compliance training record of every physician and other provider who is up for credentialing would be reviewed for assessment of completion. He stated, in sum and substance, that the compliance training would be a prerequisite for provider credentialing.

Ms. Youssouf stated that she thinks that is absolutely wonderful. It speaks so well of the workforce in general and also the Compliance Unit for getting all of that done. The number of 66 percent of the Board members speaks fairly poorly – we need to take a look at that.

Mr. McNulty proceeded with his presentation by turning to number two, section two on page 5, of the report - monitoring of excluded providers. He reported that there were no reports of excluded providers since the last time the Audit Committee convened in December 2013. Mr. McNulty moved to item number 3 on the report - staffing update. In summary, he informed the Committee that the OCC had 4 vacancies; two in Central Office; one in the North and Central Brooklyn Network; and one in HHC Health and Home Care. He added that the recruitment process for these positions had commenced. Mr. McNulty went over page 6 in section 4, of the report. He stated that his office received 87 compliance-based reports, two of which were classified as Priority A reports, meaning reports that require immediate attention. With regard to the 87 reports, 51 of them, or 58 percent, came through his office's anonymous, confidential and toll free compliance helpline.

Mr. McNulty asked there were any questions with respect to the reports, stating that he would discuss the same in greater detail in the Executive Session.

Ms. Youssouf responded that no and stated that they would go into Executive Session.

Ms. Youssouf announced that the Executive Session was over and asked for a motion to adjourn.

Capital Committee – March 13, 2014
As reported by Ms. Emily Youssef

Ms. Youssef advised that Denise Soares, Senior Vice President, Generations+/North Manhattan Health Network, would be providing a brief update on a building collapse that took place on Wednesday, March 12, 2014, whose victims were transported to Harlem and Metropolitan Hospitals.

Ms. Soares explained that an explosion on 116th Street had caused two (2) buildings to collapse, and victims and bystanders had been transported to HHC facilities. She noted that 13 patients were admitted to Harlem Hospital, and 28 to Metropolitan Hospital. At Metropolitan all patients were treated and released. At Harlem there was one 15 year old boy who had been extensively injured and was still being treated. She informed that at a press conference held by the Corporation, the availability of mental health service at both facilities was made known, for possible sufferers of post-traumatic stress.

Ms. Youssef, on behalf of the Capital Committee, thanked Ms. Soares and HHC staff for coming through in a time of need and doing an amazing job. Ms. Soares noted that the new Emergency Department had just been opened and it was getting plenty of use.

Senior Assistant Vice President's Report

Roslyn Weinstein, Senior Assistant Vice President, Office of the President, provided an overview of the meeting agenda. She advised that a resolution for lease with CAMBA would propose transformation of the "G" building on the campus to a CAMBA housing project, and a short update on the Corporation's energy projects with the New York Power Authority (NYPA) and the Department of Citywide Administrative Services (DCAS). She noted that people currently located at 346 Broadway would soon be relocating to 55 Water Street and 160 Water, and that tours had provided positive feedback. She said she expected and looked forward to having everyone in their new seats on time. That concluded her report.

Action Item:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a 99-year sublease with CAMBA Housing Ventures, Inc. ("CHV") or a not-for profit housing development fund corporation in which CHV is the sole member, or a limited partnership or limited liability company in which the general partner or managing member, as applicable, is an affiliate of CHV for the development of low-income housing, and housing for the formerly homeless on at the site of the "G Building," a parcel of land on the campus of Kings County Hospital Center (the "Facility") of approximately 97,000 square-feet at a fair market value rent established by appraisal which is currently anticipated to be not more than \$2.5 Million in total.

Robert Miller, III, Chief Operating Officer, Kings County Hospital Center, read the resolution into the record. Mr. Miller was joined by LaRay Brown, Senior Vice President, Corporate Planning and Community Health, and Dion Wilson, Assistant Director, Office of Legal Affairs, as well as Joanne Opustil, David Rowe, and Sharon Browne, CAMBA/CAMBA Housing Ventures, Inc.

Ms. Opustil narrated a Power Point presentation that included background information on CAMBA, the CAMBA Gardens I development on the campus, and the proposed new development, CAMBA Gardens II. She thanked HHC and Kings County for the exceptional work and completion of CAMBA Gardens I, which featured beautiful, studio, one (1), two (2), and three (3) bedroom affordable apartments for formerly homeless and low income individuals.

She explained that CAMBA began in 1977 to provide various services; economic development, health, legal, and education, to the underserved. In 2005 CAMBA shifted focus from running homeless shelters and created CAMBA Housing Ventures to develop affordable, sustainable, energy efficient, permanent housing. Since then 605 units have been constructed in Brooklyn, amounting to \$174 million in development. At present, there were 175 units in construction, or \$60 million, and 746 units in pre-development and \$255 million in investment. In total there were 1526 units to date.

Ms. Opustil said that work with HHC was a fantastic model because it allowed, through KCHC, the assurance that everybody has easy access to healthcare services. The hospital helps facilitate resident needs. She referenced a study that found that supportive housing saves \$10,100 per tenant. She expressed excitement at the continued relationship that had so far been phenomenal.

Ms. Opustil said the organization hoped to move forward with CAMBA Gardens II, a 253,000 square-foot parcel featuring 293 studio, one (1), two (2), and three (3) bedroom units in an energy efficient development, indoor and outdoor spaces, landscaping, all sustainably designed. She explained that 110 units were set aside as community units, which would be rented at 60% AMI, 182 units for formerly homeless/special needs individuals, and one (1) unit for a superintendent. Ms. Brown made special note that 50 of the units set aside for formerly homeless/special needs individuals would be for KCHC/DSSM patients. A point she made in reference to previous discussion that had taken place at the March 6, 2013, Public Hearing.

Ms. Youssouf asked for explanation of the Area Median Income (AMI). Ms. Brown explained that income criteria was determined by the Department of Housing and Urban Development (HUD), the Federal Government, who require that AMI define rent numbers for affordable housing. The AMI applicable for these developments includes parts of northern New Jersey, Long Island, and Westchester, as well as the five boroughs. Rents are set at 30% of income level. Ms. Youssouf noted that if rents lower than those outlined then there would be a need to have alternate revenue in order to maintain costs of operation. Mr. Rowe agreed, saying that underwriting was based on the development hitting 60% AMI. Ms. Youssouf agreed that Federal regulations were very strict and noted that rates were not the choice of HHC or CAMBA; an important fact to remember. The community should not think anyone involved is trying to withhold, said Ms. Youssouf. Ms. Brown explained there had been numerous discussions with community members and HUD representatives to explain that HHC and CAMBA were working within confines or regulations and not making their own determinations.

Mrs. Bolus said the conversation needed to be extended to include more individuals that may not reach income thresholds, and only miss them by a very small determinant. Ms. Brown said discussions are ongoing but the Community Advisory Boards (CABs) should be in front of their elected officials to bring forward the issue. She said HHC was working on hosting a forum for such discussion, that would hopefully take place in Spring or early Summer.

It was explained that the project would be supervised by the Department of Housing Preservation and Development (HPD) and that CAMBA I guidelines were redefined to permit more folks into the low income units. The CAMBA Gardens I development housed 30 community members, 13 KCHC staff, and five (5) victims of Hurricane Sandy. Ms. Opustil said there was also a 5% preference for City employees.

Ms. Youssouf advised that preferences are established by HUD and agreed to by the fair housing act, as to how many units can be set aside for what. She reiterated that the Community needs to understand all those factors. People don't realize that the developer or issuer do not make the rules. Ms. Brown said the more the discourse continues the better it will be.

Ms. Opustil reviewed construction financing, which would be provided by the following; New York State Housing Finance Agency (HFA) tax exempt bonds, Credit enhancement provided by TD Bank, Medicaid Redesign Team capital funds through HFA, Low-Income Housing Tax Credits (LIHTC), syndicated by Enterprise Community Investment, New York City Dept. of Housing Preservation and Development: Supportive Housing Loan Program (HPD), FY14 City Capital, New York State Homeless Housing Assistance Program (HHAP), NYSERDA, and Council Member Mathieu Eugene & Brooklyn Borough President Marty Markowitz each allocated \$1 million to the project.

She explained that social service funding for the project would be covered by the New York City Department of Health and Mental Hygiene NY/NY III, and New York State Office of Mental Health NY/NY III.

There being no further questions or comments, the Committee Chair offered the matter for a Committee vote and was approved for the full Board's consideration.

Information Items:

Update: Energy Projects

Cyril Toussaint, Office of Facilities Development, provided a status update on energy efficient capital projects being performed under the PlaNYC initiative, which established a goal of reducing energy costs and greenhouse gas emissions by 30% by 2017.

Mr. Toussaint summarized four (4) Corporate Energy Efficiency projects. The Coney Island Hospital window replacement, Board approved in July 2011, featured replacement of windows and air conditioning units. The facility's boiler replacement, which went before the Board in May 2012 and again in June 2013; replaced boilers, converted fuel to new gas service, provided structural repair to the boiler house and provided additional storm resiliency. Ms. Weinstein added that it was fortuitous that the windows had been replaced as she was under the belief that although the building had to be evacuated during Hurricane Sandy had the newly installed windows not been in place then damage could have been much more significant.

Ms. Youssouf asked which flood level the boilers had been raised to meet. Mr. Toussaint said they met the 100 year flood plan. Mrs. Bolus asked if FEMA monies had been received for that part of the work. Mr. Toussaint said it was anticipated that FEMA would pay for the storm resiliency work.

Comprehensive Energy Efficiency upgrade projects at Metropolitan Hospital Center and Elmhurst Hospital Center received Board approval in June 2013. Both projects featured lighting upgrades, high pressure boiler replacements, fuel conversion, and Heating, Ventilation and Air Conditioning (HVAC) upgrades with Central Chiller Plant Optimization at Elmhurst.

Mr. Toussaint outlined the total project costs at \$83,683,956, estimated energy savings of \$4,548,593 per year, elimination of 19,641 tons per year of CO₂ (or the equivalent of removing 4,100 cars from circulation).

Mr. Toussaint advised of three (3) additional energy efficiency projects being discussed for completion under the Accelerated Conservation & Efficiency (ACE) Program, funded through the Department of Citywide Administrative Services (DCAS). Those projects included work at Woodhull Medical and Mental Health Center, at an estimated \$7.9 million, for lighting and vacancy, boiler burner and steam trap upgrades among other work. That project is fully grant funded with \$7.9 million. Two other anticipated project, at Kings County Hospital Center and Harlem Hospital Center each received partial funding of \$10 million each, for window replacement, lighting upgrades and other work.

Ms. Weinstein added that DCAS had high expectations for the continuation of energy efficient project progress and would be funding two energy positions within the office of Facilities Development. Ms. Youssef said that is important, as debt is anticipated to be paid for by energy savings, it will be helpful to have a way of measuring progress and meeting goals.

Project Status Reports

Central/North Brooklyn Health Network

Daniel Gadioma, Senior Project Manager, Kings County Hospital Center, provided reports for two elevator projects at the facility. Mr. Gadioma advised that the Elevator Upgrade project in the "ABC" Buildings was nearing completion, with Phases I and II having been completed and Phase III to be completed in May, 2013. The Elevator Upgrade project in the "T" Building had been completed with all four elevators operational.

Ms. Youssef asked what had caused delays. Mr. Gadioma explained that the facility was late in receiving approval by the Fire Department of the City of New York due to fire alarm upgrades that needed to be performed. Mr. Lynch explained that some of the older buildings did not have FDNY approved Fire Alarm Systems so permits were not forthcoming. He said scrutiny from the FDNY had increased significantly and an agreement was made that HHC would bring them up to status.

Ms. Youssef asked if the Office of Facilities Development (OFD) had looked into similar issues at other facilities. Mr. Lynch said there are definitely similar problems and OFD would survey to identify them.

Kein Anderson, Associate Executive Director, Woodhull Medical Center, provided a delay report for the Obstetric Unit Expansion project at Woodhull Medical Center: Mr. Anderson was joined by Lisa Scott McKenzie, Senior Associate Executive Director, Woodhull Medical Center.

Mr. Anderson explained that project delays were due to the postponed relocation of offices and an overflow unit on site. Office had now been vacated and stripped of equipment and fixtures but relocation had not taken place. He said an alternate location was selected for relocation. Instead of floor six (6), the unit would be moved to floor seven (7), closer to the existing unit where core services were provided.

Ms. Youssef asked why the project was not more thoroughly thought out during the planning phase and how such a large portion of the budget had been spent. Ms. Scott-McKenzie said that project monies had not been spent and noted that some relocation delays were a result of unexpected displaced SANDY individuals. She explained that no money had been spent on the space on the sixth floor (6-200) because during SANDY it was housing staff from Bellevue. Space on the seventh floor (7-300) had been used as alternate care space for Podiatry using HEAL funds. As that space was opened, prior to construction, it was determined that altering the plans and consolidating services would be a better idea.

Ms. Youssef noted that the Project Status Report included in the package showed a huge draw down of funds. Ms. McKenzie said monies had not been spent on demolition. Ms. Youssef asked Mr. Anderson to repeat his previous explanation. Mr. Anderson explained that offices and an overflow unit were on the seventh floor and had to be relocated, the original plan was to relocate the overflow to the sixth floor because space on the seventh floor wasn't available, but when seven (7) became available it was determined that the unit would move into the newly available space on seven (7), therefore consolidating services.

Mrs. Bolus asked why 75% of the project budget was gone. Mr. Anderson said he was unclear as to why and said that must be an error, as no construction funds have been drawn down. Mr. Lynch said OFD would review the numbers and clarify. Antonio Martin, Executive Vice President said he would appreciate a review of the numbers and questioned the pre-planning process. He said the project should have been more thought out and well put together in the first place. Ms. Scott-McKenzie agreed.

Ms. Youssef noted that OFD had spent much time recently on reorganizing so that planning would be done up front because delays drive up cost. She anticipated an explanation of the budget confusion.

Generations+/North Manhattan Health Network

Ms. Weinstein advised that the Harlem Hospital Center Kountz Pavilion project had been completed and the Emergency Room (ER) project at Lincoln Medical Center had also been completed. A phased in opening of the ER will begin shortly.

Queens Health Network

Thomas Scully, Senior Associate Director, Elmhurst Hospital Center, provided an update on the Women's Health Center project at the facility. Mr. Scully advised that the project was still creeping forward slowly but had made considerable progress as a result of the General Contractor (GC) having had significant financial issues. He advised that 95% of the building had been enclosed and the heat was on allowing for finish work to commence on floors, final painting, and millwork to be completed. Mechanical work was going slowly due to cold weather and lack of adequate manpower from all contractors. Mr. Scully said the project would be complete and all contractor evaluation forms will be completed in an effort to avoid the same problems in the future.

Ms. Weinstein advised that CM-at-risk bids would be going out in the coming week and it would be seen if/how that affected projects.

Community Relations Committee – March 4, 2013
As reported by Josephine Bolus, RN

Chairperson's Report

Mrs. Bolus welcomed members of the CRC and invited guests.

Before proceeding with the annual activity reports from the Community Advisory Boards of the Central and North Brooklyn Networks, Mrs. Bolus highlighted some notable activities and recognitions that had occurred since the Committee's February 4th meeting.

Mrs. Bolus stated that "it is again the season for our Legislative Breakfasts which are invaluable opportunities for the Community Advisory Board members, consumers of our services and other community stakeholders to meet face-to-face with elected officials to advocate on behalf of HHC facilities and to articulate the health care needs of the communities." On behalf of the Board, Ms. Bolus thanked those Community Advisory Boards who had hosted, or will host in the coming weeks, these important forums.

Mrs. Bolus reported that, on February 24, 2014, at the request of the Health Committee of the City Council, Mr. Aviles had provided testimony to update the Council on the various initiatives that had been part of HHC's cost containment and restructuring plan. In his testimony, Mr. Aviles had provided some historical context to explain why HHC needed to undertake significant cost-containment and restructuring efforts over the last several years, pointing out several factors, such as: HHC's safety-net role which has made it especially vulnerable to deep State cuts to Medicaid, the cost of serving a rising tide of uninsured patients, and the erosion of federal funding. Mr. Aviles had outlined HHC's fiscal situation and challenges and he had then reviewed the Road Ahead initiatives and the principles that guided their implementation. He also had pointed out that, despite HHC's hard work to reduce its budget gap, future budget deficits loom and could be made deeper by pending labor arbitration outcomes and further federal budget cuts.

Mrs. Bolus reported that a number of Council Members had been very interested in the contract for the provision of acute and chronic dialysis and Mr. Aviles had responded to many questions related to continuation of the current quality and patients' access to these services. In addition, there were also a number of questions about the timing for the re-opening of maternity services at North Central Bronx Hospital. Mr. Aviles had noted that a formal staffing plan for both inpatient maternity services and the NICU will be completed this month and that HHC would be formally asking the State Health Department to extend the time for re-opening the service until sometime this summer in order to identify and bring on board a full complement of staff (especially senior level physicians) for all tours.

Mrs. Bolus had especially acknowledged Ms. Agnes Abraham, the Chairperson of the Council of CABs, who also had provided testimony at last week's City Council hearing. Mrs. Bolus noted that Ms. Abraham had been eloquent and forceful in her support of the need for there to be a strong, financially viable public hospital system. She said that, "while she may not agree with every Road Ahead initiative, she recognizes that it would be irresponsible, knowing the dire economic constraints faced by the Corporation, not to agree that something has to be done. Ms. Abraham had urged the Council to do all in its power to ensure HHC's financial health for many years to come."

Mrs. Bolus reported that more than 8,000 New Yorkers volunteer in HHC hospitals and health centers every year. She noted that several of these generous volunteers had recently been specially recognized.

Mrs. Bolus reported that The United Hospital Fund had recognized Bellevue Hospital volunteer Anthony (Tony) Austin with its 2014 Hospital Volunteer Achievement Award. Mr. Austin works three to four days per week telephoning patients to remind them of their therapy session appointments, informing waiting patients when the therapist is ready to see them and escorting them to and from their sessions. Mr. Austin's accomplishments are all the more remarkable because he has been a paraplegic since 1983 when, as a cab driver, he was shot while driving his cab. He was treated extensively at Bellevue and has now been a volunteer there for more than 10 years.

Mrs. Bolus reported that former Schools Chancellor Dennis Walcott's, a lifelong Queens native, good works had also been recently celebrated. She noted that Chancellor Walcott had spent the month of January volunteering at Queens Hospital Center (QHC). While volunteering, Mr. Walcott had spent time in the Emergency Room, Pediatric Clinic, Adult Ambulatory Care Department, and several other outpatient and inpatient

departments to observe how medical staff communicate with and engage patients. Mr. Walcott had given an hour-long, insightful presentation at QHC about his volunteer experience.

Mrs. Bolus continued her remarks and reported that staff and facility programs had also been recognized these past several weeks. Specifically, Yvette Calderon, MD, has been recognized by the New York State Department of Health with the Laubenstein Award for her decades of work in HIV/AIDS prevention efforts. Dr. Calderon, an emergency department physician and Chief of Urgent Care at Jacobi Medical Center, had contributed to HHC's efforts to combat HIV/AIDS through a variety of innovative programs focused on engaging underserved communities and at-risk populations.

Mrs. Bolus continued by sharing with those present that, in 2003, Dr. Calderon had partnered with Dr. Jason M. Leider, Medical Director of the North Bronx Health Network's Adult HIV Services, to develop and implement Project B.R.I.E.F. seeking to boost HIV awareness through rapid testing in non-traditional testing environments such as emergency departments. Research has shown that this form of non-traditional testing more effectively reaches high-risk populations that have not otherwise been tested for HIV/AIDS. She noted that more than 100,000 Bronx residents had been tested due to Dr. Calderon's and Dr. Leifer's work. Rapid testing is now routinely performed at all HHC hospitals and health centers.

Mrs. Bolus reported that The Jacobi Medical Center Auxiliary Inc., in partnership with Fellowship Tabernacle Ministries, Inc., Physicians Affiliate Group of NY (PAGNY), and Jacobi Medical Center, had received \$300,000 for the Neighborhood Violence Prevention Project, an injury prevention program incorporating a multi-pronged approach to prevent shootings and violence involving young adults in Bronx County.

Mrs. Bolus informed the Committee that the program's name is SNUG - "guns" spelled backwards. She stated that Jacobi will be implementing the evidence-based Cure Violence Model, relying on culturally appropriate staff -- often former gang members -- who respond to shootings and prevent retaliation through focused outreach. Staff members also detect and resolve conflicts that are likely to lead to shootings and prevent retaliation. Mrs. Bolus noted that an extensive schedule of social and recreational programs specifically designed to appeal to an at-risk population would be implemented. Moreover, Jacobi Medical Center will be providing expert medical leadership including pediatric, adolescent and emergency medicine specialists, as well as a hands-on intense social work component.

Mrs. Bolus reported that HHC facilities continue to conduct prevention and health promotion initiatives. HHC will once again recognize National Colorectal Cancer Awareness Month this month by educating patients, staff and the public at large about the benefits of colon cancer prevention, screening and early detection. In addition, HHC Communications staff will use all platforms available -- from internal email blasts to social media -- to remind New Yorkers who are approaching 50 to get a colonoscopy or ask about other effective colon cancer screening tests available. Moreover, HHC physicians will spread the colon cancer message in op-ed columns in the Epoch Times, Harlem News, Brooklyn Spectator, Queens Courier, El Diario, El Especialito and The Chief Leader. Mrs. Bolus stated that other campaign elements would include posters, post cards, email messages, the HHC website, a press release, banners, and screen savers. She added that HHC will also collaborate with members of the Citywide Colon Cancer Control Coalition (C5) to create awareness through a dedicated web page and unified social media campaign. Mrs. Bolus announced that, on March 6, 2014, HHC Board of Directors will hold a public hearing concerning the leasing of the G building on the HHC campus of Kings County for the development of 293 affordable apartments by CAMBA.

Mrs. Bolus concluded her remarks stating that, after 40 years of unparalleled service to HHC and its patients, Lynda D. Curtis had announced her retirement effective March 2nd. Ms. Curtis retires as Senior Vice President of the South Manhattan Network with administrative oversight of Bellevue, Metropolitan, Gouverneur, Coler, and the new Henry J. Carter long term facility. In addition, until November 2013, she has been the Executive Director of Bellevue. Mrs. Bolus noted that throughout Ms. Curtis' career, which began in 1974 as a children's counselor at Sydenham Neighborhood Family Care Center, Lynda Curtis had represented the best of HHC -- deep compassion, dedication to improving the health status and safety of patients, unflagging energy, profound integrity, and a commitment to promoting opportunity for all staff.

Mrs. Bolus called on Mr. Antonio Martin, HHC's Executive Vice President, to provide remarks on behalf of Mr. Aviles who could not be with us this evening.

President's Remarks

Mr. Martin greeted everyone. He reminded the Committee that, HHC's longest serving President, Mr. Alan Aviles, will be leaving the Corporation as of March 28, 2014. He added that, while the HHC family is saddened by the departure of a leader who, had such great vision for the Corporation, his replacement is another great leader, who is well-known to the HHC community. Mr. Martin stated that Dr. Raju will be coming back to HHC from Cook County Health and Hospitals System as HHC's new President. Mr. Martin took the opportunity to thank Mr. Aviles for his unwavering support of the Corporation throughout his leadership and to wish him well. He will certainly be missed. Similarly, Mr. Martin welcomed Dr. Raju, a friend to the Corporation, who is like-minded in style to Mr. Aviles.

Mr. Martin informed the Committee that the City of New York had sold 346 Broadway Building to a developer. Therefore, HHC's offices that were housed in that building including Legal, Facilities Development, Human Resources and Corporate Planning, will be relocated to a renovated building at 55 Water Street by next month. Mr. Martin noted that two other City Agencies are already at that location and are very happy that HHC join them. In addition, HHC will take advantage of the large meeting spaces available. Mr. Martin stated that staff are packing and are

encouraged not to bring a lot of paper with them. Mr. Martin ended his remarks stating that all efforts are being made to make the move as streamlined as possible.

Mrs. Bolus acknowledged Mr. George Procter, Senior Vice President of the North Brooklyn and Central Brooklyn Networks, Mr. Ernest Baptiste, Executive Director of Kings County Hospital Center, Mr. Michael Tartaglia, Executive Director of Dr. Susan Smith McKinney Nursing and Rehabilitation Center,

Central/North Brooklyn Family Health Network CABs' Reports

Kings County Hospital Center (Kings County) Community Advisory Board

Mrs. Bolus introduced Agnes Abraham, Chairperson of the Kings County Hospital Center Community Advisory Board (CAB) and invited her to present the CAB's annual report.

Ms. Abraham began her presentation by greeting members of the Committee, fellow CAB Chairpersons, invited guests and acknowledged George Procter, Senior Vice President, North and Central Brooklyn Network, Ernest Baptiste, Executive Director, Kings County Hospital Center.

Ms. Abraham reported that the most significant health care service concerns/ needs for Kings County community are chronic diseases such as obesity, diabetes and hypertension. Ms. Abraham added that the community concerns also include the need for services focused on gun violence, mental illness, cancer and HIV/AIDS.

Ms. Abraham continued and reported that the facility's leadership had addressed the concerns and needs of the community with the relocation of the Diabetes Clinic to better coordinate care for patients and had implemented Kings Against Violence Initiative (KAVI) to address interpersonal violence in the community. Ms. Abraham added that the administration also reorganized the mental health and substance abuse treatment programs to better meet the needs of the community.

Ms. Abraham stated that the "facility's strategic priorities is to improve access to ambulatory care services and to reduce wait times." Ms. Abraham noted that Kings CAB continues to meet with the ambulatory care staff and the administration team to ensure that the community concerns are taken into consideration. Ms. Abraham noted that Mr. Baptist has an "open door policy."

Ms. Abraham reported that the most frequent complaint at Kings County is long wait times in the clinics and emergency department and staff attitude. Ms. Abraham noted that staff attitude had improved however; there are still areas that need to be addressed. Ms. Abraham noted that compliments are on improved services and quality of care.

Ms. Abraham continued and reported that currently there are twenty-nine (29) working members with seven (7) vacancies on the CAB.

Ms. Abraham concluded the CAB's report and informed the Committee members and invited guests that the Kings CABs structure includes: Patient Care, Behavioral Health, Membership and Planning and Development Committees. Ms. Abraham added that the Planning and Development Committee are actively involved with working with the administration on the Heal Grant. Ms. Abraham noted that the Community Planning Boards designee help disseminate information to the community at large.

Dr. Susan Smith McKinney Nursing and Rehabilitation Center (DSSM) Community Advisory Board

Mrs. Bolus introduced Ms. Jeromane Berger-Gaskin, Second Vice Chairperson of the Dr. Susan Smith McKinney Nursing and Rehabilitation Center's Community Advisory Board (CAB) and invited her to present the CAB's annual report.

Ms. Berger began the DSSM CAB's report by stating that the Dr. Susan Smith McKinney Nursing and Rehabilitation Center "continues to be a Center of Excellence despite cut backs and budgetary restraints." Ms. Berger commended the leadership of Michael Tartaglia, Executive Director, Charmaine Lewis, Deputy Executive Director, and the staff for their dedication and commitment to DSSM. Ms. Berger noted the reason for the achievement was the adherence to the facility's mission and vision; keeping the focus on residents and the care they receive.

Ms. Berger informed members of the Committee and invited guests that Neponsit Adult Day Care Center of Far Rockaway, Queens, is temporarily stationed at DSSM. Ms. Berger added that the Adult Day Care Center will be returning to their site in Far Rockaway, by late Spring, 2014.

Ms. Berger highlighted the DSSM CAB's participation in 2013 outreach activities. They included:

- CAB members participated in the Go Red Event.
- During Men' Health month CAB members participated in the 2nd Annual Recognition Luncheon.

- CAB members participated in Black History Month Supper Club Presentation “From Drums to Jazz”. Ms. Berger added that at the event the CAB honored Mr. Harold Ousley, resident, who played the Cotton Club in Harlem and performed with icons such as Billy Holiday, Ella Fitzgerald, Louis Armstrong and others. Ms. Berger noted that he was presented with a Congressional Proclamation, a New York City Council Proclamation and a Borough President Citation for his contribution to Jazz Music during the Civil Rights Movement.
- Ms. Agnes Abraham, Chairperson of HHC Council of CAB, presented an inspiring “Civil Rights” message during Black History Month.
- The DSSM CAB participated in the annual Resident Satisfaction Survey. Ms. Berger noted the results were excellent.
- DSSM CAB members participated in a Special Thanksgiving Dinner that was sponsored by the Auxiliary and Brooklyn Farragut Lions Club. Ms. Berger noted that the Farragut Lions Club also presented Mr. Tartaglia with blankets for the residents.
- DSSM CAB continued to support various efforts at the center such as the Annual Christmas Tree, Menorah and Kwanzaa Lighting.

Ms. Berger concluded the DSSM CAB’s report by again thanking George Proctor, Michael Tartaglia, Charmaine Lewis, and the staff of DSSM for their support of the CAB. Ms. Berger added that the DSSM CAB pledged its continued support to all the residents and staff.

Woodhull Medical and Mental Health Center (Woodhull) Community Advisory Board

Mrs. Bolus introduced Talib Nichiren, Chairperson of the Woodhull Medical and Mental Health Center Community Advisory Board (CAB) and invited him to present the CAB’s annual report.

Mr. Nichiren began his presentation by thanking members of the Committee for the opportunity to share the Woodhull CAB’s annual report. Mr. Nichiren also thanked George Proctor, Senior Vice President, North/Central Brooklyn Network, Lynn Shulman, Senior Associate Executive Director, and Maria Hernandez, CAB Liaison for their leadership and support.

Mr. Nichiren reported that Woodhull Medical and Mental Health Center celebrated its second year of success with the innovative Center for Integrated Health. Mr. Nichiren explained that the Innovative Center integrates primary care into the hospital’s psychiatry outpatient service, with the goal of providing holistic care to psychiatric patients with other chronic diseases. Mr. Nichiren added that since its inception in 2011, more than 1,000 high-risk patients had been referred to the newly created Center.

Mr. Nichiren informed members of the Committee and invited guests that Woodhull Medical and Mental Health Center in collaboration with New York University (NYU) implemented a Video Interaction Project (VIP). Mr. Nichiren explained that VIP is designed to encourage critical interactions between parents and children through videotaped playing or reading sessions that are monitored by child development specialists, who identify and reinforce positive interactions. Mr. Nichiren added that the goal of VIP is to address the vast disparities in development, school readiness and educational achievement between children living in poverty and middle to high income families.

Mr. Nichiren reported that under the leadership of Angela Edwards, Nursing Director, Woodhull Medical and Mental Health Center continue to strengthen its affiliation with schools of nursing. Mr. Nichiren added that Woodhull Medical and Mental Health Center initiated a Registered Nurse to BSN program with Lehman College. Mr. Nichiren noted that the first graduation is expected May 2015.

Mr. Nichiren continued and reported that the facility’s strategic priorities is to redesign and continue to renovate primary and specialty care practices to accommodate growth, enhance quality of care, increase patient satisfaction and patient safety for the North Brooklyn community. Mr. Nichiren concluded the Woodhull CAB’s report by commending the administration and staff of Woodhull Medical and Mental Health Center for their dedication and commitment to the community.

East New York Diagnostic and Treatment Center (East New York D&TC) Community Advisory Board

Mrs. Bolus introduced Mr. Ludwig Jones, Chairperson of the East New York Diagnostic and Treatment Center Community Advisory Board (CAB) and invited him to present the CAB’s annual report.

Mr. Jones began the East New York D&TC CAB’s report by informing members of the Committee and invited guest of staff’s transitions. Mr. Jones added that the CAB welcomed Charmaine Valentine, Site Administrator and Mari Millet, CAB Liaison. Mr. Jones, thanked Mr. Alvin Young, Director of Community Affairs, Office of Intergovernmental Relations, for his tremendous support of the East New York CAB and Auxiliary.

Mr. Jones reported the most significant health care need/concerns of the East New York community were hypertension, diabetes, obesity and HIV. Mr. Jones noted that the facility’s leadership is addressing the needs and concerns of the community by extending hours in the medical and pediatric clinic to accommodate working families’, appointment reminder calls and jitney transportation to Kings County Hospital Center. Mr. Jones added that improved access to appointment availability had resulted in improvement of the patient satisfaction surveys.

Mr. Jones informed members of the Committee, CAB Chairpersons and invited guests that ENY D&TC CAB had started a "Banana Program." Mr. Jones explained that every morning bananas are provided for patients in the waiting areas. Mr. Jones added that patients often leave home without eating. Mr. Jones noted that the ENY CAB is also working to start a clothing and pantry program for the patients.

Mr. Jones reported that the ENY CAB had been working with the staff on ideas on beautification of the frontal exterior of the facility and poor lighting and visibility at night issues. Mr. Jones explained that since the closure of the Gas Station, that was located across the street from the facility it has left the area very dark and desolated. Mr. Jones added that the 75th Precinct had agreed to patrol the area frequently for safety of patients and staff.

Mr. Martin informed Mr. Jones, that a team from HHC's facility management department had been informed of the lighting issue and work had been done to resolve the issue. Mr. Martin added that lighting provides a sense of security for the patients and the community.

Mr. Jones concluded the ENY CAB report by stating that the CAB "currently had six members with nine (9) vacancies." Mr. Jones added that recruitment of new members from local business; churches and community organizations were ongoing.

Cumberland Diagnostic and Treatment Center (Cumberland D&TC) Community Advisory Board

Mrs. Bolus introduced Ms. Jacqueline Narine, Chairperson of Cumberland Diagnostic and Treatment Center Community Advisory Board (CAB) and invited her to present the CAB's annual report.

Ms. Narine began her presentation by thanking the members of the Committee for the opportunity to present the Cumberland CAB's annual report. Ms. Narine thanked Vincent Mulvihill, Network Associate Executive Director, Lynn Schulman, Network Senior Associate Executive Director, Cheryl Jones, Director of Business Affairs and Sherry Davis, staff for their support of the Cumberland CAB. Ms. Narine also acknowledged George Proctor, Senior Vice President Central/North Brooklyn Network for his continuity and leadership.

Ms. Narine reported that 2013 had been an exciting year at Cumberland Diagnostic and Treatment Center. Ms. Narine added that the CAB's membership continued to grow in diversity. Ms. Narine mentioned that new members appointed to the CAB include a Dentist, a Nurse, a Professor and a MIS entrepreneur. Ms. Narine noted that there were four (4) vacancies and recruitment is ongoing.

Ms. Narine continued and reported that the Cumberland CAB had continued its strong partnership with the administration. Ms. Narine added that in the last year Cumberland D&TC family were joined by Tracy Bowes, site administrator and Cheryl Re, Nursing Director. Ms. Narine stated "their fresh eyes and ideas are helping to bring Cumberland into a new era of healthcare."

Ms. Narine informed members of the Committee and invited guests that the Cumberland CAB had been involved in the process as facility transitions to a Federally Qualified Health Center (FQHC). Ms. Narine added that the facility transformation to FQHC model will help address the community concerns of chronic diseases such as: diabetes, obesity, and hypertension and will help to increase access to comprehensive care.

Ms. Narine concluded the Cumberland CAB's report by stating that "patients view Cumberland D&TC as a community center, a place where the community can obtain health care, social service, and work with a committed and dedicated staff." Ms. Narine added that as part of the facility's holiday outreach in 2013 the CAB distributed twenty-five (25) food baskets to patients. Ms. Narine noted that the CAB at Cumberland represents the consumers of health care, who regularly do walk through in the facility and listen what patients have to say. In closing Ms. Narine thanked Alvin Young, Director of Community Affairs, HHC Intergovernmental Relations and Manelle Belizaire, Assistant Director, Intergovernmental Relation for the their support. She also thanked Cumberland D&TC's CAB and Auxilliary Board Members that were in attendance.

Chairperson Bolus asked if there was any Old Business to report – there was none. Under New Business, Bette White, Harlem Hospital CAB Chair, thanked members of the Committee and CAB Chairpersons for their condolences in the loss of her beloved mother.

Finance Committee – March 11, 2013 **As reported by Mr. Bernard Rosen**

Senior Vice President's Report

Ms. Marlene Zurack informed the Committee that Victor Bekker, former CFO of Generation +/Northern Manhattan Network and most recently the Corporate coordinator and liaison with the State on obtaining data on the Exchanges was retiring after thirty years of service with HHC. Mr. Bekker began his career with the City in 1976 at HRA and later worked at OMB. In 1984, he moved to HHC and worked in various high ranking financial positions. Mr. Bekker's wit, charm and dedication will be missed but most of all his delightful and informative stories.

Ms. Zurack reported that HHC's current cash balance is \$507 million or 32 days of cash on hand (COH) which is an improvement over the FY 14 opening cash balance of \$323 million or 20 days. It is important to note that HHC is dependent upon the receipt of five UPL payments that are

delayed pending the State required approval from the Federal government for making those payments to HHC totaling \$1.6 billion, three years for one payment and two years for the other. There is some risk of slippage in the receipt of those payments; however, if received as planned, HHC is projected to end the year at the current cash level and COH. Based on the State's plan, HHC is scheduled to receive those payments by the end of the current FY 14. In terms of HHC's Financial Plan, the City issued its January Plan that was very positive for HHC. There were significant restorations in the November plan which preceded the January Plan. A total of \$12 million was restored to HHC. The City council funding that were required to be restored year over year were base-lined and an additional \$250,000 in substance abuse funding was also included in the January Plan. Mr. Covino will present to the Committee later in the agenda, HHC's January Financial Plan that includes some significant funding issues in the out-years.

Key Indicators & Cash Receipts Disbursement Reports

Ms. Krista Olson reported that utilization through January 2014, overall the downward trend in utilization that has been reported has continued. The slight increase is due to the temporary closing last year of Bellevue and Coney Island. Excluding those two facilities, visits are down by 1.6% and discharges are down by 6.5% which is up from last month at 5.7%. Nursing home days are down by 15.8%. Later in the agenda Corporate Planning Services will present to the Committee a presentation on inpatient utilization trends, one-day stays and HHC's market share compared to other hospitals in the industry as well as some of HHC's facilities specific trends relative to those trends. The calculated value for the decline in discharges totals \$58 million year-to-date (YTD) which could be offset by some revenue from capitated numbers at 12% of that which would inflate to \$100 million for the full year if the current trends continue.

Ms. Youssouf asked how much of the projected \$100 million would be offset by the capitation.

Ms. Olson stated that it would be approximately 12%. Ms. Youssouf asked if it included both inpatient and outpatient. Ms. Olson stated that on the outpatient side YTD, it totals \$14 million for the full year of which 20% capitated plan for a net loss of \$6 million YTD. Returning to the report, compared to last year, the ALOS has remained steady although there are significant variations across facilities. The CMI is an indicator of the severity of the patient cases and the driver for how HHC is paid and is up by 1.2% over last year. It is an important metric that offsets some of the losses valued at \$13 million year-to-date (YTD) and \$20 million for the full year which offset some of the losses.

Mr. Fred Covino continuing with the reporting stated that FTEs baseline comparison as of January 2014 reflected a net increase of 106 YTD. All of the facilities with the exception of Coney Island were within their targeted FTE level. Coney Island is approximately 60 FTEs over the target and Corporate Budget is working with the facility on this issue to ensure that the overage is reduced to the budgeted level.

Mr. Rosen asked if HHC's Financial Plan includes an increase in FTEs. Mr. Covino stated that the current year budget for cash includes an increase of 250 FTEs for FY 14 and is carried flat across the plan. Central office includes the centralization of procurement and the Enterprise-IT includes the hires for the EMR and the conversion of consultants to FTEs. Receipts were \$132 million worse than budget and disbursements were \$43 million over budget for a net total deficit of \$175 million.

Ms. Youssouf asked if there is one particular area where there are significant problems such as Coler/Goldwater and whether that facility's negative variance is related to the move.

Mr. Covino stated that Coler/Goldwater is a large source of the deficit combined. Bellevue also has a significant deficit. The Coler/Goldwater deficit is related to the move and a large portion of the facility's deficit is in Medicaid fee for service (FFS) and personal services expenses.

Ms. Youssouf asked for an explanation of the Coler/Goldwater staffing issue.

Ms. Zurack explained that the facility has been downsized, moving from a larger to a smaller facility which is reflected in the budget, in terms of what the restructuring goals are relative to that change. As indicated by the data the facility is yet to achieve the target which will take approximately two years to complete and once achieved will yield significant savings for the Corporation.

Mr. Covino continuing with the reporting, stating that receipts were \$272 million more than last year due to an increase in MetroPlus risk pools of \$100 million and the receipt of the \$89 million in supplementary pool payment from the State earlier than last year. There was an increase of \$34 million in the supplemental DSH compared to last year. The plan also includes an additional \$30 million for Medicaid HIT Meaningful Use funds. Expenses were up by \$230 million compared to last year due to pension payments totaling \$213 million and a prior year health insurance payment of \$27 million. FICA was up by \$20 million due to the non-recurring resident refund that was received last year and an additional payroll totaling \$84 million through January 2014. These are offset by the decline in City payments that are down by \$22 million compared to last year for the same period. Actuals compared to budget inpatient receipts were down by \$91 million due to the decline in Medicaid FFS workload. To-date paid discharges are down by 5,000, and nursing home days are down by 62,000 days. Outpatient receipts were down by \$55 million all other up by \$13.6 million due to appeals and settlements as a result of an unscheduled GME psych payment. Expenses were \$10 million over budget due to the carrying cost at Coler/Goldwater, HJ Carter move. Fringe benefits were \$6.4 million better than last year due to the receipt of \$3.4 million for FICA refund and a timing difference FY in the welfare funds payment.

Ms. Youssef asked if the inpatient and outpatient data shown on the report coincided with the data reported by Ms. Olson relative to the losses and the offsets.

Mr. Covino stated that his data is against budget. Ms. Olson stated that the data is based on the date of discharge, whereby, there are some lags in terms of payments and that the data reported by Mr. Covino is based on cash. Therefore, the \$100 million referenced earlier would be spread into next year.

Mr. Rosen clarified that the difference between the two is that Mr. Covino's data is against budget compared to Ms. Olson data which was based on raw statistics.

Ms. Youssef asked if expected and budget were the same to which Mr. Covino explained that the two are the same which would be flat. The utilization data that Ms. Olson reported was compared to the budget, whereby there are various assumptions by the major payers. Moving back to the report, OTPS was worse than budget which is due primarily to an increase in the cash caps for payments to vendors. The reporting was concluded.

Ms. Zurack asked that the order of the agenda be changed so that the utilization presentation could go next.

Mr. Rosen noted that there would a change in the agenda and that that the utilization presentation was in response to questions raised by the Committee relative utilization declines, market share and other factors.

Information Items:

HHC Utilization Trends

Mr. Victor Kim, Director, Corporate Planning introduced to the Committee Steve Fass, Senior Director, Corporate Planning Services and LaRay Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations. Mr. Kim stated that the analyses address some of the issues raised by the Committee regarding utilization at HHC and the NYC market places. The presentation would cover the data sources and methodologies; NYS and City utilization trends; HHC utilization and payer trends; HHC and NYC Medicaid market; impact of one-day-stays; facility specific reviews for Bellevue, Coney Island, Elmhurst, NCB, Queens and Woodhull; and an overall summary of the findings.

Beginning with the data sources, Mr. Kim stated that there were a number of sources employed based on calendar year data as opposed to fiscal year which provides the most current HHC data and enables HHC to better compare its data with external sources such as SPARC, a statewide system that collects and compiles administrative data throughout NYS.

Ms. Bolus asked for clarification of the difference between psych and psych DRG product line. Mr. Kim explained that it represented HHC internal data that excluded psych services based on the hospital services. In the non-HHC data it is based on the SPARC data that includes the same exclusion as HHC but the data is grouped by the DRG product line which enables HHC to exclude its psych services based on that grouping. Returning to the presentation, the data was adjusted for service with discrete admissions and reimbursement criteria including psych and prisoners services. Medicaid enrollment was incorporated and patient satisfaction HCAHP scores. Other data was reviewed and evaluated but not included in the presentation. This included population census data as well as HHC data from MetroPlus. Throughout the presentation the data sources is identified by the index number one through six as noted on page 3 of the presentation. The utilization for HHC, non-HHC hospitals, NYS hospitals; and the totals for the City and State, the comparisons are based on CY 2010 to CY 2012, the most recent full year data available from SPARC. From CY 2010 to CY 2012 total NYS discharges decreased by 3.6%. HHC inpatient volumes comprising approximately 20% of NYC discharges decreased by 8.3% during the same period and represent a decline 2.3 times greater than NYC as a whole. After adjusting for the storm last year, NYC discharges decreased by 2.6% while HHC discharges declined by 5.6%, a decline 2.1 times greater than NYC as a whole. HHC is losing discharges as a whole. HHC experienced a 13% decrease in total discharges from 2010 to 2013 which is more than half of HHC experienced double digit losses in volume from 2010 to 2013. Coney Island, NCB, Woodhull, Queens, Bellevue and Elmhurst were reviewed at the facility level and the findings will be presented by Mr. Fass later on the agenda. HHC inpatient payer mix overall from 2010 to 2013 has not changed with the exception of a shift from Medicaid FFS to Medicaid managed care. Total discharges CY 2010 of 197,830 decreased to 172,182 in CY 2013. Medicaid managed care increased from 34% to 40%. Trends in Medicaid utilization FFS and managed care showed that HHC is losing Medicaid FFS and MC volume at nearly three times the rate as other NYC hospitals, 15.3% loss compared to 5.4%. Growth in Medicaid managed care for all other NYC hospitals is 4.6 times greater than at HHC facilities, 15% compared to 3.7%. 60% of HHC discharges are covered by Medicaid. The overall loss in Medicaid market share for HHC totals 2.2%. HHC distribution of Medicaid managed care discharges from CY 2010 to CY 2013 has shifted between MetroPlus and HealthFirst from 60% to 54% for MetroPlus compared to Health First from 15% to 22% and all other payers decreased from 25% to 24%. To better understand the shifts, a review of Medicaid managed care enrollment around the City and internal volume from 2010 to 2014, Medicaid managed care plans, NYC enrollment in comparison to HHC Medicaid managed care utilization, citywide there has been a 19.7% increase in Medicaid managed care enrollment. HHC Medicaid managed care volume grew 3.7% while all other NYC facilities grew 17%. MetroPlus increased membership by 14.2% but experienced a slight decline of .8% in market share and MetroPlus discharges volume at HHC decreased by 6.7%. HealthFirst is the Medicaid managed care market leader, with a 28.4% market share and had the largest growth in members, 134,364 and a 38.6% discharges volume increase. Outside of HHC the data on

the Medicaid managed care discharges was not available in SPARC. HealthFirst acquired another plan; Neighborhood Health Plan and was included in the HealthFirst data. Fidelis and United Healthcare also added volume combined a total of over 2,700 cases.

Mrs. Bolus asked how much of HealthFirst enrollment came from their on-site marketing at HHC facilities.

Ms. Brown stated that the objective of the data base does not include that level of detail for the location of the initial enrollment. That information would be available from HealthFirst based on the internal enrollment data which is not available to HHC as a source.

Ms. Youssouf commented that Medicaid managed care has increased significantly and HHC's share of that has decreased in terms of MetroPlus.

Ms. Brown asked Dr. Saperstein, Executive Director, MetroPlus Health Plan to address the MetroPlus decline.

Dr. Saperstein stated that as Mr. Kim had indicated HealthFirst's increase in membership is due to the inclusion of the Neighborhood data. MetroPlus over the last year declined 20,000 members and there are a number of issues. MetroPlus grew due to the Exchange in the Medicaid data. The Medicaid managed care declined by 5% over the year that relates to a number of issues. First a number of individuals lost Medicaid as well as involuntary dis-enrollments. After the storm, in February 2013 MetroPlus' membership decreased by 20,000 in Medicaid and trended high over the year but has remained the same. However, there has been a very high involuntary disenrollment.

Ms. Youssouf asked what the increase in involuntary disenrollment was attributable to. Dr. Saperstein stated that it relates primarily to non-recertification; a change in income, or failure to submit the required requisite paperwork.

Ms. Youssouf asked if the percentage loss was 10%. Dr. Saperstein stated that the total loss was about 5% in Medicaid. Ms. Youssouf asked if that represented the relationship of individuals transferring from Medicaid by 5%.

Dr. Saperstein stated it is slightly higher this year than in the prior year. The involuntary disenrollment percentage was 3.5%. The second piece of the decline had to do with the voluntary disenrollment which did not increase overall but there were a significant number of transfers from MetroPlus to HealthFirst. Over the last year there were 11,107 members transfers from MetroPlus to HealthFirst of which 2,456 transferred back to MetroPlus from HealthFirst. The net decline was 8,561. A year ago, MetroPlus with the assistance of Ms. Katz ran a file on the number of transfers from MetroPlus to HealthFirst to determine if those members after the transfer to HealthFirst remained with HHC. Consequently, 78.2% of those who transferred to HealthFirst left HHC. MetroPlus as a follow-up conducted telephone interview surveys in an effort to determine why those members left HHC and the majority of the responses related to seeking providers outside of HHC leaving MetroPlus and going to HealthFirst for the purpose of leaving HHC completely. Twenty percent are staying with HHC.

Ms. Youssouf stated that it would appear that those individuals are leaving so that they can go to another facility outside of HHC and a different physician.

Dr. Saperstein stated that seventy-five percent of those who were interviewed on the phone stated that the reason for leaving MetroPlus was so they could go to a doctor outside of HHC.

Mr. Kim returning to the presentation stated those non-HHC Medicaid managed care plans are increasing their share while HHC is declining. As an industry, reducing avoidable hospital admissions and one-day-stay is a major focus. At the federal level CMS has set forth policy that securitizes short-stays that do not meet the Two-midnight thresholds. CMS hold the positions that hospitalization is necessary when a patient requires treatment for two or more days and anything short of the two-midnight stay should be handled via outpatient observation. Under the current Medicare regulation, Medicare administrative contractors (MAC) will continue limited prepayment reviews and educational outreach through September 30, 2014. In essence, MAC can deny payment to hospitals for a limited amount of short stay claims. In addition CMS recovery auditors RAC will be allowed to conduct post payment reviews and recover CMS payments for any inappropriate short stay admissions beginning October 1, 2014. The bill, two-midnight rule coordination and improvement act of 2014 was recently introduced in the Senate last week which may provide a delay for the RAC audits. At the State level, the delivery system reform incentive payment (DSRIP) program seeks to reduce Medicaid and uninsured avoidable admissions statewide by 25% over the next five years. DSRIP is part of the Medicaid Redesign task force (MRT) waiver amendment to CMS to allow statewide reinvestment of \$8 billion over a five year period to improve primary care, strengthen the healthcare safety nets, improve health disparities and address transitioning challenges to managed care. Locally, HHC has been implementing the emergency department (ED) care in case management initiative to advance reduction in avoidable hospital admissions through the ED. Reducing one-day stays are consistent with the policy objectives. System wide HHC has reduced one-day stays by 13% from 2010 to 2013 representing 21.4% of the overall loss in volume twice the rate of the voluntary hospitals. Woodhull Hospital experienced the greatest decline at 49.1% or 1500 discharges representing 48% of the overall decline in volume, while Kings County experienced the greatest increase of 59% or 1,800 one-day-stays from 2010 to 2013.

Ms. Youssouf asked if the increase in one-day stays at Kings Count was attributable to the number of hospitals that have closed in Brooklyn.

Mr. Kim stated that based on a review of the one-day stays at Kings County in 2012; there were 625 discharges versus 403 in 2013 which is a direct correlation with the decrease in one-day stays in the latest year. However, the trend over the three year period the data is not reflective of that in that it is being flattened out. While there were some high levels there was a significant decrease in CY 2013.

Ms. Brown added that the reality is that there have not been any hospital closures in the Kings County catchment area. The closure that has occurred in that area was St. Mary's which was prior to 2010. The more recent discussions in terms of potential closures would affect Kings County not necessary one-day stays but overall. However, those closures have not yet occurred.

Mr. Kim stated that in terms of the policy drivers and HHC's initiative to reduce avoidable hospital admissions, the data was adjusted for one-day stays. After that adjustment, all HHC facilities experienced a decline in discharges from 2010 to 2013. More than half of HHC hospitals continue to experience double digit- losses in volume from 2010 to 2013. The relationship between the ED utilization admissions and one day stays from 2010 to 2013; overall there, there has been a slight increase in ED utilization after accounting for the impact of Sandy. All HHC facilities other than Kings and NCB have increased their rate of ED visits that were treated and released. More than half of HHC facilities have decreased the rate of one day stays as a percent of total ED admissions. Woodhull experienced the greatest reductions at 10.9%. Metropolitan Hospital experienced the greatest increase at 14.5%. After adjusting for Sandy, excluding Bellevue and Coney Island, ED utilization grew by 2.1%. There has been a 1.7% increase in the total number of visits that were treated and released or 1.3% after adjusting for the storm and one-day stays as a percentage of the ED admissions have decreased by .3% of .7% after the adjustment for Sandy.

Ms. Youssouf asked if there was a revenue impact in analyzing the impact between the increase in the ED utilization and the exclusion of the one-day stays.

Ms. Zurack stated that the one-day stays produces the same revenue as the five-day stays. The State changed the Medicaid formula five years ago that was called the short stay outlier, whereby hospitals received a lesser payment for a statistically short stay that could be one or two days. When the State implemented the rate reform it was averaged. There is a theory that on the denial front MAC, RAC and IPRO employ nurses to look at medical records to determine whether the stay was medically necessary and retroactively take-back payments if it is determined not to be. The theory is that those are the focused areas. The one-day stays even though the revenue is earned five year later that revenue is more at risk of future disallowance. HHC has reviewed the rate of disallowances for one-day stays overall and it is high but it is not as much higher than anticipated. If one-day stays are documented, there is a significant loss in revenue to eliminate them. However, there is no retrospective data available and would therefore would require hiring a consult to review that data to determine the impact. The industry is insisting on the Two-Midnights Rule and the regulators are pushing for hospital to use the hospital observation status. When there is a situation of whether the determination to admit will take longer than the 8-hour rule that relates to the State ER rule on how long a patient can be in the ED before the determination is made. Consequently there must be reimbursement reform that recognizes that the stays that are remaining are more expensive which should be paid at a higher rate; the ED and observation rates must also be reformed. Although it is being promoted as good care and quality in actuality it is a budget cutting mechanism given that a significant amount of money is being taken out for that issue. The industry has been discussing this issue and Ms. Brown has been involved in those discussions.

Ms. Brown stated that HHC has been working with the industry on efforts to educate the congressional and senate members. Some of those efforts have been successful in the delay of the bill that has been put up by the Senate that could potentially delay the implementation of the Two-Midnight Rule to provide an opportunity for the hospital industry to continue to develop the level of documentation and argument of the case as stated by Ms. Zurack. The Two-Midnight Rule having patients placed on observation status or being in the ED relate to a public relations issue. There have been a number of media stories where there were consumers who were in the ED and stayed overnight and thought that they were admitted only to find out later through a bill from the insurance company that the coverage would only apply to an outpatient cost; a totally unexpected rate that results in a higher cost for the consumer. There are a number of drivers to the policy changes but there is also the congressional budget office that has put an amount for this rule.

Ms. Zurack stated that the other implication for consumers on the Medicare program is that there are certain services such as nursing care that are only arguable if its post admission. If a patient was in an observation bed for 2-3 days for a fracture and needed nursing home care the patient would be prohibited from getting that care because of the non-admission. There are a number of implications for hospitals and consumers, which is a major issue.

Mr. Page asked whether there is a difference in the care provided to a patient being in an admitted bed, a bed that is occupied or in an observation bed.

Ms. Zurack and Ms. Brown both responded that there is no difference in either instance in terms of the clinical resources provided to that patient.

Mr. Rosen asked if it would be better if the admissions were done through the primary care physician as opposed to the ED.

Ms. Zurack stated that HHC's percentage of one-day stays is slightly higher than the City average, 18% versus 21%. The patients seen in the ED are usually patients with chest pains that result in a one-day stay and those patients would not go through a primary care physician.

Ms. Brown stated that from an advocacy perspective, this issue is not just unique to HHC but rather it is shared by all of hospitals across the country. HHC is working with the American Hospital Association (AHA) on this issue.

Ms. Zurack stated that there was a regulatory flaw in the NYS 8-hour rule that did not have observation status until three years ago which created the need for the hospitals to admit a patient due to that rule.

Ms. Youssouf asked when did that rule change. Ms. Brown stated that the rule changed in 2011.

Mr. Fass continuing with the final section of the presentation that related to facility specific reviews for Bellevue, Coney Island, Elmhurst, NCB, Queens and Woodhull. The six facilities were selected due to their decline in volume that was greater than 10% from 2010 to 2013. Bellevue and Coney Island declines were directly attributable to the storm; NCB and Queens had service line suspensions and closures; and Woodhull and Elmhurst had large volume declines exacerbated by severe declines in one-day stay admissions. Beginning with Bellevue, the chart showed volume by service line by month between 2010 and 2013. The loss of volume due to the storm the last two months of 2012 and the facility stabilized in March 2013. Med/surg and ICU combined volume is now 4% lower than before the storm. The 4% decline is consistent with HHC's total system decline that Mr. Kim presented earlier and about twice as great as the citywide trends. Pediatric services recovered fully to pre-storm levels. Volume declined for detox, obstetrics, and neonatal are 12% below pre storm levels. Coney Island did not rebound as quickly and as fully as Bellevue. Volume by select service line, med/surg and ICU combined stabilized by May 2013, but persisted at 12% below the pre-storm volume. OB and neonatal services stabilized by October 2013 and November 2013. Pediatrics and detox services resumed recently. These services are yet to rebound. Elmhurst volume from 2010 to 2013 for service line that included ICU, neonatal, OB, Pediatrics and med/surg declined in volume ranging from 10-17% for an overall hospital decline of approximately 13%. Within med/surg more than half of the decline is related to the decrease in one-day stay admissions. Hospital wide, Medicaid managed care volume declined by 8% compared to a 5% increase across HHC hospitals.

Ms. Youssouf asked what is included in the med/surg services. Mr. Kim stated that med/surg is a broad category of services that are not specialized but rather more routine.

Mr. Fass stated that those hospitals have the greatest market share within the Elmhurst service area and were sorted by changes in the market share. Ms. Brown interjected that after drilling down to certain hospital data the focus was to identify what has happened in those hospitals' market place such as Queens that would affect the market share shifts or to identify what the other hospitals are experiencing.

Mr. Fass continued with the presentation stating that the service area for Elmhurst was defined by a group of zip codes where 75% of the hospital's patients reside excluding psych and rehab patients. The market share for the service area and the change in market share from 2010 – 2012 with the exclusion of one day stays in the total discharges. Queens increased by 1% and Elmhurst by .7% in market share. Medicaid Managed Care volume excluding one-day stays at Elmhurst declined 4.8% but total volume in its service area increased 10.4%, contributing to a 5% decline in market share overall at Elmhurst. New York Queens and Forest Hills hospitals had the greatest increase in market share and the highest Patient Satisfaction scores.

Mrs. Bolus asked why psych is always excluded.

Ms. Brown stated that operationally many individuals who need psychiatric admissions leave their catchment area due to occupancy rates of inpatient psych units, whereby all psych units are always very high and beds are not available in their catchment area or borough; however, Joyce Wales, Senior Assistant Vice President, Behavioral Health could provide more of an explanation.

Ms. Joyce Wale, Senior Assistant Vice President for Behavioral Health stated that the main reason psych is excluded is related to the LOS and discharge options.

Ms. Brown stated that Rehab is also excluded due to the LOS, services and referrals given that not every hospital has rehab services; therefore, individuals may not get it at their hospital.

Mr. Rosen asked if HHC has considered advertising in some of the local newspapers that are in the various communities.

Ms. Brown stated that HHC does some marketing but does not have the sizable marketing budget that some of the hospitals outside of HHC but does market in some of the local papers in all of the boroughs such as the *Queens Courier and Amsterdam News*. With Medicaid managed care it would appear that it is less about marketing and more about the plans and access, so that the scheduling of an appointment is within two to three days as opposed to weeks. Dr. Jenkins, Senior Assistant Vice President, Medical & Professional Affairs has undertaken a major initiative with the facilities in terms of creating additional capacity or access in ambulatory care services.

Mr. Kim reinforcing Ms. Brown statement added that it would appear based on the data for Queens that there is a direct correlation between the HCAHPS and the market share in the service areas.

Ms. Youssouf asked if the dis-satisfaction with getting an appointment was the primary reason for the decline.

Ms. Brown stated that it is one of the factors; however, the data is primarily on the inpatient stays and not the outpatient. There is also a factor relative to the perception of HHC facilities versus the volume and also the hotel services. There are numerous others but now it is more about the health plans and access.

Mr. Page asked if HHC has concluded that asking a patient who is being discharged from the hospital to rate their services would actually filter out how that patient felt about the time it took to get there.

Ms. Brown stated that was one of the reasons for the distinction between the inpatient satisfaction survey and the outpatient services areas and other factors such as utilization and having access to ambulatory care services.

Dr. Ross Wilson added that access has little or no bearing on the HCAHP score. It relates only to med/surg and is a roll-up score with a number of questions behind it. The survey is conducted by an external contractor, Press Ganey and HHC is trying to improve its scores recognizing that those scores could be better in a number of service areas. The process will take time to complete; however, until HHC gets its staff engagement scores to a satisfactory level it is difficult to improve the patient satisfaction scores. However, a lot of effort has gone into this process and the hospitals are to be commended for their efforts in address this issue.

Moving back to the presentation, Mr. Fass stated that the volume at NCB declined by 26% which is due largely to the transfer of the OB/neonatal services to Jacobi but are scheduled to re-open this summer at NCB. More than 6% of NCB total volume loss can be attributed to the service suspension totaling 1,300 discharges. Discharges decreased by 255 of which 12% of the total facility wide volume decline from CY 2010 to CY 2013 can be attributed to a reduction of the one-day stays excluding OB and neonatal. After adjusting for the suspension of services and one-day stays, Medicaid volume, FFS and managed care declined by 148 cases, representing 7% of the total decline at the facility during the period. OB and neonatal services volume declined at both Jacobi and NCB from 2010 to 2013. This downward trend continued after the consolidation of services at Jacobi in August 2013. Both hospitals combined, volume declined by 6.7% in 2011, 7.6% in 2012 and by 6% in 2013. In terms of the market share in the Bronx, excluding OBS/NEB, pediatrics, psych and rehab, total Medicaid managed care services volume excluding one-day stays within NCB's service area increased 30.7% from 2010 to 2012. Medicaid managed care volume at NCB, Jacobi and Lincoln increased by 18%, 7% and 18% respectively. For all three hospitals combined, Medicaid managed care volume increased 13% within NCB's service area. At Queens Hospital, volume decline by 20% from 2010 to 2013. The inpatient detox unit was closed in June 2011 which accounted for 39% of the hospital's total decline in the overall loss in volume. One-day stays excluding detox declined 40% or 1,150 cases from 2010 to 2013, accounted for 37% of the total decline of 3,092 cases. After adjusting for detox services and one-day stays, overall Medicaid FFS and managed care declined by 574 cases from 2010 to 2013, representing a 19% of the total decline. In terms of Queens hospital service area market share, Long Island Jewish increased by 1.9%, NY Hospital of Queens increased by 1.0%, and North Shore LIJ by 0.6% had the highest increase in market share after accounting for One-Day Stays. Overall Medicaid Managed Care volume (excluding One-Day Stays) within Queens Hospital service area increased 18.3%, with the highest growth rates at LIJ and NY Queens. Patient Satisfaction scores were highest at LIJ, NY Queens and North Shore LIJ, which also had the greatest gains in Medicaid Managed Care market share. Queens Hospital's market share declined by 0.8%; at Woodhull hospital volume declined by 20/2% from 2010 to 2013. One day stays declined 49% or 1,553 cases from 2010 to 2013 accounting for 48% of the total volume decline of 3,228 cases. Med/surg volume excluding one-day stays declined by 23% representing 43% or 1,388 cases of the overall decline. Total Medicaid volume, FFS and managed care combined excluding one-day stays declined 13% or 1,195 cases from 2010 to 2013. In terms of Woodhull service area market share, NY Methodist increased by 0.7%, Beth Israel by 0.5% and Brooklyn Hospital by 0.5% had the greatest increase in market share from 2010 to 2012, after accounting for One-Day Stays. Total Medicaid Managed Care volume (excluding One-Day Stays) within Woodhull service area increased 14.8%, while at Woodhull Hospital it increased 8.2%. Patient Satisfaction scores were highest at NY Methodist and Beth Israel, who also had the greatest increase in market share.

In summarizing the findings, Mr. Fass stated that Inpatient volume declined citywide; however HHC losses were more than twice as great as the voluntary hospitals. In shrinking markets, several HHC hospitals lost market share, however not all HHC hospitals followed this trend. In terms of decreasing one-day stays largely considered medically unnecessary and targeted by policy initiatives, HHC reduced one-day stays at twice the rate as voluntary hospitals. Several HHC hospitals made significant inroads at reducing one-day-stay admissions, led by Woodhull, Queens and Jacobi Hospitals. Other projects are in the works to reduce ED visits that result in an avoidable admission, and potentially avoidable admissions for chronic diseases. Hospital service disruptions, Bellevue recovered near to pre-Sandy levels in all service lines by April 2013; however Coney Island Hospital remains impacted with reduced volume and the closure of some services through 2013. Suspended services at North Central Bronx and Queens Hospitals contributed to their volume declines. Declining Medicaid Volume Medicaid FFS at HHC had significant declines paralleling NYC trends. New York City experienced a large increase in Medicaid Managed Care inpatient volume and enrollees; however volume at HHC was flat. Though HHC saw a large increase in volume from HealthFirst enrollees, volume from MetroPlus enrollees declined.

Mrs. Bolus asked if the Committee could get more information on the relationship between HealthFirst and HHC relative to the contractual requirement and the marketing effort at HHC facilities.

Ms. Zurack stated that HHC has a perpetual contract with HealthFirst as an equity partners. However, what might be more beneficial to the Committee would be a closer look at the decline in volume at MetroPlus. So perhaps, Dr. Saperstein could update the Committee in a few months

on the status of that issue. The data presented showed that Fidelis increased its enrollment at HHC without any presence in the facilities. Therefore, HHC needs to look more closely in that area. The rates for HealthFirst and MetroPlus are about the same. Obviously, HHC has more invested in MetroPlus as the preferred plan. However, HealthFirst must be as lucrative for HHC as MetroPlus except HHC is diversifying.

Ms. Youssouf asked if MetroPlus is prohibited from having contracts with hospitals outside of HHC.

Ms. Zurack stated that MetroPlus has contracts with other hospitals, NYU, Montefiore, Mount Sani, and Lutheran but not at the same level as HealthFirst intentionally for the purpose of loyalty to HHC out of the MetroPlus membership. Ms. Youssouf added that the investment in MetroPlus is greater than HealthFirst.

Ms. Zurack stated that it is comparable and there have been some learning experiences from both plans. Elmhurst/Queens has indicated that it has been a big investment.

Ms. Youssouf stated that the recommendation to have MetroPlus update the Committee is a good one. The reporting and the discussion were concluded.

Financial Plan

Ms. Zurack stated that it is important to have HHC's financial plan presented to the Committee as part of the NYS Public Authorities Accountability Act (PAAA) requirement. In the essence of time Mr. Covino would present some of the highlights of the plan so that it gets into the minutes.

Mr. Covino stated that each year HHC's financial plan which is part of the City's overall budget process is presented to the Committee. The plan includes the prior year actuals and projections for the current FY 14 through FY 18. The plan is comprised of three sections, receipts, disbursements and corrective actions. Some of the major changes in the plan include the transitioning of behavioral health and long term care from FFS Medicaid to Medicaid managed care. FFS Medicaid also reflects a reduction for the annual 2% trend assumption beginning in FY 15. In total approximately \$95 million transitioned from Medicaid FFS to managed care in FY 15 growing to \$285 million by FY 18. This will have a major impact on HHC's UPL payments that are based on the Medicaid FFS population and as that declines the amount of claims that HHC can put through that process decreases. As a result there are reductions in the UPL payments of \$50 million in FY 15 growing to \$158 million by FY 18. The projection is mitigated by the City's commitment to maintain their local share of those payments; therefore it is only half of the actual impact.

Ms. Youssouf asked if that commitment was confirmed by the City. Ms. Zurack stated that HHC's plan which is included in the City's overall plan was presented by the City to the monitors. HHC submitted its plan as a draft and the new administration has approved it.

Mr. Covino stated the Medicaid DSH reduction was also included and is also supported by the City as part of the Affordable Care Act (ACA) the Medicaid DSH reduction is approximately \$74 million beginning FY 16 and growing to \$305 million. The Medicare DSH which is a positive that increases revenues in Medicare in FY 14 by \$140 million growing to \$161 million by FY 18. Additionally there are some Medicare payment reforms as part of the ACA. There is a reduction for readmission penalties and value based purchasing totaling \$5 million in FY 14 growing to \$35 million in FY 18. The healthcare Exchanges are projected at \$113 million in additional receipts for FY 14 growing to \$104 million by FY 18. There are some concerns for some items that are included in the plan such as collective bargaining (CB) projected at 1.25% prospective beginning in FY 14. There are some potential retroactive liabilities based on prior patterns that could be as high as \$350 million payable in FY 14 with a recurring liability over the life of the plan of approximately \$700 million including fringe benefits.

Mr. Rosen asked if the CB beginning in FY14 at 1.25% was compounded over the life of the plan.

Mr. Covino stated that it is 1.25% each year compounded. In addition to that each percentage above the 1.25%, the cost for HHC would be an additional gap opener of \$30 million, \$22 million in wages and \$8 million in fringes. The other potential risk in the plan is that the plan does not include any reductions in workload and if that trend continues it will be a further risk to the plan.

Ms. Youssouf asked for clarification of the assumption for the workload and whether that related directly to utilization.

Ms. Zurack explained that it was held flat throughout the plan.

Mr. Covino stated that receipts over/under disbursements in FY 14 included a \$324 million positive contribution to the plan. However, as Ms. Zurack stated earlier, HHC is anticipating approximately \$1.6 billion in UPL payments by the end of FY 14 that includes \$900 million for prior year receipts. In the out-years, FY 15 – FY 17 the impact of the \$900 million non-recurring which reflects a negative \$428 million growing to a negative \$1.1 billion in the out year of the plan due to the impact of the UPL declining and the Medicaid DSH reductions as part of the ACA.

Ms. Youssouf asked if the plan included all of the assumption relative to CB and the 250 increase in FTEs. Mr. Covino stated that those were included as part of the risks to the plan. The baseline deficit in the out years of \$1.4 billion which is further at risk due to CB both retroactive and

prospective in addition to any declines in workload going forward. The plan does include the increase of 250 FTEs and revenue related to grants. The reporting was concluded.

Statement of Revenues & Expenses for the Period Ended 12/31/2013 & 2012

Mr. Jay Weinman stated that the statement represented revenues and expenses for the 2nd quarter of the current FY 14. Overall the Corporation's net loss for the current FY 14 was \$110 million compared to \$484 million in FY 13. Net patient service revenue increased by \$400 million of which \$300 million related to changes in the UPL payments, \$44 million in additional DSH maximization and \$34 million in Medicare settlements. Personal services increase by \$52 million due to \$48 million in additional MetroPlus expenses for additional services for members. Post-employment benefits decreased by \$41 million as part of an adjustment made last year based on the City's actuary's report to decrease this expenses over the next ten years. The operating loss reduced by \$55 million decreased by \$384 million due to the net patient service revenue as previously noted. Interest expense increased by \$7 million due to the reductions in capitalized interest from the City that resulted in an increase in HHC's interest expense.

Strategic Planning Committee – March 11, 2014 As reported by Josephine Bolus, RN

SENIOR VICE PRESIDENT REMARKS

Ms. Brown greeted and informed the Committee that in lieu of her remarks she would provide the Committee with an update on New York State's Medicaid Waiver. She noted that her presentation included content from various sources including the State Department of Health and HANYS.

Information Items:

New York State Medicaid Waiver Update - LaRay Brown, SVP, Corporate Planning, Community Health & Intergovernmental Relations

Ms. Brown began presentation by first describing the evolution of New York State's Medicaid Waiver:

- Two years ago, the Medicaid Redesign Team (MRT) made a recommendation for New York State to apply for a Medicaid Waiver. New York State sought approval from the federal government to use Medicaid program savings to further its goal to transform health care services delivery.
- California, Texas and New Jersey had each received approval of a waiver.
- In August 2012, New York State submitted a \$10 billion waiver to the Centers of Medicaid Services (CMS). The negotiations proceeded but there were some suspensions of those negotiations due to Super Storm Sandy in October 2012. In summer 2012 and the beginning of 2013, concern was raised about a prior waiver specifically focused on persons with disabilities (OPWDD) with the discussion focused on whether the State had to return funding back to the federal government. This occurrence significantly delayed discussions regarding the Waiver.
- In summer 2013, the State refocused its attention on the Waiver that had as one of its major components delivery system reform or improvements specifically focused on public hospitals with these entities playing a major driver vis-à-vis the local math that was required.
- In fall 2013 and winter 2014, New York State submitted more revisions of its proposal to CMS as a result of many questions and some push back on the part of the CMS.
- In late January and early February, New York State received conceptual approval of a waiver, not valued at \$10 billion, but \$8 billion. There are still ongoing discussions to finalize terms and conditions, which would in fact serve as the final official approval of the Waiver.

Funding Allocations

Ms. Brown described the Waiver's funding allocations as presented in the chart below:

DSRIP \$7.6 B
(December 2013 Submission)

State Plan Amendment: \$0.5 B

Managed Care Contracts: \$1.9 Billion

<ul style="list-style-type: none"> • Hospital transition • Public hospital innovation • Vital Access Provider (VAP) • Long Term Care Transformation • Public Health Innovation • Health Workforce 	<ul style="list-style-type: none"> • Health Homes 	<ul style="list-style-type: none"> • Primary care expansion • Health workforce (MLTC) • Managed long term services and supports for serious behavioral health/substance abuse
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DSRIP \$7.3 B
(January 2014 submission)

State Plan Amendment: \$0.5 B

Managed Care Contracts: \$2.2 B

<ul style="list-style-type: none"> • Hospital transition • Public Hospital innovation • Vital Access Provider (VAP) • Long term care transformation • Public health innovation 	<ul style="list-style-type: none"> • Health Homes 	<ul style="list-style-type: none"> • Primary care expansion • Health workforce • Managed long-term services and supports for serious behavioral health/substance abuse
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Ms. Brown informed the Committee that, in the month of January, following negotiations with the Centers for Medicare and Medicaid Services (CMS), the State had made some minor changes in what it was going to put forward in terms of the allocation of the \$10 billion. A total of \$300 million was taken out of the DSRIP (Delivery System Reform Incentive Payment) program column and placed into the managed care column. This was done specifically to provide the State with greater opportunities for investment in health care and workforce transformation. Ms. Brown emphasized that after the \$2 billion reduction, the Waiver amount would be reduced to \$8 billion; however, it was not yet clear how the \$2 billion reduction would be allocated. Whether it would be proportionate, that is 75% of the \$2 billion would be taken from DSRIP or not. A proportionate reduction is anticipated over each of the three components: DSRIP, state plan amendment and managed care contracts. Ms. Brown explained that DSRIP was the primary funding source for hospitals and health systems; and that HHC would apply for \$2.6 billion over the five year term of the Waiver.

DSRIP Funding Flows

Ms. Brown described the Delivery System Reform Incentive Payment (DSRIP) program funding flow as the following:

- Public hospitals provide Intergovernmental Transfer Funds (IGTs)
- Part of federal match for IGT will be used to support DSRIP for non-publics
- Significant funding contingent on public hospitals' cooperation and success

DSRIP Key Themes

Ms. Brown described the key themes of the Delivery System Reform Incentive Payment (DSRIP) program, which included the following:

- Different kind of Waiver
- Delivery system transformation
- Safety Net sustainability
- Potential support to build ability to assume risk
- State proposing to link other investments (\$2B Capital Fund in Executive Budget)

DSRIP Key Components

Ms. Brown described the key components of the Delivery System Reform Incentive Payment (DSRIP) program, which included the following:

- Reduce avoidable hospitalizations
- Statewide initiative for public hospitals and array of Safety Net providers
- Payments will be performance-based
- Menu of CMS-approved programs
- Collaboration is expected and rewarded
- DSRIP payments can be used to refund front-loaded investments, support new investments, or other needs

DSRIP Eligible Providers

Ms. Brown described DSRIP eligible providers as including:

- Major public general hospitals
- Safety Net providers
 - Hospitals, nursing homes, clinics including FQHCs, behavioral health providers, and home care agencies
- Safety Net criteria – under negotiation
 - December – DOH proposed broad parameters
 - January- DOH proposed 3 domains
 - HANYS advocating for definition that represents diversity across the State
- State proposing non-Safety Net hospitals and Safety Net hospitals can partner
 - Lead applicant must be a Medicaid provider

DSRIP Overarching Goal

Ms. Brown informed the Committee that the DSRIP overarching goal is to reduce preventable hospitalizations – 25% in 5 years and 50% in 10 years, which will be measured using the following metrics:

- Potentially preventable Emergency Room visits
- Potentially preventable readmissions
- Prevention quality indicators (PQI) – adult
- Prevention quality indicators – pediatric

DSRIP Program Menu

Ms. Brown shared with the Committee the three broad categories of programs that had been included as part of the DSRIP program menu. They included:

- Hospital transition projects:
 - Disease management
 - Transitional care
 - Expand/co-locate primary care
 - Integrate behavioral health with primary care
 - Care management infrastructure
 - Infrastructure for improved geriatric health services
 - Telemedicine strategies
 - Ambulatory detox capability in community
 - Evidence-based medication adherence programs
 - Expansion of palliative care
 - Comprehensive strategy to reduce AIDS/HIV Transmission
- Long term care transformation projects:
 - Transfer avoidance
 - Hospital-Home Care collaborations
 - Pressure ulcer prevention programs
 - Medication error prevention programs
 - Bed buy back
- Public health innovation projects:
 - Asthma self-management
 - Home visits (Lead poisoning/new mothers etc.)
 - Collaborations for community-based strategies to reduce health disparities
- Off-menu option projects:

Ms. Brown commented that CMS does not encourage off menu programs. Such projects will be subject to greater scrutiny with expectations of higher levels of performance.

DSRIP Project Plan Requirements

Ms. Brown reported on the DSRIP project plan requirements. She stressed that funding decisions would be based on the criteria listed below:

- A new initiative for the provider
- Substantially different from other CMS-funded initiatives, but could build, expand or augment
- Address significant health issues in the catchment area
- Substantial and transformative change
- Commitment to life-cycle change and organizational resources to ensure success
- Collaboration with other providers with special attention paid to coordination with Health Homes

Local Partnerships to Transform Delivery System

Ms. Brown described the types of local partnerships that are anticipated to transform the health care delivery system. Local partners are expected to include:

- Hospitals
- Nursing Homes
- Clinics and FQHCs
- Behavioral Health Providers
- Home Care Agencies
- Other key stakeholders

She described the role of the local partnerships as serving to:

- Identify community health needs, healthcare challenges and quality objectives.
- Develop programs and investments that address those needs, with measurable metrics and milestones.
- Transform the healthcare delivery system by working together to improve quality and health outcomes while lowering cost.

Ms. Brown discussed the DSRIP Timeline as of January 2014 and for Year 1 – Quarters 1 through 3 – of the Planning, Assessment & Project Development as shown in the charts provided below:

DSRIP Timeline (as of January 2014, details will shift)

Stage	Estimate
Target approval date by CMS	Early March 2014
Providers submit project planning application to DOH	April 4, 2014
DOH feedback on project planning applications	April 25, 2014
Funds allocated to approved planning projects	May 2, 2014
Providers submit final project plans	November 28, 2014
DOH reviews and decides on final project plans	December 26, 2014

DSRIP Timeline

DY1: Planning, Assessment & Project Development

Year 1 – Quarters 1 through 3			
Organizing and Learning	Assessment	Project Development	Deliverable For Planning Dollars During Quarter 1 Through 3
<ul style="list-style-type: none"> • Orientation to DSRIP • Education & Communication • Engagement with other providers and stakeholders • Committee Development (if needed) • Consensus on Principles and shared goals (if any) 	<ul style="list-style-type: none"> • Interviews, Focus Groups • Funding Assessment (Finances/available funds) • IGT Assessment (publics only) • Community & Regional Needs Assessment • Workforce Planning 	<ul style="list-style-type: none"> • Program Identification based on needs and goals • Project valuation • Internal Evaluations (value, sustainability, etc.) • Buy-in & Engagement • Proposal Development & Submission 	

DSRIP Final Application Requirements

Ms. Brown reported that the DSRIP final application must include the following:

- Select goals and programs
- Performance assessment
 - Current status of the community
 - Evidence of regional planning
 - Root cause of poor performance
 - Evidence of public input
- Work plan development
- Milestones and metrics
- DOH developing a “data book” for providers

DSRIP Program Valuation – Application Scoring Being Negotiated

Ms. Brown reported that the State will utilize the criteria listed below to evaluate proposed DSRIP programs (1-5 points):

- Alignment with avoidable hospitalization and quality objectives
- Potential for cost savings
- Degree of community collaboration and comprehensive partnerships
- Robustness of evidence base
- Number of Medicaid members impacted
- Financial viability of lead applicant

DSRIP Program Measures

Ms. Brown reported on DSRIP program measures, which include:

- Process measures (i.e. plan, action steps)
- Outcome measures (i.e. QARR, HEDIS, CAPHS, BRFSS, SPARCS, CHIRS)
- Avoidable hospitalization measures
- Measures of overall system change (e.g., reduction in inpatient, increases in primary care)
- Financial sustainability metrics to assess long term viability

Ms. Brown explained the planned DSRIP funding distribution stages as outlined in the chart below:

DSRIP Funding Distribution Stages (*under discussion*)

DSRIP Funding Distribution Stages	Year 2	Year 3	Year 4	Year 5
Project Process Metrics (Includes Infrastructure and Project Design and Management)	70%	60%	30%	5%
Project Specific Outcomes Metrics (Includes quality improvement, chronic disease management and population health)	10%	15%	25%	25%
Provider Financial Viability Metrics (If applicable, if not applicable to a given provider, this percentage will get moved to the other three categories)	15%	15%	15%	15%
Avoidable Hospitalizations	5%	10%	30%	55%
Total	100%	100%	100%	100%

Note: Year 1 payments will be provided primarily for planning

Final Stretch

Ms. Brown concluded her presentation by emphasizing that:

- Many outstanding issues are being negotiated with CMS, which include:
 - Safety net definition
 - Valuation goals/distribution
 - Program scoring
 - Metrics and value for attainment
- The goal is to achieve an agreement on terms and conditions by early March 2014

Improving Access to Health Care Services for Women with Disabilities

Marilyn Saviola, Vice President of Advocacy and Women's Health Program, Independence Care System

Dinah Surh, MPH, Senior Executive Administrator

David John, MD, Medical Director

Morrisania Diagnostic and Treatment Center

Edward Fishkin, MD, Medical Director

Paul Kastell, MD, Chairman, OB/GYN Services

Patrina Phillip-King, MD, OB/GYN

Woodhull Medical and Mental Health Center

Sharon Abbott, PhD, Assistant Director

Corporate Planning Services

Ms. Brown informed the Committee that this presentation represented a small but growing and very important collaboration and partnership that HHC was undertaking with Independent Care System (ICS). She added that this initiative was established on multiple fronts by a core group of women with disabilities and advocates including the New York Lawyers for the Public Interest, who documented the difficulties that women with disabilities experience when accessing health care services, across the health care spectrum, starting with mammography services. Ms. Brown reported that the New York Lawyers for the Public Interest had published a report in which HHC did not do too badly because of the work that had begun at HHC's Morrisania Diagnostic and Treatment Center. Ms. Brown reported that another stakeholder, the City Council had convened a public hearing on access to health care services for women with disabilities and HHC was asked to provide testimony at that Council hearing. Ms. Brown informed the Committee that following that hearing, the Council had reached out to HHC to learn what could be done to ensure that this area of service could be improved in public settings. The City Council provided HHC with some capital funding for capital improvements. Consequently, HHC partnered with ICS to expand the work that Independence Care System has initiated at Morrisania Diagnostic and Treatment Center and at Woodhull Medical and Mental Health Center by applying for a New York Community Trust grant to support ongoing training of staff.

Ms. Marilyn Saviola, Vice President of Advocacy and Women's Health Program of Independence Care System (ICS) greeted Committee members and thanked them for the opportunity to present on their work improve access to health care services for women with disabilities. Ms. Saviola informed the Committee that she had grown up in the HHC family. After being a resident at Goldwater for many years, she became an employee at Goldwater's Counseling Department. Soon after earning an education, she became a community advocate for services for people with disabilities. Ms. Saviola stated that women with disabilities often raised questions on how and where to get a mammogram or a pelvic exam. She stressed that, although healthcare access issues were very common among the uninsured and underinsured, for women with disabilities the issue was a lack of competency, awareness and sensitivity. Ms. Saviola stated that, it was unfortunate that this is the first time that the issue of health care access for women with disabilities is being addressed.

Ms. Saviola shared with the Committee the following comment that was made by an ICS member:

"There are too many women with disabilities who have been silenced. We can't be. Some people don't want to tell their stories because it's so painful. When it comes to health care, it's happened so many times, it feels like it's not going to change."

-M. Lyons, Member, Independence Care System

Ms. Saviola provided the Committee with a brief overview of Independence Care System as described below:

Independence Care System - Who are we?

- Non-profit Medicaid Managed Long Term Care Plan
- Coordinates home care, health care, and social services to enable adults with physical disabilities and chronic conditions to live at home
- Only plan specifically designed for people with physical disabilities
- Serves over 5000 members in Brooklyn, the Bronx, Manhattan and Queens
- Half use wheelchairs or other mobility aides
- Over 30% require 24-hour personal care
- Most are Hispanic/African-American, as well as Russian and Asian
- Approximately half are over the age of 65.
- Many ICS members use HHC facilities to meet their healthcare needs

The Beginnings

Ms. Saviola described a report, *"Breaking Down Barriers, Breaking the Silence: Making Health Care Accessible for Women with Disabilities,"* authored jointly by the Independence Care System (ICS) and New York Lawyers for the Public Interest with the Committee. She described the report as the following:

- Report released in 2012
- Described common barriers to receiving health care services
- Offered recommendations to improve access to care

Common Barriers to Accessing Healthcare Services

Ms. Saviola highlighted the common barriers to accessing health care services for women with disabilities as the following:

- Physical access
 - ✓ Facility design
 - ✓ Accessible equipment
- Communication barriers
 - ✓ Language access
 - ✓ Alternative media
 - ✓ Signage

Attitudinal barriers and lack of training

Ms. Saviola described the impact of attitudinal barriers and lack of training on access for women with disabilities. She shared with the Committee a statement made by an ICS member regarding her experience with accessing gynecological services:

“When you have a physical disability and you’re looking for a gynecologist, you usually have to settle. Most women don’t know that the facility should be accessible, so we tend to adapt. We don’t know any better, so we settle. For example, I went to one place and the only thing that was accessible was the front door.”

-C. Cruz, Member, Independence Care System

Ms. Catherine Crowther, ICS’ Patient Care Advocate, read the following example of attitudinal barriers:

Example: Attitudinal Barriers

“Another young lady with a disability was [at the gynecologist’s office] when I was there and the doctor raced around the place saying, “oh my god, she’s pregnant; I can’t believe it, she can’t be!” She was so loud everyone in the waiting room heard it. I was disgusted. When I went in for my appointment, they did a pregnancy test on me even though I didn’t request it. When it came back negative, they said “Oh, well thank god you’re not pregnant!” I cannot even begin to tell you how upset I was, not only for myself, but for the other woman – she was a grown woman with a job – and they carried on so horribly.”

-Kim Yancy, Member, Independence Care System

Ms. Saviola reported on the legal framework for providing accessible care and described ICS’ access to healthcare program for women with physical disabilities program:

Legal Framework for Providing Accessible Care

Anti-Discrimination Laws that Protect New Yorkers with Disabilities:

- Americans with Disabilities Act
- Section 504 of the 1974 Rehabilitation Act
- Local and State Anti-Discrimination Laws

ICS Access to Healthcare for Women with Physical Disabilities Program

- Aims to improve cancer screening accessibility in New York City
- Reduce/eliminating physical barriers and inaccessible equipment
 - *Mammography Project*
 - *Gynecological Project*
- Educating staff to address provider misconceptions and lack of sensitivity, awareness and competencies
- Create procedures to increase efficiency and accessibility

Ms. Nicole Mylan, ICS’ Director of Women’s Health Services shared the following statement with the Committee from an ICS member:

“It’s important because my mother had breast cancer and if I don’t get that mammogram I could get cancer and not know it. If I get the mammogram maybe I could catch it in time. I like to have my mammogram every year.”

-Esther J., Member, Independence Care System

Program Challenges

Ms. Saviola described the program challenges as the following:

- Finding medical facilities willing to create partnerships
- Securing executive and clinical staff buy-in
- Accommodations
 - ✓ Accessible equipment
 - ✓ Transfer assistance
- Time Commitments
 - ✓ Longer appointments
 - ✓ Staff Training

Ms. Saviola shared with the Committee the experience of an ICS member who was able to receive care through ICS in a manner that was sensitive and appropriate for her:

"My first time in the ICS program, everything was in one room so I didn't have to undress and come in through the back door. I usually have a real hard time with spasticity, but the chair lift worked and I was able to get on the chair pretty much by myself. That the table actually came down to me – that made a huge difference. She did the examination the way it should be done. I'm 49 years old and that was the first time I had a totally accessible experience."

-M. Lyons, Member, Independence Care System

Ms. Saviola informed the Committee that after the release of *"Breaking Down Barriers, Breaking the Silence: Making Health Care Accessible for Women with Disabilities,"* the New York State Department of Health sent out a letter to all hospitals, nursing homes, diagnostic and treatment centers and health centers, as well as large practices reminding them that they may be breaking the law by not providing accessible care for people with disabilities. They were asked to respond with a check list. Ms. Saviola informed the Committee that only HHC had responded. She added that Ms. LaRay Brown, at the City Council Meeting, made a commitment to partner with ICS. Ms. Saviola stated that, since then, she had met some of HHC's invaluable employees starting with the staff of Morrisania Diagnostic and Treatment Center (D&TC) including Patrina Phillip, M.D., David John, M.D., Medical Director and Ms. Dinah Surh, MPH, Senior Executive Administrator. For the past two years, ICS has partnered with Morrisania D&TC to serve the needs of women with disabilities.

Ms. Brown introduced Ms. Dina Surh, Senior Executive Administrator, Morrisania D&TC and invited her to share with the Committee HHC's work with ICS at Morrisania D&TC. Ms. Surh stated that Independence Care System and Morrisania was a life changing partnership, not only for the patient, but also for the staff and the community. Ms. Surh described the evolution of the ICS/HHC collaboration as the following:

- In 2011, Marilyn Saviola, VP, Advocacy and the Women's Health Access Program (ICS) and staff began a series of meetings with Morrisania D&TC leadership to explore the possibility of creating new access to services for women with disabilities.
- In May 2011, a Business Agreement was signed by HHC and ICS to start a pilot project at the Morrisania D&TC to accept ICS referrals for mammography services.

Ms. Surh provided the Committee with an overview of Morrisania D&TC. She informed the Committee that the major focus of all D&TCs like Morrisania is to provide primary and preventative health care services. She also described Morrisania D&TC's services and operations as the following:

- Part of Generations+ Northern Manhattan Network
- Provides comprehensive Primary Care, Women's Health, Adult Medicine, Pediatrics, Behavioral Health, Dentistry, HIV, Optometry, Podiatry, Child Development Clinic (CDC), Pharmacy, Radiology, Social Work, Nutrition, WIC, and enabling services including Medicaid Assistance Program (MAP) onsite.
- Hours: Mondays- Fridays 7:30 AM – 8:00 PM
- 190+ staff
- 80,000+ visits annually

Ms. Surh reported that, in recent years, the HHC Generations+ Northern Manhattan Network had developed the following Vision Statement which reads:

"We provide a caring, value added outpatient experience that anticipates patient and community needs and exceeds expectations through a highly engaged patient centered workforce."

Ms. Surh added that the above vision was crafted not to be placed on a board or to be jotted down on a piece of paper but to be a living document to serve the community. Upon meeting with Ms. Saviola, Ms. Surh stated that it was clear that ICS' needs matched perfectly with Morrisania D&TC's vision. The first step was to assess Morrisania's Mammography suite.

Morrisania D&TC – Mammography Equipment:

- Assessments of mammography and sonography suites were conducted to identify equipment needs.

- ICS provide recommendations to create a comfortable setting for women with disabilities.
- Special mammography chair and cushions were purchased to position patients for procedures.
- Hoyer lifts were obtained from HHC's Goldwater facility

Ms. Surh stated that through the series of meetings that had been convened, Morrisania D&TC Mammography services processes were enhanced to include the following:

- In 2011-12 joint ICS/Morrisania Partnership meetings were convened to develop patient referral processes, appointment schedules, communication strategies between caregivers, patients and support staff to coordinate care and provide consultative reports and plan for staff training.
- Traditional mammography and sonography services were offered in 2012.
- In 2013, Morrisania D&TC installed a new digital mammography unit with federal funding from HRSA.

Ms. Surh introduced David John, M.D., Medical Director of Morrisania D&TC and invited him to describe the various gynecological services offered at Morrisania D&TC. Dr. John stated that he always felt that his role as a physician was to humbly serve all. Dr. John added that as a medical director of a facility, he was embarrassed after learning from Ms. Saviola about the various barriers that women with disabilities faced in accessing care and felt that those barriers must be addressed if HHC were to remain truthful to its mission to serve all New Yorkers. Following the improvements made to the mammography services area, Morrisania D&TC made the following improvements within gynecological services:

- Special equipment purchased: Hoyer lifts, weight scale, exam table, large exam room
- Women Health Services has provided 400+ visits/year:
 - ✓ Routine GYN visits
 - ✓ Colposcopy services
 - ✓ Abnormal uterine bleeding evaluation and treatment
 - ✓ STD testing and treatment
 - ✓ Mammography and sonography services
- ICS has a dedicated nurse educator who accompanies ICS' members to appointments at Morrisania D&TC.

Dr. John's emphasized that ICS's nurse educator facilitates the visits in many ways. He added that this service provided by ICS works well at Morrisania D&TC.

Ms. Surh emphasized that a key factor that was essential for the success of the Morrisania/ICS partnership was staff training. She described Morrisania D&TC's staff training initiatives:

- In 2012, a series of Disability Sensitivity and Awareness Staff training workshops were conducted by ICS
- Training included didactic training and role playing with interdisciplinary staff in Women's Health, Radiology, Adult Medicine
 - ✓ Staff participants included clerical, nursing, clinical providers, administrators and other support staff
- Staff responded positively to training workshops

Dr. John concluded his presentation of the Morrisania/ICS partnership experience by sharing with the Committee the lessons learned and Morrisania D&TC's next steps which include the following:

Lessons Learned from Morrisania D&TC

- Provided access to services for women with disabilities
- Learned about clinical barriers to care (e.g. spasticity)
- Enriched clinical acumen of providers
- Provided staff expertise and promoted staff ease in providing care to women with disabilities

Morrisania D&TC - Next Steps:

- Adult Primary Care services to start in April 2014
- Special emphasis on preventative medicine
- Chronic disease management
- Expand the number of physicians providing services
- With City Council funding, a bathroom located within mammography suite will be renovated to become handicap accessible

Ms. Brown introduced Edward Fishkin, MD, Network Medical Director for HHC's North Brooklyn Healthcare Network and invited him to present the initiatives that are being conducted at Woodhull Medical and Mental Health Center to address healthcare access issues for women with disabilities. Dr. Fishkin informed the Committee that he had the privilege of meeting Ms. Saviola and her team at ICS almost two years ago. He highlighted that the meeting was an epiphany. Ms. Saviola had made it abundantly clear how much trouble women with disabilities experience every day trying to obtain quality and dignified health care services. Dr. Fishkin reported that, at the first meeting he had a soul searching experience similar to what Dr. John described earlier. Dr. Fishkin informed the Committee that until then, Woodhull Medical and Mental Health Center's staff had dealt with disabled or special needs patients on a one to one basis, not really considering the "community of disability." Dr.

Fishkin commented that Ms. Saviola had actually sensitized him, in this case, on the need to consider not only the individual patient's experience with care but the need to address the health of the community of disabled women.

Dr. Fishkin stated that a commitment to extend access to timely, quality and respectful care and service to Ms. Saviola's patients was made. He reported that together with its partners from ICS, Woodhull's leadership holds its team of physicians, nurses and support staff accountable to deliver the same health outcomes for ICS patients as for all of its patients. Dr. Fishkin affirmed that Woodhull's leadership was willing and committed to trying new ideas and new approaches, collaborating with ICS to exceed its goals and its patients' expectations. He added that Woodhull wants to be a model for others and a center of excellence for its disabled patients. Dr. Fishkin introduced Patrina Phillip King, M.D. to explain how Woodhull's entire staff was trained for this new collaboration.

Dr. Patrina Phillip-King greeted members of the Committee. She introduced herself as an attending physician of Woodhull Medical and Mental Health Center's Women's Health Practice. Dr. Phillip-King emphasized that Woodhull's women's health practice was committed to providing optimal care for women with physical disabilities. She explained that the facility worked with ICS to design a two-part training exercise to prepare the staff to be able to provide quality and compassionate health care services. Dr. Phillip-King explained that the most important objective of that exercise was to overcome attitudinal and environmental barriers that contribute to lack of access to care for women with physical disabilities.

Dr. Phillip-King reported that the first exercise was sensitivity training. She informed the Committee that nurses, physicians, clerks, financial counselors and social workers had taken part in that session. She noted that the scope of disability in women was covered. They role played real life scenarios of cultural insensitivity experiences, and interactive discussions with the audience were also held. Dr. Phillip-King reported that the second exercise had been competency training. It included a power point presentation followed by questions and answers. She highlighted that nurses, physicians, physician assistants and midwives were the active participants in that session. Also in that session, areas in the medical interview, which are particularly sensitive for women with physical disability, such as sexuality and psychosocial issues with an emphasis on caretaker and domestic abuse were also covered and addressed. Dr. Phillip-King stated that the mechanisms involved with examining women with physical disability with more sensitivity were reviewed. Dr. Phillip-King noted that, in this segment, the staff was introduced to different techniques used to transport clients with impaired mobility to the examination table. She added that clinicians were shown the different positions in which a client could be examined and different types of specula that could be used to facilitate cervical cancer screening. Dr. Phillip-King explained that the issues of screening and documentation of skin health, which are of significant importance for women with disabilities but frequently overlooked were also addressed during the training.

Paul Kastell, M.D., Woodhull Medical and Mental Health Center's Chief of Obstetrics, reported on the environmental improvements and improved accommodations for ICS patients that were currently being planned at Woodhull Medical and Mental Health Center. Dr. Kastell stated that, when Woodhull first met with the ICS team several years ago, they had a walkthrough, followed by a review of practice areas that would be primarily utilized by ICS patients. Dr. Kastell added that special attention was given to the Woman's Health pavilion and the outpatient mammography unit. Dr. Kastell informed the Committee that the Women's Health pavilion had recently been constructed and all bathrooms, hallways and rooms were built to be ADA compliant. Dr. Kastell added that several items have been identified that needed to be available, specifically a Hoyer lift and a patient scale. He noted that both items have been purchased and are currently being used to provide optimal care.

Dr. Kastell also informed the Committee that the mammography unit had been recently updated and contained state-of-the art digital equipment. He reported that the walkthrough had indicated the need to retrofit a bathroom to make it ADA compliant. Funds have been identified and renovations will begin shortly.

Expanding Efforts to Improve Access to Services for Women with Disabilities across HHC

Ms. Brown introduced Sharon Abbott, Ph.D., Assistant Director, Corporate Planning Services and asked her to share with the Committee HHC's current efforts to improve access to services for women with disabilities across HHC. Dr. Abbott informed the Committee that there were currently three projects underway as described below:

Three key projects:

- An environmental survey of accessibility at 9 HHC facilities
- Accessibility renovations made possible by City Council funds
- Curriculum development and staff training made possible by a New York Community Trust grant

Environmental Assessments

Dr. Abbott described the environmental assessment initiative:

- HHC contracted with ICS to conduct environmental assessments of the Women's Health Services areas of 9 HHC facilities
 - ✓ **Manhattan:** Bellevue, Renaissance D&TC, Metropolitan
 - ✓ **Bronx:** Lincoln Hospital, North Central Bronx Hospital
 - ✓ **Brooklyn:** Cumberland D&TC, Woodhull
 - ✓ **Queens:** Elmhurst Hospital, Queens Hospital

- ✓ **Staten Island:** 155 Vanderbilt D&TC (desk review)
- ICS developed a standardized assessment tool
- ICS will provide HHC with findings and short term recommendations that could be implemented with minimal investment at targeted facilities to improve access to services for women with disabilities

\$5 million City Council Funding Commitment for FY'14 and FY'15

Dr. Abbott reported on the \$5 million City Council Funding Commitment for FY'14 and FY'15:

- Received \$2.5 million in FY'14 with \$2.5 million pledged for FY15
- Led by Council Members Maria Del Carmen Arroyo and Julissa Ferreras
- Part of a Council initiative to expand access to women's healthcare services for women with disabilities
- Will fund renovations and equipment to make exam rooms and bathrooms optimally accessible for persons with disabilities
 - ✓ In hospitals, D&TCs, long term care facilities
 - ✓ Exam rooms, including adjustable exam tables and Hoyer lifts
 - ✓ Bathrooms used by women in wheelchairs
 - ✓ Radiology suites that provide mammograms
- First phase preliminary design work and cost estimates for 8 facilities to be completed in June 2014

Dr. Abbott reported on the training curriculum development initiative that is currently being done in collaboration with ICS:

- HHC secured grant funding from New York Community Trust totaling \$135,000 to develop a training curriculum and to train staff
- ICS will develop two curriculums
 - ✓ Face-to-face training
 - ✓ Online teaching using PeopleSoft
 - ✓ Provide face-to-face training at 8 facilities
- HHC will:
 - ✓ Purchase equipment for training
 - ✓ Facilitate a curriculum advisory group
 - ✓ Conduct a comprehensive project evaluation

What's next for ICS/HHC Partnership?

Ms. Brown concluded the presentation by sharing with the Committee next steps for ICS/HHC partnership:

- Presentation to the New York State Department of Health Accessibility Workgroup convened by Deputy Executive Commissioner Sue Kelly (April 2014)
- Replication of model into additional facilities
- Development of Model Program/ "Center of Excellence" criteria
- Expansion to men with disabilities and other healthcare areas
 - ✓ Develop/train on clinical competencies
 - ✓ Extension of environmental survey to other areas of facilities
- Work in partnership to facilitate continuity of care

Mrs. Bolus, while applauding all the efforts being made to facilitate access for women with disabilities, took the opportunity to raise the issue that chairs in the waiting room areas at some HHC facilities were too low. She stated that these chairs were uncomfortable because they were too low and made it very difficult for seniors to get up. In addition, Mrs. Bolus stated that city hospitals should only dispense adjustable walkers to patients as they can develop other major health issues by bending over.

Ms. Brown added that the ICS's assessments will be looking at all span of disabilities and making recommendations to the Office of Facilities Development (OFD). She reassured Committee members that she will also mention these additional issues.

Ms. Anna Kril, Board Member, inquired about ER services for persons with disabilities. Ms. Saviola responded that the ER Department was also another huge concern. ER Departments are not well-equipped to serve the disabled population. She explained that EMS will not take a patient in their wheelchair or the walking dog. She added that ICS' partnership with HHC is a first step in addressing healthcare access issues for people with disabilities. She noted that all ICS' members received their healthcare services at HHC.

Mr. Robert Nolan, Board Member, asked why these nine particular hospitals were selected for the environmental assessments of the Women's Health Services areas. Ms. Brown answered that some of the hospitals were awaiting the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey and she did not want the assessments to interfere with the survey. In addition, facility leadership had been consulted in terms of their readiness to participate in the environmental assessment. Ms. Brown added that she was hopeful that there would be

another year to work on this project. She also added that the Council Members who committed to the funds last year were still members of the Council. Ms. Brown announced that these projects will be rolled out to other hospitals and D&TCs by next year.

Mr. Nolan thanked Ms. Brown and encouraged her to continue to seek funding not only at the City Council level but also at the Borough President level and citywide.

Mr. Aviles acknowledged Morrisania D&TC and Woodhull Medical and Mental Health Center's leadership for taking the lead in making these changes that were well overdue. He stated that the Corporation looks forward to making these changes throughout the entire system.

SUBSIDIARY BOARD REPORT

MetroPlus Health Plan, Inc. – March 11, 2014

As reported by Mr. Bernard Rosen

Chairperson's Remarks

Chair Rosen welcomed everyone to the MetroPlus Board of Directors meeting of March 11th, 2014. Chair Rosen stated that Dr. Saperstein would present the Executive Director's report and Dr. Dunn would report on Medical Management issues. Mr. Rosen stated that there would be two resolutions presented at the meeting.

Executive Director's Report

Dr. Saperstein reported that total plan enrollment as of February 28th, 2014 was 429,076. Breakdown of plan enrollment by line of business was as follows:

Medicaid	357,991
Child Health Plus	11,593
Family Health Plus	26,451
MetroPlus Gold	3,319
Partnership in Care (HIV/SNP)	5,301
Medicare	7,940
MLTC	477
QHP	15,685
SHOP	465

Dr. Saperstein stated that MetroPlus membership has decreased slightly since his last report to the Board, with losses in the Medicaid line of business. The Plan gained over 3,000 Exchange members this month. There was a brief discussion regarding membership and payment options for the Exchange members.

Dr. Saperstein reported that, in regards to the New York State of Health (NYSoH), as of February 24th, 2014, MetroPlus has received over 27,000 completed applications and have over 17,500 paid members. The Plan has added approximately 9,200 new Medicaid members. MetroPlus has identified that there is a lag in the time from when a consumer completes an application to when they are enrolled in a health plan. Given this delay, as well as continued consumer interest, the Plan anticipates a continued increase in membership until the open enrollment period ends on March 31st, 2014. Since the launch of the MetroPlus products on the NYSoH, the Plan has been working very closely with the State on data transmission challenges that are causing customer service issues. MetroPlus is in communication with the NYSoH on a nearly daily basis and are working towards mutually beneficial resolutions.

Also this month, the NYSoH and the Department of Financial Services issued the invitation to health plans to participate on the Exchange in 2015. Many of the provisions from 2014 will remain, with some anticipated changes. Among the changes discussed during the invitation webinar were that the NYSoH will require plans to offer an out-of-network benefit in 2015 and plans will be required to increase more transparency of in network offerings.

Dr. Saperstein advised the Board, as he had reported at the last Board meeting, after months of preparation to join the Fully Integrated Duals Advantage (FIDA) program; MetroPlus has completed its on-site FIDA readiness review. Reviewers from New York State Department of Health (SDOH) and CMS conducted their review beginning on January 14th, 2014 and ended the following day. MetroPlus is expecting formal feedback from the auditors, but were informed this month that the oral feedback received at the end of onsite visit was the only feedback that the Plan should expect from the review team. Overall, it was a successful site visit and the verbal feedback provided by the reviewers has been taken into consideration as MetroPlus continues to push towards an October 1st, 2014 deadline. Dr. Saperstein stated that it looked like 16 plans are going through the application process.

This month, MetroPlus received a notice from SDOH of its intent to begin on-site focus surveys of the Plan's compliance with the Fraud and Abuse Program Integrity requirements. This is a result of the findings of an audit of SDOH's oversight of these requirements by CMS. The first component of the survey is a review of certain documents that are to be submitted no later than February 11, 2014. The second component of the survey is an on-site review of the Plan's Fraud and Abuse Program, as well as compliance with Medicaid Program Integrity requirements. During the on-site component, the team will meet with key staff who are responsible for the Plan's Fraud and Abuse Program and Medicaid Integrity Compliance Program, including the Plan's Fraud and Abuse Director (and/or compliance officer), Medical Director or Director of Credentialing, and staff responsible for fraud and abuse and compliance training for all Plan employees. MetroPlus' Compliance area is currently compiling all of the documentation that will be needed for the onsite visits as well as ensuring that pertinent MetroPlus staff is ready for their respective interviews. The Plan expects SDOH to be onsite on March 18th, 2014.

Finally, Dr. Saperstein stated that MetroPlus had been preparing for the carve-in of the nursing home population beginning January 1st, 2014. This carve-in has been delayed until April 1st, 2014, pending CMS approval.

Mr. Martin asked if there was a strategic document that can be reviewed by the Board, Dr. Saperstein stated that it is being currently worked on and he will try to have it ready to bring to the next Board meeting. Mr. Martin stated that since MetroPlus seems to have so many competing priorities, having a strategic document to show the Board and HHC's Medical and Professional Affairs Committee would be helpful.

There was a brief discussion regarding the transition of Behavioral Health Care integration into managed care.

Medical Director's Report

Dr. Dunn stated that Quality Assurance Reporting Requirements (QARR) season is very important to MetroPlus. There have been many requirement changes that the State has implemented around QARR. One of the changes is that a letter from a Psychiatrist stating that they saw a member is no longer allowed; instead a copy of the chart needs to be provided. The goal this year, as always, is to be number one.

Dr. Dunn reported that MetroPlus only received 50 percent of the QARR incentive this year. The Plan got hit on 3 major items. One of those items was the fact that MetroPlus received 0 points on the Consumer Satisfaction Survey on "Getting Care Needed". One other was that the Plan lost 4 compliance points on 2 access issues involving appointment availability.

Dr. Dunn stated that, as part of MetroPlus Health Plan's continuing efforts to provide health education and valuable information to its members, the Plan completed several mailings. The Ask 12 member survey was a mailing to Medicare Members reminding them to take their medications and to see what barriers may be in the way of taking medications, the survey assesses whether they need help or assistance with administration or refills. The children's immunization and lead registry mailing are reports sent to physicians and other group practices reminding them to comply with the mandate to immunize children aged 6-36 months and check children for lead exposure. The public health reporting requirements is a mailing that is sent to all independent and group based providers reminding them to report when a patient is diagnosed with a disease or condition of a communicable nature, toddlers at risk for developmental delay and suspected child abuse. The bone density mailing is a Medicare mailing that was sent to all members over the age of 65 with information about osteoporosis and the importance having a bone density screening performed. The Americans with Disabilities Act (ADA) Attestation consisted of the Quality Management (QM) Department mailing over 10,000 attestations to all independent and organizational providers to assess their compliance with the ADA.

Dr. Dunn stated that the QM Department mailed to all primary care providers and facilities the HEDIS/QARR indicators, specifications, time period, and identifying codes. The indicators were: Adolescent Preventive Care, Prenatal/ Postpartum Care, Lead Screening in Children, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Well-Child Visits in the First 15 Months of Life, Adult BMI Assessment, Care for Older Adults, Glaucoma Screening, Colorectal Cancer Screening, Cholesterol Management for patient with cardiovascular Disease, Comprehensive Diabetes Care, Controlling High Blood Pressure, Follow-up after Hospitalization for Mental Health Illness and Appropriate Testing for Children with Pharyngitis.

MetroPlus is in the final stages of contracting with a vendor to provide the exercise intervention component of its Diabetes Improvement Project. The Family Center will offer a program that promotes weight loss with exercise, dieting and portion control. They will also give regular reports back to the Plan regarding participant's progress.

The QM Staff presented at the HHC finance workgroup regarding importance of Clinical Risk Group (CRG) scores and why HHC providers need to improve their coding. Higher CRG scores generated additional revenue for facilities. MetroPlus' goal for 2014 is go to all HHC facilities and provide training on how to improve their coding. The first meeting at Woodhull Medical and Mental Health Center in February was well received.

Action Items

The first resolution was introduced by Mr. Dan Still, Chairman of the Finance Committee.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to increase the spending authority for the contract with New York County Health Services Review Organization ("NYCHSRO"), dated April 1, 2010, and to allocate additional funds for the fulfillment of the contract, with the total amount not to exceed \$4,859,000 for the total 5 year term which was extended until March 31, 2015.

Dr. Dunn gave the Board a detailed overview of why the additional funds are required.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors.

The second resolution was introduced by Dr. Dunn.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to increase the spending authority for the contract with Healthcare Technology Management Services, LLC, an Emdeon Company (HTMS), dated November 8, 2013, and to allocate additional funds for the fulfillment of the contract, with the total amount not to exceed \$450,000 for the one year term until November 7, 2014.

Dr. Dunn advised the Board that during the testing strategies with HTMS, MetroPlus realized that there was a lot more work that would need to be done to have the Plan ready for ICD 10 implementation by October 1, 2014 which is the reason the additional funds are needed.

The resolution was passed unanimously by the MetroPlus Health Plan Board of Directors.

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

**ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
MARCH 20, 2014**

JOINT COMMISSION GIVE KUDOS TO QUEENS HOSPITAL ON SURVEY

In late February, The Joint Commission conducted its triennial unannounced survey at Queens Hospital Center, the second HHC facility surveyed by TJC this year. The four-day survey was conducted by a team of seven surveyors: a physician, two nurses, an administrator, a Life Safety Code specialist and two Behavioral Health surveyors. The facility received full accreditation.

With the exception of the team leader, none of the surveyors had surveyed an HHC hospital before and were consistent in their praise of Queens Hospital and HHC. They were impressed with the level of medical staff participation in the survey and the knowledge and enthusiasm of nursing and other staff.

The team leader commented that "staff was engaged in the organization's efforts to deliver the best care on their path to high reliability." The nurse surveyor stated that the school-based programs visited were "one of the best embedded integrated programs in a school" that she had seen. The life safety surveyor said "the level of engagement and attention to detail and striving for perfection was remarkable."

Congratulations to the leadership of Queens Hospital Center -- Chris Constantino, Senior Vice President; Julius Wool, Executive Director; Jasmin Moshirpur, MD, Medical Director; Joan Gabriele, RN, Chief Nurse Executive; Jean Fleishman, MD, Quality Management; Kenneth Hart, Regulatory Affairs; and the staff of Queens Hospital Center for a job well done.

The Joint Commission is surveying Bellevue Hospital Center this week, and the results of that survey will be in next month's report to the Board. Four facilities remain to be surveyed this year: Coler, Henry Carter, North Central Bronx and Woodhull.

HHC'S PATIENT SAFETY FORUM AND 2014 PATIENT SAFETY CHAMPIONS

In recognition of Patient Safety Awareness Week, on March 5th we hosted our annual Patient Safety Champions Award Ceremony and Forum. The event is our opportunity to acknowledge and celebrate the commitment of HHC staff to increasing safety across the enterprise and to reducing harm to the patients we serve.

This year, awards were given to Champions from each HHC facility and HHC Health and Home Care. Twenty-one facility teams and one individual were recognized. The work of

all of the Champions was impressive and well-worthy of recognition. The 2014 President's Choice Award was presented to the Interdisciplinary Expression of Unmet Needs Team at Sea View Hospital Rehabilitation Center and Home who, over a two year period, achieved a 51 percent reduction in the number of residents receiving antipsychotic medications, thereby improving their quality of life and decreasing risk for harm.

Patient Safety Awareness Week, an annual international patient safety awareness and education campaign for healthcare workers and the communities they serve, is sponsored by the National Patient Safety Foundation (NPSF). This year the NPSF encouraged healthcare organizations to help both patients and staff to "Navigate Your Health...Safely."

In keeping with that message to staff and patients, the keynote presentation was provided by Doug Bonacum, Vice President for Quality, Safety, and Resource Management at Kaiser Permanente. He focused his remarks on the critically important topic and next horizon of our safety work, "Creating Joy, Meaning, and Safer Health Care -- Building a Culture of Worker and Patient Safety." Doug deepened our understanding of the inextricable link between worker and patient safety, defining worker safety as a pre-condition to patient safety. His presentation and group facilitation was an important step towards our focusing greater attention on identifying and leveraging opportunities to create synergy between the two "safeties" and improving outcomes for both staff and patients. Mr. Bonacum has been an active partner with HHC along our nine-year patient safety journey. He is a nationally renowned speaker who is also a Board member of the National Patient Safety Foundation, and faculty member for the Institute for Healthcare Improvement's Patient Safety Executive Program.

The patient safety event, held at the Conference Center at Jacobi Medical Center, was attended by over 250 employees, medical staff and administrative leaders from across the enterprise. In addition, over 50 teams participated via live streaming to their facility.

Thank you to Senior Vice President Caroline Jacobs, Mei Kong and their staff for organizing the event and for being relentless HHC patient safety champions throughout my tenure as President.

HARLEM AND METROPOLITAN HOSPITALS TREAT VICTIMS OF EAST HARLEM EXPLOSION

HHC hospitals played a key role in treating victims of the East Harlem explosion and building collapses earlier this month. Harlem Hospital Center received 13 patients from the disaster and Metropolitan Hospital Center received 19. A press briefing was held

that day at Harlem Hospital for staff from both hospitals to provide the media with updates on the victims and steps taken to help them. Kudos to the staff at both hospitals for their outstanding, level-headed and well-organized response to this terrible tragedy.

FEDERAL UPDATE

President Obama's FY 2015 budget proposal, released March 4, included \$402 billion in healthcare cuts over 10 years, including \$354 billion in cuts to Medicare providers. If the President's proposal prevails, the cut in federal dollars to HHC over ten years would be \$391 million, specifically:

- \$90 million in cuts to Indirect Medical Education funding;
- \$17 million in bad debt funding;
- \$19 million from changes in post-acute care payments;
- \$17.5 million in cuts to inpatient rehabilitation services payments; and
- \$247.5 million in Federal DSH funds as a result of the extension of cuts to these supplemental Medicaid funds through FFY 2024.

STATE UPDATE

Last week Governor Cuomo released his Executive Budget for State Fiscal Year (SFY) 2014-15. The \$142 billion proposed budget includes an increase of 3.8 percent in Medicaid funding -- \$604 million. Total Medicaid funding is proposed at \$58.2 billion. Although there are numerous budget provisions affecting HHC, staff is still analyzing the details of the proposals. A comprehensive overview of the Executive Budget will be presented at the next meeting of the Board's Strategic Planning Committee.

The following is a brief summary of some of the key provisions of interest to HHC:

- Extension of the Global Cap on Medicaid spending until March 31, 2016 -- one additional year -- and associated State Department of Health (SDOH) "superpowers" to make cuts to keep spending within the Cap;
- Restoration of the two percent across-the-board cut to Medicaid provider rates beginning on April 1, 2014;
- Authorization of SDOH to share savings with Medicaid providers if Medicaid spending is below the Global Cap. No less than 50 percent of the savings would be distributed proportionately to all providers and plans and no more than 50 percent to "financially distressed and critically needed providers as identified by the commissioner;"
- Allocation of \$1.2 billion over seven years for a new capital program for hospitals, nursing homes, diagnostic and treatment centers and licensed clinics. The program would provide grants to improve financial sustainability and

increase efficiency through collaboration. Funding can be used for closures, mergers, restructuring, infrastructure improvements, expanding primary care capacity, promoting integrated delivery systems and providing continued access to essential health services;

- Streamlining of the process for HIV testing by eliminating the requirement for written informed consent, except for patients in correctional facilities;
- Authorization of SDOH to implement an Affordable Care Act insurance option for individuals between 138-200 percent of the federal poverty level. Under this option, the State would implement a Basic Health Plan, which provides public health insurance as an alternative to private insurance that would be purchased through the Health Exchange;
- Allocation of up to a total of \$95 million for health information technology, including funding for the operation of the State Health Information Network of New York (SHIN-NY) and the establishment of a statewide electronic medical record and an All-Payer Claims Database for health insurance claims; and
- Allocation of \$7 million to establish 11 Regional Health Improvement Collaboratives, which will convene healthcare stakeholders to identify challenges, then recommend and implement solutions.

**CITY COUNCIL HEALTH COMMITTEE HOLDS HEARING ON
HHC PRELIMINARY BUDGET AND FINANCIAL PLAN;
IBO REPORT RELEASED**

Last week, the City Council Health Committee heard testimony from HHC on the FY 15 Preliminary Budget and Financial Plan. HHC's testimony mainly focused on the Corporation's ongoing efforts to reduce budget gaps, factors that could increase the deficit and areas where new revenue will be seen. The Council focused many of their questions on prior year cost containment and restructuring initiatives, risks to the Financial Plan and how New York State's tentative Medicaid waiver will affect HHC. New York City Public Advocate Letitia James joined members of the Health Committee at the hearing. Her questions centered on the status of the former Neponsit facility, the proposed dialysis contract with Big Apple Dialysis and what effect the Affordable Care Act would have on the number of uninsured patients served by HHC. A second budget hearing on the FY 15 Executive Budget will be held by the City Council later this year in May.

Also released was the Independent Budget Office's (IBO) report on HHC's Preliminary Budget, which focused on the Corporation's projected operating deficits through FY 18. The report highlighted the "well documented" causes of the projected budget gap: State & Federal reimbursement cuts, a high Medicaid and uninsured population, declining utilization and high cost of labor fringe benefits. The report also highlighted MetroPlus's enrollment achievements through New York State of Health and the Affordable Care Act health insurance marketplace for New York. The report concluded

by emphasizing MetroPlus's strategic importance to HHC's long term financial outlook.

ANNUAL PUBLIC MEETINGS

HHC's annual public meetings for fiscal year 2014 were held in each borough through the end of calendar year 2013. Our Intergovernmental Relations staff will draft individual responses to comments made by the speakers at those meetings by June.

PLAN ANNOUNCED TO REOPEN LABOR AND DELIVERY SERVICES AT NORTH CENTRAL BRONX HOSPITAL

This week, North Central Bronx Hospital announced plans to reopen Labor and Delivery services by late summer 2014 with an experienced team of medical professionals who specialize in obstetrics and gynecology care and reflect HHC's commitment to restore safe, high quality and comprehensive maternity services for the North Bronx community. Inpatient maternity services were suspended last August due to physician and other staff vacancies that HHC and NCBH leadership believed could put at risk the quality and safety of patient care.

The details of the reopening plan for maternity services include an investment of nearly \$4.5 million for restructuring the staff and operations of the Women's Health Services at NCBH. A new staff model will provide a core team of experienced physicians, physician assistants, specially trained registered nurses and licensed midwives essential to operate a quality community hospital maternity unit. The North Bronx network is committed to maintaining the midwives' central role on the healthcare provider team. NCBH will continue its work to improve access and productivity of its entire array of ambulatory OB-GYN services including prenatal care, family planning, and gynecological surgical services. Throughout the process, there will be regular community stakeholder updates.

HARLEM HOSPITAL TO COMPLETE MODERNIZATION WITH OPENING OF NEW ADULT AND PEDIATRIC EMERGENCY ROOMS

Tomorrow Harlem Hospital will cut the ribbon on new \$19 million Adult and Pediatric Emergency rooms, completing the final phase of its recent \$325 million modernization project. The new Emergency Department doubles current adult ED space and nearly triples pediatric ED space to expand patient access and privacy and improve patient flow and comfort.

The new Adult Emergency Department, located on the first floor of the Mural Pavilion, has 26 private treatment rooms and four trauma bays, increases the number of treatment chairs for asthma patients from four to eight, and adds eight additional observation bays. The new Pediatric Emergency Department, also located on the first

floor of the Mural Pavilion, has two trauma care bays and six treatment room, and increases the treatment chairs for pediatric asthma patients from six to eight.

The recent multi-year modernization project also encompassed primary and specialty care suites, new adult intensive care and burn units, a Bariatric Center of Excellence, surgical clinics, a new women's imaging department and testing suites. The Mural Pavilion is also home to a gallery of priceless WPA murals by local artists of the 1930s.

NEW YORKERS CONTINUE TO CHOOSE METROPLUS COVERAGE UNDER AFFORDABLE CARE ACT

As of early this week, nearly 50,000 New Yorkers have chosen MetroPlus Health Plan on the New York State health insurance exchange. March 31 is the deadline for individuals to enroll in health insurance coverage to avoid a penalty for not obtaining insurance in 2014 under the Affordable Care Act (ACA). The deadline is expected to bring in more last-minute shoppers to MetroPlus, and ongoing enrollment continues to be available as well for small businesses and Medicaid and Child Health Plus members.

Gouverneur Health and other HHC facilities are continuing to partner with MetroPlus to provide bilingual health insurance counselors, especially for Spanish- and Chinese-speaking patients. The lack of access to bilingual counselors has been identified as a major barrier for enrolling limited English speaking New Yorkers in health insurance under the ACA. HHC facilities are making available certified, bilingual enrollment counselors to inform and educate the community about the best health insurance options and ways to minimize premiums and out-of-pocket costs.

HHC TO RELEASE BETTER, THE 2014 REPORT TO THE COMMUNITY

Later this spring, HHC will release its first Report to the Community in eight years. Titled Better, this comprehensive document highlights the many accomplishments of HHC's leadership and staff since 2006 that enabled us to make significant progress toward our strategic and organizational goals.

The report captures our improvements in patient safety and quality, the adoption of new care delivery models, and describes how advancements in IT and robust work in Breakthrough are supporting our transformation into a more integrated, efficient and effective healthcare system. The report includes a message from new President and CEO Dr. Ramanathan Raju, in which he briefly lays out his vision for HHC's future.

Although the document speaks to the challenges and uncertainties that we face, it also tells the story of the many ways in which HHC is a better healthcare organization -- providing better patient care and better population health at a better value. Better, which will be available electronically, will provide a compelling portrait of HHC's work on

my fronts to a wide range of audiences and stakeholders.

KINGS COUNTY HOSPITAL CENTER FEATURED IN RECENTLY PUBLISHED BOOK ON LEAN PROCESS IMPROVEMENT IN BEHAVIORAL HEALTHCARE

Early this month, Oxford University Press released *LEAN BEHAVIORAL HEALTH, the Kings County Hospital Story*. This book, about the stunning Breakthrough work conducted at Kings County, was co-edited and written by Dr. Joseph Merlino, Joanna Omi and Dr. Jill Bowen, with contributions from almost 20 additional writers from Kings County and Metropolitan hospitals, as well as the corporation's central office. Writers include many whose names you will recognize -- Marlene Zurack, Joyce Wale, Antonio Martin, Roslyn Weinstein, George Proctor and Claire Patterson.

Other HHC contributing writers include Kristen Baumann, Olga Deshchenko, Robert Berding, Renuka Ananthamoorthy, Lora Giacomoni, Regine Bruny-Olawaiye, Richard Freeman, Roumen Nikolov, Akinola Adebisi, Linda Paradiso, Lancelot Deygoo, Todd Hixson and Janine Perazzo.

This book is intended not as a treatise on Lean, but rather as a very personal and reflective look at the work and lessons learned by the many people involved in transforming the way behavioral health services are provided at Kings County Hospital. We believe that many healthcare organizations will benefit from understanding, in great detail, how Kings County made dramatic improvements to the patient experience in the CPEP, significantly calmed inpatient units making them safer for patients and staff, and streamlined outpatient services to remove waste and increase valuable time with providers.

I want to thank the HHC staff who produced this fine work. As we move into a new healthcare environment, this publication is a very effective way to show the world the innovative work taking place at our hospitals. We have provided each of you with a copy of this book.

HHC CELEBRATES THE SOCIAL WORKERS IN NYC PUBLIC HOSPITALS

March is National Social Work Month, a time to honor HHC's social workers whose professional dedication helps our patients achieve better, healthier lives. Social workers often step into the lives of patients at critical and difficult times. The assistance they provide embodies the essence of the social work profession, grounded in the commitment to the well-being of others, and the caring work that helps resolve complex personal issues. Whether it is supporting a patient and family through a crisis, or connecting them to hospital or community resources, social workers offer a knowledgeable, personalized approach to meeting the often complex needs of those we

serve.

This year, the theme of Social Work Month is "All People Matter." It reaffirms the profession's core principle that all people deserve and should be treated with dignity and respect. In serving some of the City's most vulnerable populations, HHC social workers function in multidimensional roles, serving as advocates, collaborators, problem-solvers, and educators. And with every patient or family interaction, their efforts exemplify this theme.

I know the Board joins me in celebrating our social workers and their dedication to the needs of our patients and their families.

FINAL MESSAGE FROM HHC PRESIDENT AVILES

As many of you already know, I will be stepping down as President of HHC on March 31st. I can truthfully say that my seventeen-year tenure here, in a variety of roles, has been the most satisfying period of my long professional career. I consider myself very fortunate.

When Mayor Bloomberg asked me to assume the leadership of HHC in 2005, I had already spent four years as General Counsel and another four years on the executive staff of the Queens Health Network. Those positions gave me invaluable insight into the inner workings of our vast, far-flung system. But, even more importantly, having those positions enabled me to observe first-hand the incredible dedication and talent of the HHC workforce.

Tireless thousands of HHC employees have ministered to the complicated healthcare needs of millions of the most vulnerable New Yorkers, without regard to their immigration status or ability to pay. As I reflect on my long tenure here, there are so many indelible images that will stay with me forever. All of us at HHC mirror the extraordinary diversity that makes New York City such a unique and vibrant community. I will never forget the multitude of patients in our care -- from the tiniest preemies in our NICUs to our fragile centenarians. But, most of all, I will remember the compassion and empathy that HHC workers bring to caring for them day in and day out.

I am immensely proud to have shared this experience with the staff at HHC and want to express my eternal gratitude for their hard work in service of HHC's noble mission. These feelings make it difficult to say goodbye. It has been an honor and a privilege to have led this extraordinary organization.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

Press Conference Harlem Hospital, Denise Soares, SVP, Dr. Maurice Wright, Chief Medical Officer, Harlem, Dr. Reynold Trowers, Chief of Emergency Medicine, Harlem, Dr. Zafar Sharif, Chief of Psychiatry, Harlem, Dr. Gregory Almond, Chief of Emergency Medicine, Metropolitan, NY1, FOX 5, WCBS, 3/17/14

Counselors Made Available to Help Non-Native Speakers Apply for Health Insurance, Dr. Martha Sullivan, Executive Director, Gouverneur Health, Roger Milliner, Deputy Executive Director, MetroPlus, NY1, 3/18/14 (Also covered in The Epoch Times, NTDTV (New Tang Dynasty TV)

North Central Bronx Hospital to Reopen Labor and Delivery Unit in Summer, President Alan D. Aviles, Dr. William Walsh, SVP, HHC North Bronx Healthcare Network, NY1, 3/17/14

North Central Bronx Hospital Set to Announce Reopening of Labor and Delivery Unit, NCB, NY1, 3/16/14

City Public Hospital System Hopes to Get Federal Funding Headed to State for Hospitals President Alan D. Aviles, NY1, 3/14/14

That's so NY: Volunteering at City Hospitals, Irene David, Director of Therapeutic Arts, Bellevue, Coney Island, Bellevue, NYC Media, March 2014

Jacobi Medical Center sees rise in bariatric surgeries, Dr. Ajay Chopra and Dr. Jayne Lieb, Jacobi, News 12 Bronx, 3/7/14

Print

The Day the Drills Paid Off, Dr. Maurice Wright, Chief Medical Officer, Harlem, Denise Soares, SVP, Generations + Northern Manhattan Network, The Wall Street Journal, 3/14/14

Harlem Hospital set to open new state-of-the-art emergency department, New York Daily News, 3/3/14

Should City Hospitals' Dialysis Be Privatized?, President Alan D. Aviles, WNYC, 3/13/14

Tish James warns de Blasio to reject for-profit dialysis deal, President Alan D. Aviles

Capital New York , 3/13/14

Healthcare-Agency Deficit Faces Further Expansion, President Alan D. Aviles, The Wall Street Journal, 3/13/14

City hospital head fears short-changing by state, President Alan D. Aviles, Capital New York 3/13/14

IBO: Medicaid waiver could be a loser for city hospitals, President Alan D. Aviles, Capital New York 3/13/14

Obamacare is a 'Plus' for insurer, MetroPlus, New York Daily News, 2/26/14

NCBH will Deliver Late on Maternity Ward, Michael Zinaman, Chairman, OBGYN HHC North Bronx Healthcare Network, Dr. Ross Wilson, Chief Medical Officer, Norwood News, 3/17/14

Op-ed: A test that could save your life, Dr. Joshua S. Aron, Elmhurst, Queens Courier, 3/16/14

Harlemites 50 + Urged to Get Colonoscopy, HHC, President Aviles, Joan A. Culpepper-Morgan, MD, Harlem, Harlem World, 3/7/14

Primary Care Practice At Elmhurst Hospital Recertified Highest Level Patient-Centered Medical Home, Queens Gazette, 2/26/14 (Also covered in Town & Village)

Over 32,000 New Yorkers Choose MetroPlus Health Plan On the State-Sponsored Health Insurance Marketp, MetroPlus, HHC, The Jewish Voice, 3/19/14 (Also covered in Manhattan Times)

Study: Obamacare care improves competition in New York, MetroPlus, Capital New York, 3/17/14

Henry J. Carter Specialty Hospital in Harlem, HHC, Henry J. Carter Speciality Hospital and Nursing Facility, Harlem World, 3/5/14

Lincoln Recognized for Lactation Care, HHC, Bronx Times, 3/7/14

HIV/AIDS: What Every Woman Should Know, Dr. Ray Mercado, Lincoln, Bronx Free Press, 3/12/14

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a 99-year sublease with CAMBA Housing Ventures, Inc. ("CHV") or a not-for profit housing development fund corporation in which CHV is the sole member, or a limited partnership or limited liability company in which the general partner or managing member, as applicable, is an affiliate of CHV for the development of low-income housing, and housing for the formerly homeless on the site of the "G Building," a parcel of land on the campus of Kings County Hospital Center (the "Facility") of approximately 97,000 square-feet at a fair market value rent established by appraisal which is currently anticipated to be not more than \$2.5 Million in total.

WHEREAS, since 1977, CAMBA, a non-profit organization based in Brooklyn, New York, has been providing services in New York City which include homelessness prevention, housing relocation, emergency and transitional housing, and permanent affordable and supportive housing; and

WHEREAS, CHV, is a not-for-profit corporation affiliated with CAMBA and incorporated in 2005 for the purposes of undertaking supportive and low-income housing development; and

WHEREAS, CHV will develop and operate on the Facility's campus at the site of the "G Building" a new building, named CAMBA Gardens Phase II ("CGII") containing low-income housing, and housing for the formerly homeless subject to review and approval by the New York City Department of Housing Preservation and Development ("NYCHPD") and such other lenders, investors, or government agencies as may be required by the financing and structure of the project;

WHEREAS, an affiliate of CHV recently completed the development of a similar project at the Facility at the site of the former "J" and "N Buildings," named CAMBA Gardens; and

WHEREAS, a Public Hearing was held on March 6, 2014, in accordance with the requirements of the Corporation's Enabling Act, and prior to execution, the sublease is subject to approval of the City Council and the Office of the Mayor.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be, and he hereby is, authorized to execute a 99-year sublease with CAMBA Housing Ventures, Inc. or with a not-for profit housing development fund corporation in which CHV is the sole member, or with a limited partnership or limited liability company in which the general partner or managing member, as applicable, is an affiliate of CAMBA Housing Ventures, Inc. for the development of low-income housing, and housing for the formerly homeless on the site of the "G Building," a parcel of land on the campus of Kings County Hospital Center of approximately 97,000 square-feet at a fair market value rent established by appraisal prior to entry into the lease, which is currently anticipated to be not more than \$2.5 Million in total.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Petrone Associates LLC to provide Hospital Medical Physicist Consulting Services to all Corporation facilities on an "as needed" requirements basis. The Hospital Medical Physicist Consulting Services contract will be for a term of three years with two, one year options to renew, exercisable solely at the discretion of the Corporation, for a total cost not to exceed \$5,117,004. The contract amount includes a 12% contingency reserve of \$537,460 for additional physicist services that may be required.

WHEREAS, the Corporation requires Nuclear Medicine Physicist services currently not available in-house to provide regular testing and audits to ensure compliance with regulatory agencies as required in order to maintain ACR Accreditation, assist in accreditation process, provide onsite support as needed for Nuclear Medicine therapy treatments and provide consultant physicist services to other Radiation areas; and

WHEREAS, a Request for Proposals ("RFP") was issued seeking the services of a Hospital Medical Physicist Consulting Services firm; and

WHEREAS, a selection committee comprised of representatives from the Corporation's Office of Operations and Contract Control, several facility Associate Executive Directors and representatives from several facilities' Office of Radiology Administration using criteria specified in the RFP, determined that Petrone Associates LLC was the highest rated of all proposers and will best meet the Corporation's requirements for nuclear medicine physicist services; and

WHEREAS, the Senior Vice President of each network utilizing the agreement shall be responsible for monitoring and enforcing the contract terms.

NOW, THEREFORE, BE IT RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to negotiate and execute a contract with Petrone Associates LLC to provide Hospital Medical Physicist Consulting Services on an "as needed" requirements basis. The Hospital Medical Physicist Consulting Services contract will be for a term of three years with two, one year options, to renew, exercisable solely at the discretion of the Corporation for a total cost not to exceed \$5,117,004. The contract amount includes a 12% contingency reserve of \$537,460 for additional physicist services that may be required.

EXECUTIVE SUMMARY

The accompanying resolution requests approval to negotiate and execute an agreement with Petrone Associates LLC (Petrone Associates) to provide Hospital Medical Physicist Consulting Services on an "as needed" requirements basis. The cost of the contract is \$4,579,544 and a 12% contingency of \$537,460 for a total not to exceed \$5,117,004.

On September 11, 2013 the Queens Healthcare Network submitted an application to the Contract Review Committee to issue a Request for Proposals ("RFP") seeking consulting Nuclear Medicine Physicist services currently not available in-house to provide regular testing and audits to ensure compliance with regulatory agencies as required in order to maintain ACR Accreditation, assist in accreditation process, provide onsite support as needed for Nuclear Medicine therapy treatments and provide consultant physicist services to other radiation areas. The Contract Review Committee recommended that the RFP be expanded to incorporate all Corporation facilities requiring this service. QHN followed this recommendation and issued an RFP seeking the services of a Hospital Medical Physicist Consulting Services firm for all Corporation facilities. At the end of the process, the selection committee awarded the contract to Petrone Associates.

Petrone Associates has implemented and maintained comprehensive medical physics programs for more than 25 Medical Centers, 25 Imaging and Therapy Centers and countless private practitioners throughout the five boroughs of NYC for 30 years.

Petrone Associates currently conduct programs for 7 of the 11 acute-care hospitals in the NYC Health and Hospitals Corporation (HHC) as well as private diagnostic and treatment centers of HHC. Petrone Associates have serviced some HHC facilities for more than 20 years and have never defaulted on any service agreements with any client.

Petrone Associates' plan involves the following overall scope of work:

1. Evaluation of equipment according to accepted standards and regulations with efficient and clear communication of recommendations to the facility.
2. Education of facility staff in all aspects of radiologic standards.
3. Continual updates in anticipation of additional and/or changing standards.
4. Continual streamlining of information flow utilizing electronic and cloud-based resources.
5. Enhanced administrative support for clients through systematic implementation of programs. This includes scheduling, report distribution, education and clear and efficient communication.
6. Physics presence and interaction with key facility personnel through frequent on-site visits.

Petrone Associates deliverables are:

1. Regular weekly visits to carry out evaluations.

2. Onsite participation in high dose inpatient and outpatient treatments.
3. Hundreds of equipment evaluation reports according to NYS, NYC, Federal, MQSA, ACR, etc. standards and regulations; clearly and efficiently communicated.
4. Education according to needs of each facility. Delivered through live lectures and other supplemental means.
5. Attendance at meetings, inspections and other important events.
6. Regular updates in anticipation of standard and regulation changes.
7. Rapid response (physically if required) to facilities' unanticipated and/or emergent needs.
8. Other items as determined by the in-scope needs of the individual center.

Petrone Associates will assess the needs of the facilities and perform an assessment that must be mutually agreed upon by each facility. Petrone Associates shall provide consultant physicist services to other Radiation areas as required. Petrone Associates will work under the supervision of the Facility Radiology Administration.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Hospital Medical Physicist Consulting Services
Project Title & Number: Hospital Medical Physicist Consulting Services
Successful Respondent: Petrone Associates, LLC
Project Location: HHC Corporate and Facilities
Requesting Dept.: Queens Healthcare Network
Number of Respondents: 2

Contract Amount: The cost of the contract is \$479,544 and a 12% contingency of \$537,460 for a total not to exceed \$5,117,004.

Contract Term: Three years with two -1 year options to renew, exercisable solely at the discretion of HHC.

Range of Proposals: Petrone- \$100 to \$165 per hour, Landauer - \$299 per hour

Minority Business Enterprise Invited: Yes

Funding Source: Facility

Method of Payment: Time and Rate

EEO Analysis: Yes

Compliance with HHC's McBride Principles? Yes

Vendex Clearance Yes

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

CONTRACT FACT SHEET(continued)

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

The purpose of this Contract is to have an agreement with a Medical Physicist Consulting Firm to provide regular testing and audits to ensure compliance with regulatory agencies to continue ACR Accreditation as required that is not available by in-house HHC staff. The contractor shall assist in accreditation process and provide on-site support as needed for Nuclear Medicine therapy treatments. The contractor is required to be on site as needed to perform testing, provide necessary documentation and support, and to respond to any emergency situation within a predetermined response time. The contractor will assess the needs of the facilities and perform an assessment that must be mutually agreed upon by each facility. The contractor shall provide consultant physicist services to fill the void of retiring in-house staff and to other Radiation areas as required for a period of three (3) years with two – 1 year options to renew solely exercisable by the Corporation. The contractor will work under the supervision of the Facility Radiology Administration.

CONTRACT FACT SHEET(continued)

Contract Review Committee

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

The Contract Review Committee (CRC) reviewed and approved the issuance of a Request for Proposal (RFP) on its September 11, 2013 meeting.

The Contract is being presented for approval on February 26, 2014.

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

No.

CONTRACT FACT SHEET<continued)

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

Selection Committee Members:

1. Joseph Quinones, SAVP, Operations, Chairman
2. Larry Kassen, Radiology Director, NBHN
3. Gaetano Cumella, Asso. Director, Coney Island
4. Francisco Mercado, Sr, Asso. Director, Lincoln
5. Trim, Asso. Director, Queens
6. David Baksh, Asso. Executive Director, Queens
7. Robert Zeuner, Sr. Asso. Director, Elmhurst
8. Georges Leconte, Asso. Executive Director, Elmhurst

List of firms responding to RFP:

1. Landauer Medical Physics in partnership with Upstate Medical Physics Diagnostics Radiology
2. Petrone Associates, LLC

The RFP process was utilized to test the market. Through advertisement and sending the RFP to a broad range of firms we received interest at the "bidders' conference" from three firms and two firms submitted proposals. The Evaluation Committee selected Petrone Associates, LLC cost effective plan to provide with Hospital Medical Physicist Consulting Services.

The selection criteria was:

1. Previous quality management program including staff arrangement, scope of services and practice overview.
2. Ability to have adequate resources available to meet goals and objectives. Firm must provide methodologies or strategies, deliverables, timetables and management plan.
3. Prior engagements with health care facilities
4. Ability to provide a defined management approach that is appropriate for hospital medical physicist services to be rendered.
5. Cost of proposal

The justification for the selection of Petrone Associates, LLC was its cost effective plan to provide HHC with Hospital Medical Physicist Consulting Services

Scope of work and timetable: Monthly, Quarterly, Semi-Annual and Annual evaluation of equipment; participation in 131 & other radiopharmaceutical treatments; delivery of education; Full curriculum in Radiologic Physics for Radiology residents; fetal & adult dosage calculations; accreditation activities; liaison with regulatory & certifying agencies; facility private web portal; regulatory filings.

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

Hospital Medical Physicist Consulting Services are provided to HHC facilities on an individual basis at different rates. This agreement will standardize costs on a requirements basis. Petrone Associates will provide physicist consulting services at a flat rate.

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

See Attachment "A"

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

Corporate staff does not have the requisite experience, resources or expertise in such matters

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?

NONE

CONTRACT FACT SHEET <continued>

Contract monitoring:

Julios-wool – Queens Hospital-center; Executive Vice-President/Chief Operating Officer
Chris Constantino-Elmhurst Hospital Center, Executive Vice-President

Equal Employment Opportunity Analysis

Received By E.E.O.: November, 12, 2013

Analysis Completed By E.E.O. November 13, 2013

Manasses Williams. AVP. Affirmative Action/EEO

	A	B	C	D	E	F	G	H	I	J	K	L
1	ATTACHMENT "A"											
2												
3												
4	Comparison of unit prices under current service agreements vs. new HHC rate card-2014											
5	COST Benefit Analysis											
6												
7	Services and Support	LIN	QHC	HHC	CIH	JMC	NCB	EGH		Avg	HHC New	% Discount
71	MRI - Acceptance Testing	\$3,217	\$3,867	\$3,854	\$3,830	\$3,436	\$3,528	\$3,887		\$3,660	\$3,000	18%
72	MRI - ACR Accreditation /3 year Renewal	\$3,753	\$4,512	\$4,497	\$4,468	\$4,009	\$4,116	\$4,534		\$4,270	\$3,500	18%
73	MRI - Equipment Survey - Annual Physics Review	\$1,609	\$1,934	\$1,927	\$1,915	\$1,718	\$1,764	\$1,943		\$1,830	\$1,500	18%
74	SAFETY - MRI Safety Review - annually	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
75	MRI Safety Training (1 hour instruction - 10 attendees)	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
76												
77	I-131 CASE SUPPORT (in-patient and out-patient) includes dose assay, administration, room preparation, patient and staff education, release and documentation	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
78												
79	Nuclear Camera or PET unit Acceptance Testing	\$2,145	\$2,578	\$2,570	\$2,553	\$2,291	\$2,352	\$2,591		\$2,440	\$2,000	18%
80	Nuclear Camera or PET unit - ACR Accreditation / 3 year renewal	\$1,930	\$2,320	\$2,313	\$2,298	\$2,062	\$2,117	\$2,332		\$2,196	\$1,800	18%
81	Nuclear Camera or PET unit - ACR Annual Physics Review	\$1,072	\$1,289	\$1,285	\$1,277	\$1,145	\$1,176	\$1,296		\$1,220	\$1,000	18%
82	Nuc Med or PET Department Audits - Monthly	\$214	\$258	\$257	\$255	\$229	\$235	\$259		\$244	\$200	18%
83	Nuc Med or PET Department - Performance Audit - Quarterly	\$643	\$773	\$771	\$766	\$687	\$706	\$777		\$732	\$600	18%
84												
85	Brachytherapy Department Performance Audit - Quarterly	\$912	\$1,096	\$1,092	\$1,085	\$974	\$1,000	\$1,101		\$1,037	\$850	18%
86	Comprehensive Radiation Safety, Q.A. annual review of X-ray, CT, Mammo, Nuclear and PET department programs to ensure compliance during facility inspections. Participates in dose reduction initiatives per ACR, NYS, JC, etc. Emergency response to radiation safety concerns, spills, surprise inspections - Detail dependent (per year)	0-\$10,000	0-\$10,000	0-\$10,000	0-\$10,000	0-\$10,000	0-\$10,000	0-\$10,000		0-\$10,000	0-\$8,000	20%
87	Lead Apron Integrity Check	\$27	\$32	\$26	\$32	\$29	\$29	\$31		\$29	\$25	15%
88	SAFETY - Quality Assurance and Radiation Safety Manual	\$858	\$1,031	\$771	\$766	\$916	\$941	\$945		\$890	\$600	33%
89	Monthly - Monitoring Badge Review -w/ALARA Follow-up	\$322	\$387	\$385	\$383	\$344	\$353	\$389		\$366	\$300	18%
90	Quarterly -Monitoring Badge Review - w/ ALARA Follow-up	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
91	Occupational Worker Dosimetry Review (single investigation)	\$322	\$387	\$385	\$383	\$344	\$353	\$389		\$366	\$300	18%

	A	B	C	D	E	F	G	H	I	J	K	L
1	ATTACHMENT "A"											
2												
3												
4	Comparison of unit prices under current service agreements vs. new HHC rate card-2014											
5	COST Benefit Analysis											
6												
7	Services and Support	LIN	QHC	HHC	CIH	JMC	NCB	EGH		Avg	HHC New	% Discount
92	Fetal Dose Calculation	\$643	\$773	\$771	\$766	\$687	\$706	\$777		\$732	\$600	18%
93	Patient Dose Estimate (Average) Complexity dependent	\$322	\$387	\$385	\$383	\$344	\$353	\$389		\$366	\$300	18%
94	SAFETY - Rad Entrance Skin Exposure Analysis - Common Procedures	\$214	\$258	\$257	\$255	\$229	\$235	\$259		\$244	\$200	18%
95		\$0				\$0	\$0					
96	RAD - CR Reader/DR Unit Acceptance Testing	\$536	\$645	\$771	\$766	\$573	\$588	\$694		\$653	\$600	8%
97	RAD - CR Reader/DR Unit Annual Testing	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
98	RAD - CR Reader/DR Unit Quarterly Testing	\$188	\$226	\$225	\$223	\$200	\$206	\$227		\$213	\$175	18%
99		\$0										
100	RAD - Primary Diagnostic Monitor (workstation) Acceptance Testing	\$322	\$387	\$385	\$383	\$344	\$353	\$389		\$366	\$300	18%
101	RAD - Primary Diagnostic Monitor (workstation) Annual survey	\$161	\$193	\$193	\$191	\$172	\$176	\$194		\$183	\$150	18%
102	RAD-Primary Diagnostic monitors (workstation) Quarterly	\$54	\$64	\$64	\$64	\$57	\$59	\$65		\$61	\$50	18%
103												
104												
105	SAFETY - Radiation Protection Survey (Post Installation)	\$402	\$483	\$482	\$479	\$430	\$441	\$486		\$457	\$375	18%
106	Area Radiation Survey (per tube)	\$375	\$451	\$450	\$447	\$401	\$412	\$453		\$427	\$350	18%
107	SHD - Shielding (Rad, Fluoro, Mammo, and Bone Density)	\$322	\$387	\$385	\$383	\$344	\$353	\$389		\$366	\$300	18%
108	SHD - Shielding (CT, CBCT) CT-Simulator	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
109												
110	RAM - Radioactive Materials License Development, New Application	\$2,145	\$2,578	\$2,313	\$2,298	\$2,291	\$2,352	\$2,499		\$2,354	\$1,800	24%
111	RAM - Radioactive Materials License - Renewal	\$1,072	\$1,289	\$1,285	\$1,277	\$1,145	\$1,176	\$1,296		\$1,220	\$1,000	18%
112	X-Ray RSO & Dosimetry Review Service	\$214	\$258	\$257	\$255	\$229	\$235	\$259		\$244	\$200	18%
113	RSC - Meeting Attendance - Quarterly	\$214	\$258	\$257	\$255	\$229	\$235	\$259		\$244	\$200	18%
114	RSC - Prepare Meeting Agenda, and Meeting Minutes - Quarterly	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
115	SAFETY - Fluoroscopy Credentialing	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
116	SAFETY - Online (Annual) Radiation Safety Refresher Program	\$0	\$0	\$0	\$0	\$0	\$0	\$0		\$0	\$0	
117	SAFETY - Classroom Radiation Safety Training	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%

	A	B	C	D	E	F	G	H		J	K	L
1	ATTACHMENT "A"											
2												
3												
4	Comparison of unit prices under current service agreements vs. new HHC rate card-2014											
5	COST Benefit Analysis											
6												
7	Services and Support	LIN	QHC	HHC	CIH	JMC	NCB	EGH		Avg	HHC New	% Discount
118	Comprehensive lecture series directed toward preparation for the ABR Exam-LIVE (per year) lecture recorded for future use	\$16,086	\$19,335	\$19,272	\$19,149	\$17,181	\$17,642	\$19,433			\$15,000	
119	Comprehensive lecture series directed toward preparation for the ABR Exam-LIVE (remote) via WEBEX (per year) lecture recorded for future use	\$8,579	\$10,312	\$10,278	\$10,213	\$9,163	\$9,409	\$10,364		\$9,760	\$8,000	18%
120	US - Ultrasound Acceptance	\$536	\$645	\$642	\$638	\$573	\$588	\$648		\$610	\$500	18%
121	US - Ultrasound Q.C. program and Semi-Annual Reviews	\$322	\$387	\$385	\$383	\$344	\$353	\$389		\$366	\$300	18%
122	US - Ultrasound ACR Accreditation	\$536	\$645	\$771	\$766	\$573	\$588	\$694		\$653	\$600	8%
123												
124	OTHER - General Medical Imaging / Health Physics Services											
125												
126	Secure access, 24/7/365 to cloud based client portal for retrieval of all physics related documents (reports, credentials, calibrations, etc.). Education, forms, links, regulatory alerts, other Compliance and Quality management tools	NC	NC	NC	NC	NC	NC	NC		NC	No Charge	
127												
128	Average Discount on new HHC rates											18%
129												
130	Current Annual (2013)	\$47,700	\$104,868	\$70,008	\$107,184	\$49,800	\$24,816					
131	New HHC rate annual if service scope unchanged	\$44,526	\$82,292	\$55,940	\$85,211	\$43,378	\$20,926					
132												
133	Comparative Savings If service scope unchanged	\$3,174	\$22,576	\$14,068	\$21,973	\$6,422	\$3,890		TTL	\$72,103		
134												



NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
125 Worth Street · Suite 401 · New York · New York · 10013
212-788-3380 · Fax: 212-788-3689 · E-mail: manasses.williams@nychhc.org

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

TO: David Larish
Director, Procurement Systems & Operations
Central Office - Operations

FROM: Manasses C. Williams

DATE: November 13, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Petrone Associates LLC, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): HHC Corporate-Wide

Contract Number: Project: Hospital Consulting Medical Physics Services

Submitted by: Central Office - Operations

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

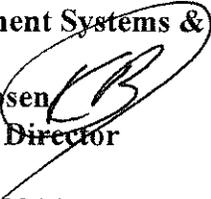
COMMENTS:

c:

Office of Legal Affairs

MEMORANDUM

To: David Larish
Procurement Systems & Operations

From: Karen Rosen 
Assistant Director

Date: April 10, 2014

Subject: VENDEX Approval

For your information, on April 10, 2014 VENDEX approval was granted by the Office of Legal Affairs for the following company:

Petrone Associates, LLC.

This approval is based upon prior VENDEX approval for the above-named company, which falls within 90 days of your current request.

cc: Norman M. Dion, Esq.

Board of Directors

*Petrone Associates LLC
Hospital Medical Physicist Consulting Services*

April 24, 2014

History

- HHC completed a RFP to identify a Medical Physicist Consulting Group to provide enterprise wide Medical Physicist services.
- HHC is seeking a contract agreement with Petrone Associates LLC, the selected Medical Physicist Consulting Firm, to provide regular testing and audits to ensure compliance with regulatory agencies and to continue ACR Accreditation as required which is not available by in-house HHC staff. The consulting group shall assist in the accreditation process and provide onsite support as needed. They are required to be on site as needed to perform testing, provide necessary documentation and support and also to respond to any emergency situation within a pre-determine response time.

Scope of Work

- Evaluation of equipment and reports according to NYS, NYC, Federal, MQSA, and ACR accepted standards and regulations.
- Education of facility staff in all aspects of radiologic standards.
- Regular visits to carry out evaluations.
- Onsite participation in high dose inpatient treatments.
- Regular updates in anticipation of standard and regulation changes.
- Attendance at meetings, inspections, and other important events.
- Rapid response (physically if required) to facilities' unanticipated and/or emergent needs.
- Coordination of Regulatory Compliance related to the initiation of New Services.

Projected Savings

	<u>LIN</u>	<u>QHC</u>	<u>EHC</u>	<u>CIH</u>	<u>JMC</u>	<u>NCB</u>
<u>Current Annual (2013)</u>	\$47,700	\$104,868	\$70,008	\$107,184	\$49,800	\$24,816
<u>New HHC rate annual if service scope unchanged</u>	\$44,526	\$82,292	\$55,940	\$85,211	\$43,378	\$20,926
<u>Comparative Savings if service scope unchanged</u>	\$3,174	\$22,576	\$14,068	\$21,973	\$56,422	\$43,890
<u>Projected overall average % Savings</u>	18%					

Thank You

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (“Corporation”) to negotiate and execute an agreement with KPMG LLP (“KPMG”) to provide the Corporation with auditing services and other directly related services including debt issuance related services, debt compliance letter, tax services, and certification/attestation for cost reports for a term of four (4) years, for an amount not to exceed \$3,487,000 plus a 10% contingency reserve of \$340,000.

WHEREAS, the Corporation is required by Corporate By-Laws, bond covenants and city, state and federal regulations to engage an independent certified public accounting firm to audit its annual financial statements; and

WHEREAS, the Corporation’s current contract with an independent certified public accounting firm ends June 30, 2014; and

WHEREAS, the Corporation in accordance with its policies and procedures issued on January 2, 2014, a Request for Proposals to perform annual audits of the financial statements, to issue annual management letters, and to perform other directly related services for the New York City Health and Hospitals Corporation, MetroPlus Health Plan, Inc., HHC Insurance Company, Inc. and HHC Accountable Care Organization, Inc.;

WHEREAS, the RFP Evaluation Committee reviewed and rated the submitted proposals using criteria specified in the Request for Proposals and gave KPMG the highest rating of any other proposer; and

WHEREAS, the overall responsibility for managing and monitoring the contract shall be under the Senior Vice President/CFO and Corporate Comptroller.

NOW, THEREFORE, Be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (“Corporation”) be and hereby is authorized to negotiate and execute an agreement with KPMG LLP (“KPMG”) to provide the Corporation with auditing services and other directly related services including debt issuance related services, debt compliance letter, tax services, and certification/attestation for cost reports for a term of four (4) years, for an amount not to exceed \$3,487,000 plus a 10% contingency reserve of \$340,000.

EXECUTIVE SUMMARY

Background:

External audit of the Corporation's financial statements is a requirement of the Corporate By-Laws, bond covenant and city, state and federal regulations. Additionally, some of the Corporate health care entities cost reports filed with various federal and state agencies require certification/attestation reports from the auditors.

KPMG is one of the top accounting firms in the United States and has been the Corporation's independent public accounting firm for over twenty years. The Corporation's current contract with KPMG expires on June 30, 2014.

RFP Issued:

On January 2, 2014, HHC issued a Request for Proposals (RFP) to provide Auditing Services for the Finance Division of HHC. The purpose of the RFP was to select an independent public accounting firm to perform annual audits of the financial statements for four fiscal years beginning June 30, 2014 through 2017 and to perform other directly related services for the New York City Health and Hospitals Corporation, MetroPlus Health Plan, Inc., HHC Insurance Company, Inc and HHC Accountable Care Organization, Inc.

Responses Received:

The RFP was sent to the 21 financial institutions that met the RFP's minimum qualifying requirements, which were to be on the New York City Office of the Comptroller's Pre-Qualified CPA List and to employ more than 100 professional staff (accountants). Three financial institutions responded to the RFP with their proposals. They were KPMG LLP; Deloitte & Touche LLP; and BDO USA, LLP.

Selection Process:

The Selection Committee was provided with a copy of the RFP, the proposal from each firm and evaluation forms. The Selection Committee members are as follows:

1. Marshall Bondy, Chairperson, Deputy Corporate Comptroller
2. James Linhart, Deputy Corporate Comptroller
3. Pauline Lok, Director Corporate Reimbursement
4. Wayne Hanus, Controller Metroplus
5. Anthony Saul, Comptroller Kings
6. Brian Stacey, Network CFO Queens Health Network
7. Linda Dehart, AVP, Corporate Reimbursement

The Selection Committee unanimously voted KPMG LLP as the selected contractor. Please refer to the Contract Fact Sheet for a complete description of the selection process.

Implementation:

Once the contract is awarded, KPMG will:

- Audit and render an opinion on the annual financial statements of New York City Health and Hospitals Corporation.
- Issue a management letter for the Corporation.
- Audit and render an opinion on MetroPlus Health Plan's annual statutory financial statements (calendar year-end).
- Issue a management letter for MetroPlus Health Plan, if deemed necessary by the auditor.
- Issue a report to the Audit Committee for MetroPlus Health Plan
- Audit and render an opinion on HHC Insurance Company, Inc's annual statutory financial statements (calendar year-end)
- Issue a management letter for HHC Insurance Company, Inc, if deemed necessary by the auditor.
- Audit and render an opinion on HHC ACO, Inc's annual statutory financial statements (calendar year-end)

EXECUTIVE SUMMARY

- Issue a management letter for HHC ACO, Inc, if deemed necessary by the auditor.
- Audit and issue a certification/attestation report re: the Annual Report of Ambulatory Health Care Facility (AHCF-1) for 6 facilities.
- Audit and issue a certification/attestation report re: the Annual Report of Residential Health Care facility (RHCF-4) for 3 facilities.
- Audit and issue a certification/attestation report re: the Annual Report for Long-Term Home Health Care Program for 1 facility.
- Annually audit and render an agreed-upon procedures letter re: the Corporation's compliance with NYS Health Regulations Part 86, i.e., bad debt and charity care pool audits. The purpose and scope of this work is to report on whether the Corporation's procedures/operations are in compliance with the regulations related to collection efforts and bad debt policy.
- Issue an annual Debt Compliance Letter in connection with the Corporation's Health System Bonds, as required, for each Series.
- Provide up to 250 hours of tax advisory services over the 4 year contract period, on an as-needed basis.
- Provide 5 full days of Continuing Professional Education per year for up to 140 attendees per year, either through your own CPE courses or by sponsoring Corporation staff at seminars held by professional organizations, e.g., HFMA, HANYS, etc.
- Provide documentation related to the total hours worked on contract each year by audit firm staff and those under contract. This requirement is solely related to the Wage Index Survey instrument.
- Perform as needed, a stub-period review of interim financial statements and issue comfort and consent letter related to debt issuance.

The Office of the Corporate Comptroller and the Chief Financial Officer will monitor the progress of the above goals.

Contract Costs:

The contract for these services will be for a period of four years, with no renewal option, at a cost not to exceed \$3,827,000. The breakdown is as follows:

Budget Breakdown:

<u>Total Contract Amount:</u>	
2014	\$ 825,000
2015	\$ 840,000
2016	\$ 855,000
2017	\$ 875,000

\$ 3,395,000

Contingency Reserve for additional auditing services (10%) = \$340,000

Debt issuance fees per occurrence not to exceed \$92,000

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: AUDITING SERVICES FOR FINANCE DIVISION OF NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

Project Title & Number: DCN 2149

Project Location: Corporate Wide

Requesting Dept.: Corporate Comptroller

Successful Respondent:	<u>KPMG LLP.</u>
Contract Amount:	<u>not to exceed \$3,827,000 over the contract period</u>
Contract Term:	<u>4 years</u>

Number of Respondents: Three
(If sole source, explain in background section)

Range of Proposals: \$3,395,000 to \$11,451,250

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

* The RFP was sent to the 21 financial institutions on the New York City Office of the Comptroller's Pre-Qualified CPA List that had more than 100 professional staff (accountants), RFP's minimum qualifying requirements.

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

Method of Payment: Lump Sum Per Diem Time and Rate
 Other: explain On progress billing of deliverables. Paid based on the institution's provided detailed billing statement.

EEO Analysis: KPMG and its subcontractors have submitted a Supply and Service Employment Report. E.E.O. is in the process of reviewing it.

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

Vendex Clearance Yes No N/A *Pending*

(required for contracts in the amount of \$50,000 or more awarded pursuant to an RFP or as a sole source, or \$100,000 or more if awarded pursuant to an RFB.)

Vendex documents provided by the vendor & its subcontractors have been sent to the Office of Legal Affairs.

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 Corporation's annual financial statements must be audited by an independent certified public accounting firm, as required by the Corporate By-Laws, bond covenant and city, state and federal regulations. Additionally, some of the Corporate health care entities cost reports filed with various federal and state agencies require certification/attestation reports from the auditors.

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 CRCs:

N/A

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

The Selection Committee members are:

1. *Marshall Bondy, Chairperson, Deputy Corporate Comptroller*
2. *James Linhart, Deputy Corporate Comptroller*
3. *Pauline Lok, Director Corporate Reimbursement*
4. *Wayne Hanus, Controller Metroplus*
5. *Anthony Saul, Comptroller Kings*
6. *Brian Stacey, Network CFO Queens Health Network*
7. *Linda Dehart, AVP, Corporate Reimbursement*

The financial institutions responded to the RFP:

KPMG LLP
Deloitte & Touche LLP
BDO USA, LLP

CONTRACT FACT SHEET (continued)

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

The Selection Committee consisted of representatives of those divisions/ departments in the Corporation most familiar and experienced with the audit process. Each member was provided with a copy of the RFP, the proposal from each firm and evaluation forms. The Committee then invited two firms (KPMG and Deloitte) to give presentations. The firms were evaluated based on their proposals and presentations using the evaluation criteria. The breadth of knowledge, experience and audit approach of the two firms were comparable however KPMG's pricing was favorable to HHC, hence KPMG unanimously received the highest score and was chosen.

Scope of work and timetable:

- Scope of Work: Annual audits of the financial statements for four fiscal years beginning June 30, 2014 through 2017 and to perform other directly related services for the New York City Health and Hospitals Corporation (the Corporation) and its blended and discretely presented component units (fiscal year basis), MetroPlus Health Plan, Inc. (calendar year basis), HHC Insurance Company, Inc (calendar year basis) and HHC Accountable Care Organization, Inc (calendar year basis). The contract period encompasses the financial statement preparation time related to calendar year and fiscal year-end financial statements of the Corporation and its component units for the years 2014-2017.
- Deliverables/Timeframes:
 1. Audit and render an opinion on the annual financial statements of a) New York City Health and Hospitals Corporation, b) MetroPlus Health Plan, Inc., c) HHC Insurance Company, Inc., and d) HHC ACO, Inc.
 2. Issue a management letter (if deemed necessary) for the a) Corporation, b) MetroPlus Health Plan, Inc., c) HHC Insurance Company, Inc., and d) HHC ACO, Inc..
 3. Issue a report to the Audit Committee for MetroPlus Health Plan
 4. Audit and issue a certification/attestation report re: the Annual Report of Ambulatory Health Care Facility (AHCF-1) for 6 facilities.
 5. Audit and issue a certification/attestation report re: the Annual Report of Residential Health Care facility (RHCF-4) for 3 facilities.
 6. Audit and issue a certification/attestation report re: the Annual Report for Long-Term Home Health Care Program for 1 facility.
 7. Annually audit and render an agreed-upon procedures letter re: the Corporation's compliance with NYS Health Regulations Part 86, i.e., bad debt and charity care pool audits.
 8. Issue an annual Debt Compliance Letter in connection with the Corporation's Outstanding Health System Bonds, as required, for each Series.
 9. Provide up to 250 hours of tax advisory services over the 4 year contract period, on an as-needed basis.
 10. Provide 5 full days of Continuing Professional Education per year for up to 140 attendees, either through your own CPE courses or by sponsoring Corporation staff at seminars held by professional organizations, e.g., HFMA, HANYS, etc.
 11. Provide documentation related to the total hours worked on contract each year by audit firm staff and those under contract. This requirement is solely related to the Wage Index Survey instrument.
 12. Perform as needed, a stub-period review of interim financial statements and issue comfort and consent letter related to debt issuance.

CONTRACT FACT SHEET (continued)

Costs/Benefits:

External audit of the Corporation's financial statements is a requirement of the Corporate By-Laws, bond covenant and city, state and federal regulations.

During the last contract period, in addition to the all-inclusive fee for auditing services of \$3.7 million, the Corporation incurred \$170,000 for two bond issuances and \$240,000 for additional services totaling \$4.1 million. The approved budget for this RFP was \$4.4 million (derived by anticipating a 4% rise in cost per year over FY13 costs). However, the selected firm has proposed an all-inclusive fee of \$3.4 million for providing the auditing services and \$92,000 per bond issuance. With the addition of a 10% contingency fee for additional services, the total cost requested for the new contract period is \$3.8 million (\$3,395,000 + \$92,000 + \$340,000 contingency fee); well under the approved budget.

Why can't the work be performed by Corporation staff:

Corporate By-Laws, bond covenant and city, state and federal regulations require HHC to hire an independent public accounting firm.

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

No

Contract monitoring (include which Vice President is responsible):

Marlene Zurack, Senior Vice President/Chief Financial Officer and Jay Weinman, Corporate Comptroller

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. 3/14/14
Date

Analysis Completed By E.E.O. _____ Manasses C. Williams
Date Name

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: Jayashri Nagaraja
Senior Management Consultant
Office of the Corporate Comptroller

FROM: Manasses C. Williams 

DATE: April 2, 2014

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, KPMG 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): Office of the Corporate Comptroller

Contract Number: _____

Project: Audit of Financial Statements

Submitted by: HHC's Office of the Corporate Comptroller

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

COMMENTS: AA/EEO # 31079B

MCW:gsp

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute requirements contracts with four firms; Environmental Planning & Management, Inc.; LiRo Engineers, Inc.; Warren & Panzer Engineers, PC; and Woodard and Curran to provide environmental services; on an as-needed basis at various facilities throughout the Corporation. The contracts shall be for a term of one year with two (2) one-year options for renewal, solely exercisable by the Corporation, for a cumulative amount not to exceed \$3,000,000 for services provided by these consultants.

WHEREAS, the facilities of the Corporation may require professional environmental services; and

WHEREAS, the Corporation has determined that the needs of the Networks for these services can best be met by utilizing outside firms, on an as-needed basis, through a requirements contract; and

WHEREAS, the Corporation conducted a selection process for such professional services through a Request for Proposals (RFP), and determined that these consultants' proposals best met the Corporation's needs; and

WHEREAS, the overall monitoring of this Contract shall be under the direction of the Senior Assistant Vice President, Facilities Development.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to negotiate and execute requirements contracts with four firms: Environmental Planning & Management, Inc.; LiRo Engineers, Inc.; Warren & Panzer Engineers, PC; and Woodard and Curran to provide environmental services; on an as-needed basis at various facilities throughout the Corporation. The contracts shall be for a term of one year with two (2) one-year options for renewal, solely exercisable by the Corporation, for a cumulative amount not to exceed \$3,000,000 for services provided by these consultants.

EXECUTIVE SUMMARY

REQUIREMENTS CONTRACTS

ENVIRONMENTAL SERVICES

ENVIRONMENTAL PLANNING & MANAGEMENT, INC.; LIRO ENGINEERS, INC., WARREN & PANZER ENGINEERS, PC; AND WOODARD AND CURRAN

OVERVIEW: The Corporation seeks to execute four (4) requirements contracts for one year, with options to renew for two additional one-year periods, for a total amount over three years, not-to-exceed \$3,000,000 to provide Environmental Professional Services on an as-needed basis at any HHC facility.

NEED: The various facilities of the Corporation may require/need Environmental Services. Due to fluctuating demands and the licensing requirements for these services, the Corporation has determined that these needs can best be met by utilizing outside firms on an as-needed basis through requirements contracts.

TERMS: The professional services will be provided pursuant to the terms and conditions of the requirements contracts.

COSTS: Not-to-exceed \$3,000,000 pool over three years, for the four (4) firms.

FINANCING: Capital, pending development of specific projects to be funded by bond proceeds, expense or other funds.

SCHEDULE: Upon contract execution, a base period of one year, with an option to renew for two additional contract periods of one year each, solely at the discretion of the Corporation.

HHC EXPERIENCE:

Consultant	Previous HHC Contracts
Environmental Planning & Management, Inc.	\$3M Pool 2/14/11 to 2/13/14 \$13,383 spent to date
LiRo Engineers, Inc.	\$3M Pool 2/14/11 to 2/13/14 \$969,093 spent to date
Warren & Panzer Engineers, PC	\$900,000 Contract 10/31/07-10/30/10 Full value of contract spent
Woodard and Curran	\$3M Pool 2/14/11 to 2/13/14 \$397,869 spent to date

VENDEX: Approval pending
EEO: Approval W & C, pending

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

TO: Marsha K. Powell
Director, Engineering Services
Central Office – Office of Facilities Development

FROM: Manasses C. Williams

M.C.W. ^{K.S.P.}

DATE: March 19, 2014

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Environmental Planning & Management, 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): Office of Facilities Development

Contract Number: DCN 2138 Project: Provide Environmental Services & Hazardous Materials Survey/Testing/Monitoring Services

Submitted by: Office of Facilities Development

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

COMMENTS:

c:

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

TO: Marsha K. Powell
Director, Engineering Services
Central Office – Office of Facilities Development

FROM: Manasses C. Williams *M.C.W. / M.P.*

DATE: March 19, 2014

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, LiRo Engineers, 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): Office of Facilities Development

Contract Number: DCN 2138 Project: Provide Environmental Services & Hazardous Materials Survey/Testing/Monitoring Services

Submitted by: Office of Facilities Development

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

COMMENTS:

c:

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: Marsha K. Powell
Director, Engineering Services
Central Office – Office of Facilities Development

FROM: Manasses C. Williams

M.C.W. / S.P.

DATE: March 19, 2014

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Warren & Panzer Engineers P.C., 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): Office of Facilities Development

Contract Number: DCN 2138 Project: Provide Environmental Services & Hazardous Materials Survey/Testing/Monitoring Services

Submitted by: Office of Facilities Development

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

COMMENTS:

c:

TO: Marsha K. Powell
Director, Engineering Services
Central Office – Office of Facilities Development

FROM: Manasses C. Williams

DATE: March 27, 2014

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Woodward & Curran, 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): Office of Facilities Development

Contract Number: DCN 2138 Project: Provide Environmental Services & Hazardous Materials

Survey/Testing/Monitoring Services

Submitted by: Office of Facilities Development

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

COMMENTS:

c: