

BOARD OF DIRECTORS MEETING
THURSDAY, APRIL 30, 2015
A~G~E~N~D~A

<p><u>CALL TO ORDER - 4 PM</u></p> <p>Call for a Motion to Convene an Executive Session</p> <p>Executive Session / Facility Governing Body Report</p> <ul style="list-style-type: none"> ➤ Metropolitan Hospital Center <p>Semi-Annual Governing Body Report (Written Submission Only)</p> <ul style="list-style-type: none"> ➤ Coney Island Hospital ➤ Sea View Hospital Rehabilitation Center & Home <p>Diagnostic & Treatment Center Annual Quality Assurance Plan / Evaluation 2014 (Written Submission Only)</p> <ul style="list-style-type: none"> ➤ East New York Diagnostic & Treatment Center 	<p align="center">Dr. Boufford</p>
<p><u>OPEN SESSION – 5 PM</u></p> <p>1. Adoption of Minutes: March 26, 2015</p>	<p align="center">Dr. Boufford</p>
<p><u>Acting Chair’s Report</u></p>	<p align="center">Dr. Boufford</p>
<p><u>President’s Report</u></p> <ul style="list-style-type: none"> ➤ Information Item: Supply Chain Transformation Update – Antonio Martin, Executive Vice President & Chief Operating Officer <p>>>Action Items<<</p>	<p align="center">Dr. Raju</p>
<p><u>Corporate</u></p> <p>2. RESOLUTION amending a previously adopted resolution on July 25, 2013 to increase the authorization for one or more borrowings to finance various capital projects from an aggregate not to exceed amount of \$40,000,000 to a new not to exceed amount of \$60,000,000 <i>(Finance Committee – 04/14/2015)</i></p>	<p align="center">Mr. Rosen</p>
<p>3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a sole source contract for proprietary software licenses, maintenance and support services agreement with 3M Health Information Systems (3M) for the Coding and Reimbursement Information System installed at HHC’s acute care hospitals, long-term care facilities and MetroPlus. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is \$13,510,101 which includes a contingency of \$643,338. <i>(Med & Professional Affairs/IT Committee – 04/16/2015)</i> <i>EEO: / VENDEX: Pending</i></p>	<p align="center">Dr. Calamia</p>
<p>4. RESOLUTION authorizing the New York City Health and Hospitals Corporation to purchase storage hardware, software, and associated maintenance from various vendors via Third Party Contract(s) to support the EPIC implementation in an amount not to exceed \$13,220,000 for a one year period. <i>(Med & Professional Affairs/IT Committee – 04/16/2015)</i></p>	<p align="center">Dr. Calamia</p>
<p>5. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute Indefinite Quantity Construction Contracts with two (2) firms: Vastech Contracting Corporation; and Rashel Construction Corporation, Inc. that were pre-qualified through the HHC public bid process, to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$6,000,000. The total authorized value of these contracts is \$12 million. <i>(Med & Professional Affairs/IT Committee – 04/16/2015)</i> <i>EEO: Approved / VENDEX: Rashel-Approved; Vastech-Pending</i></p>	<p align="center">Ms. Youssouf</p> <p align="right"><i>(over)</i></p>

BOARD OF DIRECTORS MEETING

THURSDAY, APRIL 30, 2015

A~G~E~N~D~A – Page Two

Committee Reports

- Audit
- Capital
- Equal Employment Opportunity
- Finance
- Medical & Professional Affairs / Information Technology
- Strategic Planning

Subsidiary Board Report

- HHC Assistance Corporation - Central Services Organization
~ One-City Health Service

>>Old Business<<

>>New Business<<

Adjournment

**Ms. Youssouf
Ms. Youssouf
Mrs. Kril
Mr. Rosen
Dr. Calamia
Mrs. Bolus**

Dr. Wilson

Dr. Boufford



LEVEREDGE SUPPLY CHAIN

Supply Chain Transformation Update

April 30, 2015

Paul Albertson, Sr. AVP, Supply Chain Services

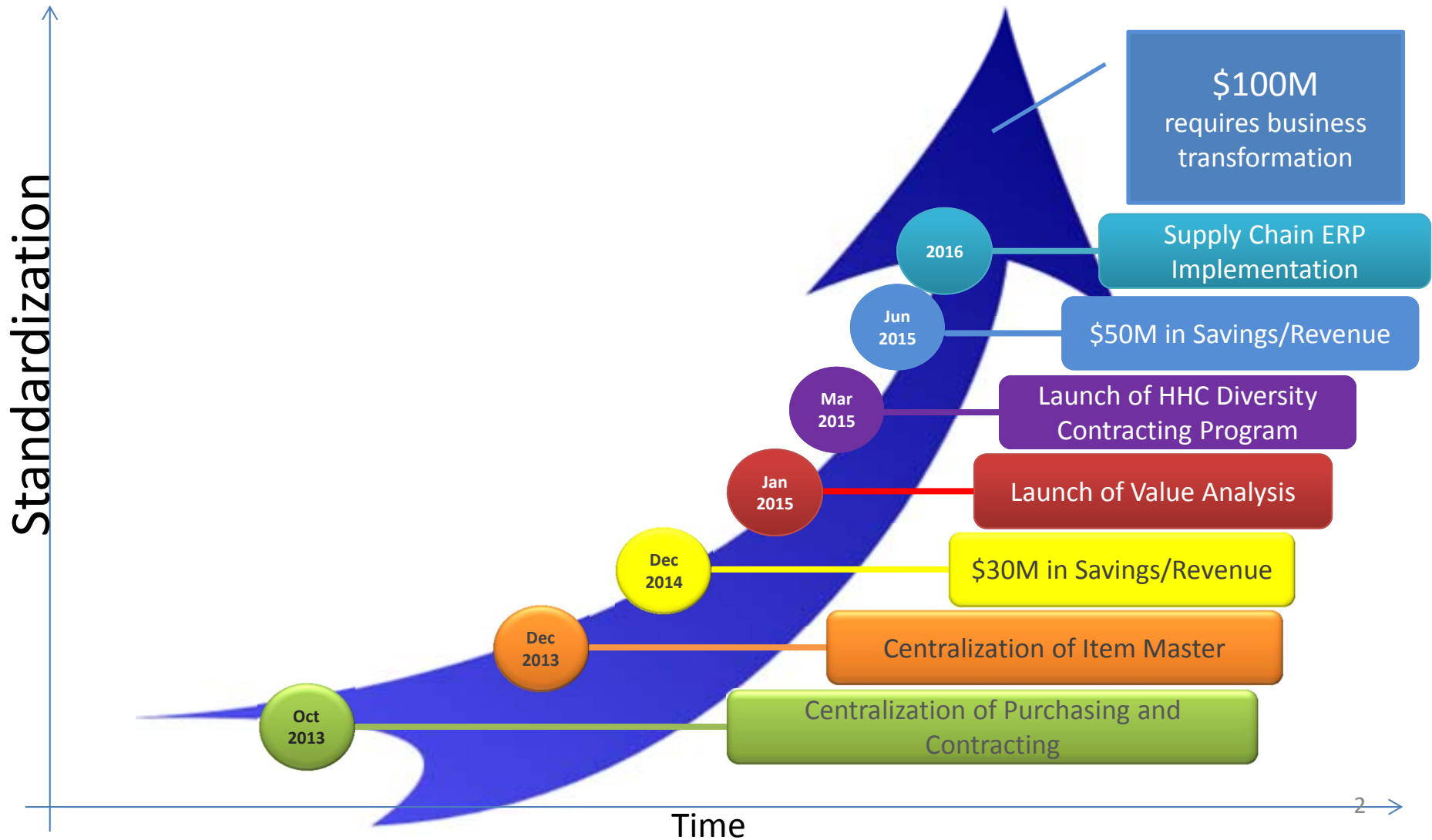
Providing
**quality,
affordable care**
to all New Yorkers



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



Supply Chain Transformation Plan

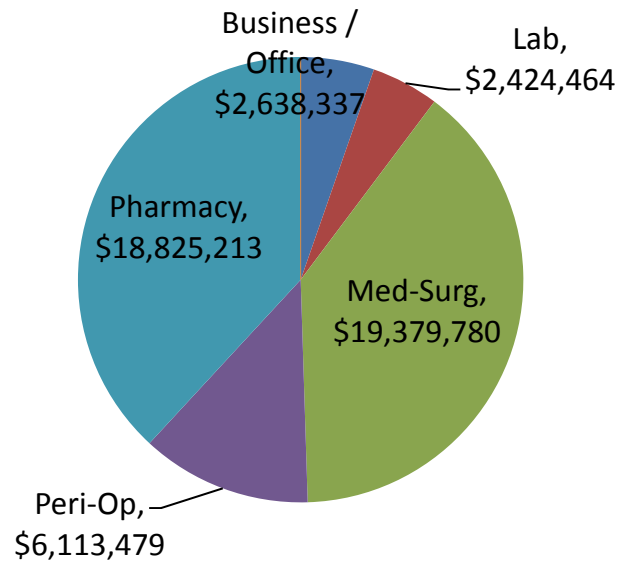




Successes

Savings

\$49,381,275.99



Product Fairs



Launch of Lab VA team



Ebola Preparedness





Value Analysis: The next phase in HHC's Supply Chain Transformation

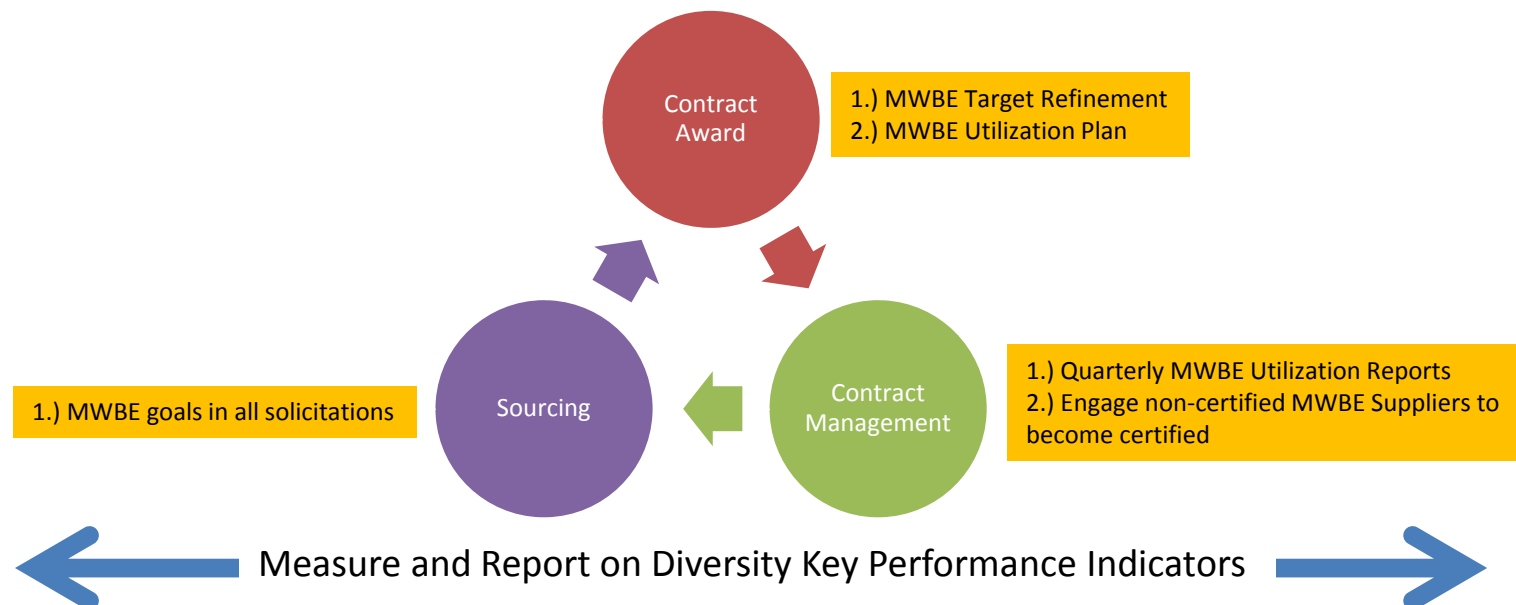
- Vision: Transform HHC's business methods into a centralized, systematic and evidence-driven Value Analysis Program that sharpens supply chain decision-making and drives HHC's mission of **Cost** reduction while ensuring best **Quality** and assuring excellent patient **Outcomes (CQO)**





HHC's Diversity Contracting Program

- Goal: To create a standardized, data and evidence driven, strategic sourcing program that engages a diverse supplier base and promotes employment and business participation for certified minority and woman owned businesses.





HHC Leverages Buying Power and Earns ECRI Award 2014 and 2015!



Our Healthcare Supply Chain Achievement Award honors healthcare organizations that demonstrate excellence in overall spend management and in adopting best practice solutions in their supply chain processes while leveraging the full range of ECRI Institute's supply chain services.

The 2015 winning organizations were chosen out of nearly 3,000 hospitals, health systems, and other organizations who participate in ECRI Institute's PriceGuide™ and SELECTplus™ supply and capital procurement programs. [Read the press release](#) for more details.



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 26th of March 2015 at 4:00 P.M. pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Jo Ivey Boufford
Dr. Ramanathan Raju
Mr. Steven Banks
Dr. Gary S. Belkin
Dr. Vincent Calamia
Dr. Herbert F. Gretz, III
Ms. Anna Kril
Mr. Robert Nolan
Mr. Mark Page
Mr. Bernard Rosen
Ms. Emily A. Youssef

Dr. Boufford chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

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

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Boufford reported that, 1) the Board of Directors, as the governing body of Coler Rehabilitation & Nursing Care Center, received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report presented; 2) as governing

body of the Henry J. Carter Specialty Hospital & Nursing Facility, the Board received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report presented; and 3) as governing body of Woodhull Medical and Mental Health Center, the Board reviewed and approved its semi-annual written report.

ADOPTION OF MINUTES

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

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

CHAIRPERSON'S REPORT

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

Dr. Boufford reported that Coney Island Hospital was the first HHC facility to undergo its triennial Joint Commission survey in 2015. She thanked Mr. Rosen for representing the Board during the survey's leadership meeting. Mr. Rosen reported that the survey went extremely well.

Dr. Boufford reported that hospitals to be surveyed this year are Queens Hospital Center on April 27th; Gouverneur Healthcare Services on April 28th; Jacobi Medical Center on May

19th; Kings County Hospital Center on May 20th; and Sea View Hospital Rehabilitation Center and Home on May 21st.

PRESIDENT'S REPORT

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

INFORMATION ITEM

Dr. Ross Wilson, Senior Vice President and Corporate Chief Medical Officer, provided the Board with an update on the Accountable Care Organization (ACO), a subsidiary company of HHC, and highlighted the progress being made. He explained that in this era of healthcare reform, we are striving to improve the quality of care while saving money at the same time.

ACTION ITEMS

RESOLUTIONS

2. Authorizing the President to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation and **Base Tactical Disaster Recovery, Inc.**, to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency (**FEMA**) for expenses incurred by the Corporation in connection with damages caused by **Super Storm Sandy**. The extension will be for a term of 12 months commencing August 1, 2015 through July 31, 2016 for an amount not to exceed \$2,500,000.

- and -

3. Authorizing the President to negotiate and execute a contract between the New York City Health and Hospitals Corporation and **Arcadis-US, Inc. and Parsons Brinckerhoff, Inc.** to provide professional architectural and engineering services to assist in

the recover, reconstruction and hazard mitigation of **Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital Center and other HHC facilities**, which were damaged as a result of the **Super Storm Sandy** disaster. The contract will be for a term of 12 months commencing October 1, 2015 through September 30, 2016 in an amount not to exceed \$5,000,000.

Marlene Zurack, Senior Vice President, Finance, explained to the Board the importance of extending the contract with the consulting firm which has been with working with HHC since Super Storm Sandy, and with expert architectural and engineering firms, to best support our efforts to secure reimbursement from FEMA.

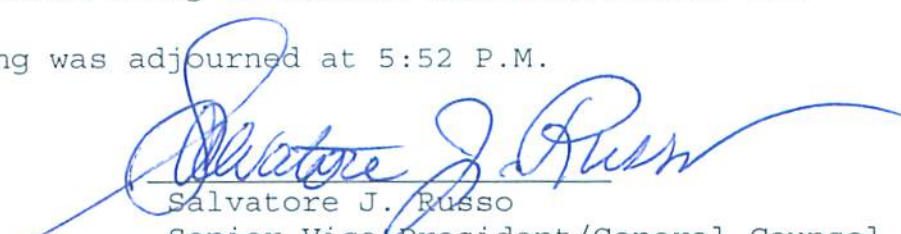
Mr. Rosen moved the adoption of the resolutions which were duly seconded and unanimously adopted by the Board.

SUBSIDIARY AND BOARD COMMITTEE REPORTS

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

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 5:52 P.M.



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

COMMITTEE REPORTS

Capital Committee – March - Canceled

Community Relations Committee – March 10, 2015 As reported by Josephine Bolus, RN

Chairperson's Report

Mrs. Bolus welcomed everyone. She shared with the Committee members highlights of some recent events that had occurred across HHC over the past two months.

Mrs. Bolus reported that nearly every Community Advisory Board had held its annual legislative breakfast. She noted that these forums are held to educate the community and elected officials about key federal and state budget and policy proposals and how they affect HHC facilities. Mrs. Bolus added that she attended the breakfast at Woodhull Medical and Mental Health Center on February 20th and the Central Brooklyn Network held at Kings County Hospital on February 27th. Mrs. Bolus commended the CABs and facility staffs for conducting these well attended and informative forums.

Mrs. Bolus continued and reported that at Woodhull, the audience heard from Senator Martin Dilan, Assembly Member Maritza Davila and Council Member Stephen Levin and representatives who spoke about their support for the hospital and the important role that it plays in the community. Mrs. Bolus noted that she spoke and emphasized the importance of every community member's voice being heard by the policy makers and elected officials about the needs of their neighborhoods, including their HHC facilities.

Mrs. Bolus reported that at the breakfast forum convened by the CABs of Kings County Hospital, the Dr. Susan Smith McKinney Nursing and Rehabilitation Center and the East New York Diagnostic and Treatment Center, invited guests heard from several elected officials and their representatives. Mrs. Bolus noted that the highlight of the morning was a capital funding award presented by Council Member Mathieu Eugene. Mrs. Bolus informed members of the Committee that Council Member Eugene presented a check for \$2.8 million to Kings County for the purchase of two (2) state-of-the-art PET/CT scanners. Mrs. Bolus stated that "the purchase of this equipment will enable the hospital's Radiation Oncology Department to diagnose cancer conditions and evaluate patients' response to treatment faster; and it would replace older equipment in the Emergency Department."

Mrs. Bolus informed members of the Committee, CAB Chairs and invited guests that Metropolitan Hospital Center recently won the annual "Big Fig" awarded by The Fund for HHC. Mrs. Bolus noted that Metropolitan Hospital Center would use the grant to update its sensory room in the hospital's adolescent inpatient psychiatry unit.

Mrs. Bolus announced that Mrs. Mireille Leroy, RN, who works in Lincoln Medical and Mental Health Center's Ambulatory Surgery Department, was honored by Dr. Raju as an HHC "Featured Employee". Mrs. Bolus noted that her international and local volunteer service, particularly in her native Haiti, had also been recognized by the Haitian-American Nurses' Association, which named Ms. Leroy "Nurse of the Year".

Mrs. Bolus continued and congratulated Mrs. Prativa Singh, a nurse at Elmhurst Hospital Center, who recently received the Daisy Foundation Award for noting a serious medical condition in a newborn which was immediately diagnosed and treated.

Mrs. Bolus informed members of the Committee, CAB Chairs and invited guests that in January, Harlem Hospital Center hosted a quarterly meeting of the American Congress of Obstetricians and Gynecologists. Mrs. Bolus noted that this had been the first time this event was held at an HHC facility. Mrs. Bolus explained that their focus was on the "Safe Motherhood Initiative," She noted that this initiative would develop and implement standard approaches for handling obstetric emergencies associated with maternal mortality and morbidity. She added that more than 125 providers across New York State attended the event.

Mrs. Bolus announced that, both the Harlem World Magazine and The Daily News recognized the important contributions made to the health care field and to the Harlem community by Dr. Gene-Ann Polk. Mrs. Bolus noted that Dr. Polk was longtime director of Pediatrics and Ambulatory Care Services at Harlem Hospital. Mrs. Bolus added that Dr. Polk passed away on January 3rd at the age of 88.

Mrs. Bolus concluded her report by publicly thanking HHC's longtime friend and supporter, Mr. Henry (Hank) Carter. Mrs. Bolus reported that, Mr. Carter presented specially equipped motorized wheel chairs, specialty mattresses, and alternative augmentative

communication devices to the residents at Coler Specialty Hospital and Nursing Facility and the Carter Specialty Hospital and Nursing Facility. Mrs. Bolus noted that Mr. Carter founded Wheelchair Charities, a non-profit philanthropic organization that had been in existence for more than four decades.

Mrs. Bolus turned the meeting over to President Raju for his remarks.

President's Remarks

Dr. Raju greeted everyone. He informed the Committee that he would like to share with them the following highlights about the Corporation:

Designation of HHC's Gotham Health Inc. as a Federally Qualified Health Center (FQHC)

Dr. Raju announced that HHC's Gotham Health Inc. has been designated as a Federally Qualified Health Center (FQHC) look alike. He commended Ms. LaRay Brown, Senior Vice President for Corporate Planning, Community Health and Intergovernmental Relations, for making this happen. Dr. Raju informed the Committee that HHC's Gotham Health will integrate all six of HHC's Diagnostic and Treatment Centers and community-based centers' 39 facilities under one umbrella as a city-wide network. In addition, Dr. Raju stated that this will help to strengthen HHC's focus on community-based, patient-centered ambulatory care.

DSRIP

Dr. Raju reported that HHC is proceeding well with its Delivery System Reform Incentive Program, or DSRIP, application with the New York State Department of Health. He informed the Committee that "One City Health" is the name of HHC's "Performing Provider System" (PPS) under DSRIP. He noted that the PPS includes four borough-spanning "hubs" and includes more than 400 external partners.

Accountable Care Organization (ACO)

Dr. Raju informed the Committee and invited guests that they will hear more tonight about the Accountable Care Organization (ACO) at the Council of CAB's meeting following the CRC meeting. He reported that HHC's Accountable Care Organization (ACO) has been concentrating on progressively relating the practices of all HHC's affiliated physicians to emphasize prevention and to foster referral for the appropriate level of care. He announced that because of their hard work in providing better, timely, right and cost-effective care to the patients which resulted in reducing unnecessary waste in the system, HHC is one of the few selected ACOs in the country which has a shared saving model. Dr. Raju explained that HHC received compensatory monies to share with the physicians that made this happen. Dr. Raju re-stated that ACO will be explored more later this evening.

HHC's A+ Rating

Dr. Raju reported that the global credit rating agency, Fitch Ratings last month had affirmed HHC's A+ rating for \$833.3 million in outstanding bonds and issued a "stable" rating outlook for HHC. Dr. Raju noted that Fitch had emphasized the strong support from the City of New York and HHC's "essential role as the primary safety net provider to the City's Medicaid and indigent population". In addition, Fitch had highlighted HHC's "seasoned management team that continues to produce a relative stable financial performance."

Lincoln Medical and Mental Health Center designated as "Baby-Friendly" Hospital

Dr. Raju reported that Lincoln Medical and Mental Health Center has been officially designated as a "Baby-Friendly" hospital. Dr. Raju noted that Lincoln is the third HHC facility to earn this designation. The other two are Harlem Hospital Center and Queens Hospital Center. Dr. Raju informed the Committee that to get this designation, a hospital has to go through a very rigorous process of getting certified and making sure that everything is in place.

HHC's Strategic Goals

Dr. Raju reminded the Committee that two of his strategic goals are to expand access to care and increase HHC's market share. He reminded the Committee that currently one in six New Yorkers are served by HHC. He shared with the Committee his goal to increase this to one in four New Yorkers. Dr. Raju acknowledged CAB members and auxiliaries who are already helping with this goal. He also thanked them for being vital links in their community as they help to educate and inform community members about the services offered at their facilities.

Dr. Raju concluded his remarks by thanking the CAB members and auxiliaries for their efforts and asking them to redouble their efforts for the betterment of their community, facility and HHC.

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Central/North Brooklyn Family Health Network CABs' Reports

Kings County Hospital Center (Kings County) Community Advisory Board

Mrs. Bolus introduced Mr. Kenneth Campbell, Chairperson of Kings County Hospital Center and invited him to present the CAB's annual report.

Mr. Campbell began his presentation by greeting members of the Committee, fellow CAB Chairs, invited guests and he commended George Proctor, Senior Vice President, North/Central Brooklyn Network and Ernest Baptist, Executive Director, Kings County Hospital Center for their outstanding leadership.

Mr. Campbell announced that he had been appointed Chair of the Kings County CAB in September 2014. Mr. Campbell stated that "as the newly elected Chair he had taken the initiative to present details of his vision for the Kings County CAB." Mr. Campbell noted that the CAB's Vision is consistent with the goals of the facility.

Mr. Campbell concluded the Kings County CAB report by stating that the Vision is about culture change, customer service and to work with the facility's leadership to design models of care that are set to achieve the highest standard of patient care.

Ms. LaRay Brown, Senior Vice President, Corporate Planning, Community Health and Intergovernmental Relations thanked Mr. Campbell for his presentation and reminded everyone that Mr. Campbell shared a hard copy of his Vision: Service of Excellence with Council of CABs at a prior meeting.

Dr. Susan Smith McKinney Nursing & Rehabilitation Center's (DSSM) Community Advisory Board

Mrs. Bolus introduced Antoine Jean-Pierre, Chairperson of Dr. Susan Smith McKinney Nursing and Rehabilitation Center and invited him to present the CAB's annual report.

Mr. Jean-Pierre began the DSSM CAB's report by stating "Dr. Susan Smith McKinney Nursing and Rehabilitation Center continues to be a center of Excellence." Mr. Jean-Pierre noted that under the leadership of Mr. Michael Tartaglia, Executive Director and Ms. Charmaine Lewis, Deputy Executive Director, DSSM had maintained a five (5) star status. Mr. Jean-Pierre commended the leadership for their dedication and commitment.

Mr. Jean-Pierre continued and explained that the reason for the high achievement is based on the facility's health care practices that are in alignment with the Corporation's six (6) guiding principles. Mr. Jean-Pierre noted that the six guiding principles are: keeping the focus on residents, ensuring the safety of everyone at DSSM; working together, manage resources, strive for higher ideals and humane innovative ways to take care of our residents and our staff.

Mr. Jean-Pierre highlighted the DSSM CAB's participation in 2014 outreach activities and events. They included:

- GO Red Event
- Black History Month
- Father's Day Spa & Luncheon
- Resident Art Expo
- Thanksgiving Dinner sponsored by DSSM Auxiliary and Brooklyn Farragut Lions Club.
- Auxiliary sponsored Annual Super bowl event and the residents first evening trip to see the Holiday Lights at the famous Dyker Heights area in Brooklyn
- The CAB Annual Resident Satisfaction Survey
- The Annual Memorial Service (for the families of former residents)

Mr. Jean-Pierre noted that the outreach/events activities are planned and executed with participation from the residents and staff, and that the activities and events boost patient care and staff morale.

Mr. Jean-Pierre concluded the DSSM CAB's report by again thanking the senior leadership George Proctor, Michael Tartaglia, Charmaine Lewis, Angela Cooper, CAB Liaison for their support of the CAB. Mr. Jean-Pierre closed by stating "as we celebrate Women History Month "Weaving the Stories of Women's Lives there is a real power in hearing women's stories, both personally and in a larger context. We must remember all women caregivers who blazed the trails and sacrificed for us. Remembering and recounting tales of their talents, sacrifices, and commitments because their work should be an inspiration for today's generations;

opening the way to the future; a future saturated with quality care, quality health care, especially at Dr. Susan Smith McKinney Nursing & Rehabilitation Center.”

East New York Diagnostic & Treatment Center's (East New York) Community Advisory Board

Mrs. Bolus introduced Mr. Ludwig Jones, Chairperson of the East New York CAB and invited him to present the CAB's annual report.

Mr. Jones began ENY CAB report by greeting members of the Committee, CAB Chairpersons and invited guests. Mr. Jones added that he was honored to present for the ENY's CAB report.

Mr. Jones reported that for over thirty-six (36) years ENYD&TC had been providing quality health care to residents in one of the most underserved communities' in Brooklyn. Mr. Jones added that ENYD&TC is located in the Brownsville section of Brooklyn. Mr. Jones added that the clinic is striving to maintain their reputation in the community.

Mr. Jones reported that the most significant health care needs/concerns of the East New York community were hypertension, diabetes, obesity, mental health and HIV/AIDS. Mr. Jones noted that the facility's leadership addressed the needs and concerns of the community by implementing "Care Teams." Mr. Jones explained that Care Teams consists of a Physician, Nurse and Patient Care Associate (PCA) to assist patients in the treatment and management of hypertension, diabetes through educational classes, nutritional counselling and peer discussion.

Mr. Jones informed members of the Committee, CAB Chairpersons and invited guests that ENYD&TC received a Grant to purchase Blood Pressure Monitoring Kits. Mr. Jones explained that the kits are given to patients to monitor their blood pressure at home. Mr. Jones continued and noted that in addition Healthy Buck Coupons and free cooking lessons are given to patients to encourage and promote healthy cooking and eating.

Mr. Jones concluded the ENY CAB's presentation with an announcement. Mr. Jones announced that for the year 2014, ENY D&TC received over 300 complimentary notes and only 7 complaints. Mr. Jones thanked Mari Millet, site administrator.

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

Mrs. Bolus introduced Mr. Talib Nichiren, Chairperson, 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, Network Senior Vice President/Executive Director, Lynn Schulman, Senior Associate Executive Director and Maria Hernandez, Network Associate Director.

Mr. Nichiren reported that the facility strategic priorities are to redesign and continue to renovate primary care practices and specialty practices to accommodate growth, enhance quality of care and 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 commitment and dedication to the LGBT community by the opening of the new LGBT clinic. Mr. Nichiren added that he is a proud member of the Woodhull CAB.

Cumberland Diagnostic & Treatment Center's (Cumberland) Community Advisory Board

Mrs. Bolus introduced Ms. Veronica Obie, CAB member, and invited her to present the CAB's annual report.

Ms. Obie began her presentation by thanking member of the Committee for the opportunity to present the Cumberland CAB's annual report. Ms. Obie thanked Dr. Ram Raju, President, Mr. George Proctor, Dr. Walid Michelen, Executive Director, Gotham Health.

Ms. Obie reported that 2014 had been an exciting year at Cumberland D&TC. Ms. Obie continued and stated that Cumberland had extended its practice hours to meet the needs of the community.

Ms. Obie continued and reported that the Cumberland CAB's outreach efforts had been extensive during 2014. Ms. Obie added that the CAB reached out to the community during their annual community health fair. Ms. Obie noted that the event resulted in community residents receiving preventive health screenings and the distribution of educational materials. Ms. Obie highlighted the Cumberland CAB's participation in 2014 outreach activities and events. They included:

- Take Care NY
- Go Red for Women's Health
- NYCHA Tenant's Association Meetings
- American Cancer Society Making Strides Against Breast Cancer
- Participation in the Delivery System Reform Incentive Payment (DSRIP) education forums
- Meet and Greet with the Brooklyn Borough President
- Voter Registration Drives

Ms. Obie added that the CAB recently hosted a successful Legislative Breakfast, providing the community a venue by which to express their health concerns to elected officials.

Ms. Obie concluded the her presentation by informing members of the Committee, CAB Chairpersons and invited guests the Cumberland CAB intends to address the issues of budget cuts and their impact on health care accessibility. Ms. Obie added that the CAB will work to maintain gains made in patient safety. Ms. Obie noted that the CAB members will focus on goals this year, which includes attending and representing Cumberland at community meetings. Before closing Ms. Obie thanked Tracey M. Bowes, Administrator, Cheryl Jones and Sherry Davis for their continued support.

Old Business

Bellevue Hospital Center CAB's Styrofoam Resolution

Ms. Louise Dankberg, Vice Chair, Bellevue Hospital Center reported that in August 2007, New York City Council Member de Blasio presented a local law to amend the administrative code to restrict the use of polystyrene. Ms. Dankberg added that within the document it states, "Polystyrene foam is a pollutant that breaks down to smaller, non-biodegradable pieces that are ingested by marine life ...thus injuring or killing them. Due to the physical properties of polystyrene foam, The United States Environmental Protection Agency (EPA) states, "that such materials can also have serious impacts on human health, wildlife, the aquatic environment and the economy."

Ms. Louise Dankberg, Bellevue continued and reported that on June 12, 2013, Int. 1060-2013 was introduced to restrict the sale or use of polystyrene items and in January 2015, a final decision was decided; New York City will ban polystyrene in July 1, 2015.

Ms. Dankberg stated that she would focus on the impact of human health. Ms. Dankberg noted "that if you pour hot tea and squeeze a lemon wedge into a polystyrene cup, a hole will appear where the lemon wedge rests." Ms. Dankberg noted that the demonstration shows that the polystyrene cup has migrated into the liquid in the cup.

Ms. Dankberg noted that migration of styrene occurs when foods containing acids, fat and/or alcohol leech into the foods, more quickly when foods or drinks are hot.

Ms. Dankberg reported the Health and Hospitals Corporation uses polystyrene products. Inpatients in public hospitals and public nursing homes are some of our most vulnerable populations in our community. Ms. Dankberg noted that when food is served on polystyrene products, the hazardous chemicals cause the following health problems:

- fatigue
- nervousness
- lack of concentration
- difficulty sleeping
- mucous membrane and eye irritation
- depression
- hearing loss

Ms. Dankberg noted that these symptoms are often attributed to seniors and styrene is a volatile organic compound (VOC). She noted that the damage is cumulative.

Ms. Dankberg informed members of the Committee and invited guests that in February 2013, the Bellevue Hospital Center Community Advisory Board, BHC-CAB adopted a resolution opposing the use of Styrene. She noted that the resolution also supported the proposed ban of polystyrene by former Mayor of New York City, Hon. Michael Bloomberg because its impact on landfills. Since 2007, former NYC Councilmember and now the Mayor of New York City Bill de Blasio has publically supported banning polystyrene in New York City.

Ms. Dankberg reported that in September 2014 at the Municipals Council of CAB's meeting, the Chairpersons unanimously voted in favor of the Bellevue Hospital CAB submission of documentation about the health hazards of polystyrene to HHC's Community Relations Committee.

Ms. Dankberg concluded by stating the Bellevue CAB resolution calls on the Municipal CABs of HHC to join the ban of polystyrene products at HHC facilities. Ms. Dankberg noted that the health and welfare of HHC's patients should always come first.

Finance Committee – March 10, 2015

As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Marlene Zurack informed the Committee that Julian John, who was the CFO for the Central Brooklyn Health Network had been appointed to replace Jay Weinman, Corporate Comptroller. Additionally, Elsa Cosme was appointed CFO of Gouverneur Healthcare Services. Ms. Zurack asked that the Committee, particularly Mr. Rosen and Mr. Page assist Mr. John in his new role in understanding the City financial structure. Ms. Cosme comes from the voluntary sector and we look forward to working with her in new role.

Ms. Zurack informed the Committee that HHC had received a grant funded by the United Hospital Fund (UHF) for a project that was put together by HHC at the request of Patsy Yang, of the Deputy Mayor's Office. The project is funded at \$144,000 to support research on utilization as well as focus groups with patients to determine if HHC should do something to change its HHC Options program to make it more aligned with healthcare reform to better meet the needs of its patients for better care coordination. The current Options program is based on a fee-scaling process consistent with fee-for-service reimbursement. HHC will work with CUNY who were named in the grant and will do the research on behalf of HHC. The next item in the reporting, HHC's cash on hand (COH) was at 19 days as of March 6, 2015 and is projected to increase to 36 days by June 30, 2015 that is based on HHC's receipt of all the UPL payments that are currently outstanding and HHC making all the payments to the City and pension fund. The final item included the State budget. Governor Cuomo has issued the State Executive Budget and some of the highlights that relate to HHC would be presented to the Committee. First, the budget includes language to support the State's change in the UPL payment to allow the New York State Department of Health (NYSDOH) flexibility to comply with the Centers for Medicare/Medicaid Services (CMS) and to expand the distribution of the payments to more hospitals at HHC than had been prior which is a precursor to getting the payment that is reflected in the cash flow.

Mr. Rosen asked when those payments are expected to flow to HHC. Ms. Zurack stated that by April 2015; however, CMS approval is required and must be obtained by the State. There are proposed changes in the indigent care methodology for NYS. The indigent care methodology drives the Disproportionate Share (DSH) payment to HHC. As previously reported as part of the Affordable Care Act (ACA), beginning in FY 2018, NYS will see massive reductions in its DSH allocations from the federal government. The current process or rule for the distribution of DSH amongst the different hospitals in NYS include a series of various positions adopted over the years that include various pieces of state law that include the creation of the following: the indigent care pool; the public hospitals adjustment pool; the IGT; the DSH maximization for public hospitals other than HHC. There is a provision that allow HHC to get its maximization if there is room in the State allocation after all those items have been satisfied. If there is no room HHC does not get its maximization. HHC's DSH maximization has been from \$550 - \$600 million per year. HHC is the last priority in the current State law. Accordingly in HHC's financial plan if the DSH cuts are passed down to the State, the entire first two years of DSH cuts would come exclusively to HHC which would be a major problem. Additionally, as part of the ACA there is discussion that the HHS Secretary was to setup a methodology for allocating the national DSH cut to states and that methodology should favor states that treat the most Medicaid and uninsured. NYS current methodology for the DSH maximization, the \$600 million that HHC gets represents 35 – 40 percent of State's DSH and the other publics also get a fair amount of the total dollars distributed. A large portion goes to the high Medicaid and uninsured hospitals. However, if the State does not change its allocation of the DSH in law, when the cuts are passed down that would go away given that the highest DSH hospitals are the first to get cut based on those old statues. Included in the State budget is language that would allow the SDOH to delegate that authority to change those methodologies to the SDOH in response to the federal cuts.

Mr. Rosen stated that it would appear that the State is trying to anticipate the loss of the federal DSH and mitigating that loss.

Ms. Zurack stated that the State is trying to move the discussions away from the legislature and have it be exclusively the SDOH in order to have the flexibility to adapt to the unknown. In October 2013 the HHS Secretary issued regulations on how the DSH cuts would be done. However, at that time there were issues relative to the data on the uptake of insurances for the ACA. Therefore, the Secretary only put forth temporary regulations that expire with the anticipation that new ones would be done at the end of calendar year 2015, whereby more permanent methodology will be developed on how the DSH cuts will be done

effective 2018. At some point the State will need to have a discussion with the federal government regarding this issue. The language in the State budget put it in the hand of the Governor's administration and therefore it would not make it a subject of the legislature process. Prior to the MRT, the formulas for the distribution of the payments were very detailed. From an HHC perspective, discussions have been done with the SDOH who understands the importance of retaining the federal share. HHC has asked that there be language that would be more inclusive of the process and involvement by HHC in the issuance of regulations or rules that would allow for HHC to comment on those changes.

Dr. Raju added that as Ms. Zurack had stated, HHC has expressed its concerns to the State regarding the issues relative to the DSH maximization. It is important to note that what HHC is proposing is not only for HHC but it would be good for the State as well. There must be a process and the concept of the allocation relative to Medicaid and the uninsured. HHC has had discussions with the various stakeholders, politicians, and communities and leaders regarding this issue and will keep the Committee updated on the status.

Ms. Zurack noted that the most important part of the State budget included extension of the Medicaid global cap indefinitely, setting the maximum increases at the consumer's price index at 3.6%. Any projected savings below the cap can be shared with providers. This is another example that there are some proposed rate increases and restoration of some rate adjustments/cuts. If passed, the preventable complications rate adjustment would be worth \$3.5 million for HHC. In addition there was an implementable MRT obstetric reimbursement reduction designed to fund the malpractice reform but is being proposed to be restored that is worth \$4 million to HHC. There is an item in the State budget that allows for the creation of a basic health plan that is a provision of the ACA that allows stated to create a publically sponsored plan similar to a Medicaid managed care plan that would allow the State to get the benefit of what would have been the tax subsidy to the individual purchasing their own health insurance on the exchange. There is a population in NYS of immigrants that due to a lawsuit that HHC was also a participant are given state only Medicaid and due to the provision of the Personal Responsibility Act (PRA).

Committee member Mark Page asked how that would work with the local participation of the Medicaid cost. Ms. Zurack stated that due to the county cap on Medicaid expenses there is no county share because the state is paying over the cap with the amount in savings it is possible to go below the cap.

Mr. Page asked if the local share has been exempted from the cap.

Ms. Zurack stated that it is not clear at this time if that would apply for that population. However, it is not clear how this one works but would do some research and report back to the Committee on the findings. As part of the ACA, from the Medicaid perspective the Medicaid expansion that was the single adults between 87% of poverty and 138% are now eligible for Medicaid as part of the ACA. That new population gets a federal matching rate that varies each year from 85% to 92% as part of the federal matching rate for the entire country. When the ACA was passed the cost sharing for the Medicaid expansion was much lower than what it had been for straight Medicaid. There were enormous savings to the State from those savings which is a positive for HHC. There was a potential cut in the State budget for crossover payments for individuals with both Medicaid and Medicare. The combined payment between Medicare and the crossover cannot exceed what Medicaid would have paid for the same services. That is a potential \$92 million statewide cut to all providers in the State and HHC's share of that cut is yet to be determined. The State budget includes \$290 million for safety net providers to apply for vital access grants dollars of which HHC will receive a small amount. Also included in the State budget is \$1.4 billion for capital of which \$700 million is for central and east Brooklyn. Ms. Zurack deferred to Dr. Raju for further elaboration.

Dr. Raju stated that HHC has been a part of the discussions on how the \$700 million in capital for central and east Brooklyn should be distributed and have suggested that it should follow the DSRIP transformation process under the capital component so as to improve more ambulatory and access to care. HHC also proposed that there should be public involvement in the process of how those funds should be applied. Essentially, HHC's position is that central Brooklyn lacks adequate access to care and those funds could assist in improving that disparity through the Governor's involvement in putting more funding resources in central Brooklyn. However, it is important those funds are used appropriately in addressing some of the major health access issues facing that community for the uninsured and under insured.

Committee member Josephine Bolus asked if the basic health plan would have an impact on MetroPlus.

Ms. Zurack stated that it would in that MetroPlus will be able to participate and have a product that will help in increasing enrollment which is a major part of HHC's strategic agenda to assist MetroPlus in driving market share to HHC. The reporting was concluded.

Key Indicators/Cash Receipts & Disbursements Reports

Mr. Rosen informed the Committee that given the lengthy agenda, the Key Indicators and Cash Receipts and Disbursements Reports would be submitted into the record.

Action Items:

Authorizing the President to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation (“HHC” or the “Corporation”) and Base Tactical Disaster Recovery, Inc. (“Base Tactical”) to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency (“FEMA”) for expenses incurred by the Corporation in connection with damages caused by Super Storm Sandy. The extension will be for a term of 12 months commencing August 1, 2015 through July 31, 2016, for an amount not to exceed \$2,500,000.

Authorizing the President to negotiate and execute a contract between the New York City Health and Hospitals Corporation (HHC or Corporation) and Arcadis U.S., Inc. and Parsons Brinckerhoff, Inc. to provide professional architectural and engineering services to assist in the recovery, reconstruction and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital and other HHC facilities, which were damaged as a result of the Super Storm Sandy disaster. The Contract will be for a term of 12 months commencing October 1, 2015 through September 30, 2016 in an amount not to exceed \$5,000,000.

At the request of Ms. Zurack, the two resolutions were read consecutively given that the presentation would be done jointly by her and Mr. Martin.

Ms. Zurack informed the Committee that she would do the first resolution for Base Tactical consultancy services and that Mr. Martin would address the second resolution relative to the architectural and engineering services provided by Arcadis and Parsons Brinckerhoff. Via way of background which would explain why it is necessary to extend the contracts, the brief presentation which was a revision of the one previously distributed as part of the Committee’s package would cover the FEMA process and the architectural and engineering services. In the middle of the storm in 2012 it became apparent to the leadership of HHC that there was a need to have a FEMA consultant on site immediately. There was an emergency declared by the federal government and HHC. Through that process emergency procurement rules were allowed for securing the necessary services and as a result of that process base Tactical who had its own architectural and engineering service firms to assist in the initial assessment process during the early stages of the process. The contract for Base Tactical for that engagement was for \$2.7 million which covered architectural and engineering services and FEMA work. Subsequently and RFP was issued in November 2012 and a contract was awarded to Base Tactical presented to the Board in January 2013 for an amount not to exceed \$4.4 million from February 2013 through July 31, 2014. As part of that engagement Base Tactical worked with HHC on the project worksheets and payback for some of the emergency work, restoration at Bellevue and Coney Island and in getting those two facilities back up and running at their levels before the storm. A second extension of Base Tactical contract was done to assist HHC in its efforts to complete hazardous mitigation from August 2014 to July 31, 2015 for an amount not to exceed \$2.6 million. The current extension is for another year to complete the current scope from the original RFP and at this stage it would not be in the best interest of the Corporation to change consultants to get through the project work. However, if in the near future there is a need for HHC to continue this service, an RFP will be issue at that time. HHC in response to the Committee’s request will present the process for managing the cost of construction relative to the FEMA allocation of \$1.7 billion.

Mr. Martin continuing with the second half of the presentation stated that the work to be performed under this one year extension included: continued preparation of FEMA documents to support the \$1.7B grant and environmental assessments at Bellevue, Coler, Coney Island and Metropolitan hospitals; design mitigation projects which include mechanical infrastructure raised to higher elevations; design major mitigation projects including floods walls, new elevators, generator platforms and water pumping stations; assist in procurement packages by issuing scope and responding to bidder questions; review and approve shop drawings; and provide overall construction observation activities.

Ms. Zurack stated that the number of steps involved in the process of getting the FEMA reimbursement for the \$1.7 billion for the projects that must be undertaken were outlined on the last slide of the presentation. It is anticipated that there might be a need for some ongoing FEMA consultancy imbedded in that process. The steps involved in securing those FEMA dollars and the potential need going forward for those services as part of that process. The information included in the presentation was prepared by Base Tactical.

The resolutions were approved for the full Board’s consideration.

Information Items:

PS Key Indicators Report 2nd Quarter FY 15

Mr. Fred Covino informed the Committee that HHC is transitioning to a new monitoring process for FTEs. Historically, the reporting was done by various categories; however, going forward the reporting will include all categories this will be global FTEs. Global FTEs include, full time, part time, hourly, overtime, agency temps and affiliation. As part of that process the workload was benchmarked with the global FTEs to workload across the Corporation that resulted in a net reduction of 1,000 FTEs over the next eighteen months based on workload. FTE targets have been developed by facility and those targets were reviewed with the facilities for FY15 and FY 16. The monitoring and reporting of the facilities performances against those targets will begin in March 2015 and reported in April 2015 to the Committee.

Mrs. Bolus asked for clarification of the change from the various categories to an expansion of those categories.

Mr. Covino explained that both a dollar and FTE cap as part of the global FTE was developed with the expectation that the facilities will reduce their reliance on agency temps and move those staff into either hourly or full time positions.

Ms. Zurack further explained that the former approach included having an FTE cap compared to a full time staff budget for the hospitals and managing within that budget, backfilling positions as vacancies occurred. The global FTE cap will allow the facilities the flexibility to manage their resources without having to go through central office. By creating a limit on certain resources, the facilities have opted to use other resources such as temps to meet their staffing needs, thereby circumventing the VCB process. The global cap allocation allows the facilities the opportunity to use their resources as needed in staffing their facilities by employing temps, hourly, full time, part time staff and affiliation. The goal is to create the most comprehensive way to measure and monitor the staffing at the facilities so that the hospitals can be managed by the Network leadership and held accountable for their overall performance against the global cap allocation.

Mrs. Bolus asked how the agency nurses were counted in the cap. Ms. Zurack stated that it was counted as part of the conversion of the usage and dollars spent for those services. Mr. Covino added that it is based on hourly.

Mr. Martin added that the goal is to reduce the use of agency temps by giving the Senior Vice President/ Executive Director for the network or facility the maximum amount of flexibility in determining the best way to manage their facilities. One of the things that is extremely important to the network leadership is to have the flexibility to manage their resources independent of central office and not being constrained by any given situation.

Mrs. Bolus stated that the concern is that one the issues that is a constant response in the quality management meeting is that there is a need for additional staff and if central office is to assist in addressing that issue what role would can the Board play in helping the facilities within the new global cap.

Dr. Raju stated that it was a valid point and by focusing only on the FTEs it forces the facilities to seek other options such agency temps to meet their needs. The global cap is a better methodology given that it allows for greater flexibility in being able to make decisions about how to staff the facilities. Oftentimes it is not about the lack of resources but rather how those resources are managed and deployed. This allows greater opportunity to deploy resources needed to operate the day-to-day operations without central office intervention. There is a level of accountability as well in managing those resources.

Ms. Zurack stated that a lot effort on the part of Krista Olson, Assistant Vice President, Corporate Budget and her staff went into the completion of this project and the methodology. The targets were developed using workload. For any particular hospital the workload is up; however, there are fewer staff doing the work and at some point it does normalize in that the cap relates to the amount of workload. It is a new methodology and is not full proof but it is not arbitrary.

Mrs. Bolus stated that there is a concern in there being a positive outcome by using that methodology given the various situations that occur within the hospitals relative to delivering patient care.

Ms. Zurack stated that there are some things that are not included in the cap that would be added to the budget such as collective bargaining and any new programs/grants.

Salvatore Russo, Senior Vice President & General Counsel added that the unions have expressed concerns regarding the use of temporary staff as opposed to hiring full time staff. Moreover, HHC is moving in the direction of having a more realistic approach in meeting the needs of the facilities as oppose to just tracking the headcount.

Mr. Martin stated that the facilities will have the flexibility to make the types of decisions necessary to manage and operate their facilities based on their targets. If there is a need to intervene in the process there is a mechanism to do so through his office. While the facilities will be held accountable, central office is aware that there might be some extenuating circumstances. It is important to note that the purpose of this methodology is not to penalize any given facility but rather there are discussions and negotiations with the facilities on an ongoing basis with his office and finance.

Dr. Raju stated that in terms of the core issue, corporate has questioned the network affiliations on the jobs that are budgeted but are not filled. There are some recruitment issues that must be addressed as opposed to a budgetary issue. This has been the thrust of the discussions with the facilities relative to recruiting and staffing appropriately with the available resources. The facilities focus has to be more global in recruiting staff. Within HHC there are a number of qualified personnel that can be utilized by the facilities in meeting their needs and this issue must be addressed by the networks.

Mr. Covino continuing with the report stated that the budgeted increase in FTEs is 325 compared to the year-end staffing level for FY 14. The allocation of that increase include: 90 FTEs for Gouverneur to staff the opening of 160 beds; 76 FTEs for enterprise IT for EMR trainers, 36 and 40 consultant conversions; 50 FTEs for multiple facilities for the hospital medical home grant; 33 FTEs at North Central Bronx for staffing the labor and delivery services; 27 FTEs at Bellevue for the Ebola virus preparedness and readiness; 24 FTEs multiple facilities for the CMMI grant, Healthcare Innovation Award; 17 FTEs residents at Coney Island and 8 FTEs for the re-opening of Homecrest. If the workload increases the targets will be adjust accordingly.

Mr. Rosen asked if by the end of the FY 15 the FTE headcount would be higher by the 325 increase. Mr. Covino stated that it would not due to some reductions that were factored in based on the right sizing of the FTEs based on workload.

Ms. Zurack added that the 1,000 FTE reduction target is for June 30, 2016; therefore there will be some ups and downs in the FTE count.

Mr. Covino stated that the PS disbursements through January 2015, expenses were \$4.1 million over budget; FTEs were 299 higher than last year due primarily to the budgeted FTEs. However, there were some significant increases outside of that budgeted increase. In addition to the EBOLA FTEs, Bellevue was up by 97 FTEs of which 61 FTEs were for nurses; 9 dental residents and 12 medical records specialist. Lincoln was up by 63 FTEs due to the new emergency department and psych unit. Gouverneur is up by 52 FTEs for the staffing of the new units and the Queens's network is up 100 FTEs due to the shifting away from using temp services and moving to full time staff. The 299 FTE increase by major category included an increase of 149 nurses; 118 managers; 49 tech/spec; 16 environmental/hotel; 15 residents; 9 aides and orderlies; 2 physicians and a decrease of 58 clericals. Overtime versus actual was flat against the budget; however, compared to last year it is up by \$200,000. It is important to note that of the current year-to-date actual \$5 million is related to prior year for collective bargaining and by excluding that expense the current YTD is better than the prior year. Nurse registry was up by \$8.3 million due to new contract terms with the vendors to pay within 90 days. Bellevue had a significant increase due to the conversion process of agency nurses to full time staff. Allowances increased due to the facilities efforts to reduce the usage of temp series and the conversion to full time staff. In addition to that transition there are overtime expenses, \$6 million included due to a shift in the usage of those staff. The reporting was concluded.

Financial Plan

Mr. Covino stated that HHC's Financial Plan is part of the City's budget process; therefore, there are iterations of the plan each year. The November Plan which was passed, the preliminary budget which is what is being presented to the Committee and finally the Executive budget that result in the adoption of the budget. HHC's Plan includes actual results for the prior FY 14, the budgets for FY 15 and 16 and the Corporation's plan for FY 17 through FY 19. Each year an overview of the January Plan which is presented to this Committee and forwarded to the State in compliance with the Public Authority Accountability Act (PAAA) and is due May 1, 2015. The financial plan is comprised of three sections receipts, disbursements forecasts over the life of the plan and corrective actions. Beginning with the receipts, one of the major developments in the plan is the transition between Medicaid fee-for-service and Medicaid managed care. As behavioral health long term care transition from fee-for-service to managed care there is a significant reduction beginning in FY 15 of \$7 million growing to approximately \$304 million as the transition progresses in the out years. The shift is dollar for dollar with no workload reduction. However, that transition to managed care will impact the UPLs. As the dollars are moved to managed care which is not eligible for UPL calculations only fee-for-services it has a significant reduction on the UPL payments beginning in FY 16 maintaining the City's share and solely focusing on the loss of the federal share of \$67 million reduction, increasing to \$150 million by FY 19. Also, the actuals for FY 14 and the projections for FY 15--the DSH for FY 14 was significant and some funds were advanced from FY 15 to cover for the cash flow problem in FY 14. Consequently last year the UPL was very low only \$205 million compared to approximately \$2 billion for FY 15 of which \$1.25 billion of the UPL for this year is retroactive which has been reported monthly to this Committee relative to HHC's cash flow.

Mr. Rosen asked if it is a one-time expense. Mr. Covino stated that it is non-recurring. In terms of the ACA, there are several items that will have an impact HHC's revenues. First, the Medicaid DSH reductions beginning in FY 18 is a loss of \$305 million growing to \$314 million in FY 19. Over the life of the plan the Medicare DSH impact is reduced; therefore, in FY 15 the projection is \$330 million and as the ACA grows with more people getting insured, the projection reduces to \$161 million. Medicare payment reforms are projected to be approximately \$13 million in FY 15 growing to a \$35 million reduction in FY 19. The health care exchanges are projected at \$40 million positive to the current plan growing to \$50 million by FY 19. Overall there is a positive impact of \$263 million; however, in the later part of the plan that positive trend will decrease significantly by a loss of \$130 million each year. The current plan has incorporated all of the collective bargaining settlements to-date. There is an additional payroll included in FY 17 of \$90 million. OTPS and medical malpractice increase in FY 15 due to the carryover of City payments that reflect two years of payments that are reflected in debt service, OTPS, and medical malpractice. In FY 15 receipts versus disbursements there is a positive \$343 million due to \$1.25 billion in prior years UPL payments. In the beginning of FY 16 those payments are projected as a negative from \$750 million due to the non-recurrence of the UPL and in FY 17-19 the projection grows from \$1 billion to \$1.5 billion as the DSH and UPL declines. This is a major impact on HHC financial plan. The below the line items which reflect HHC's corrective action plan. There are two new items included in the plan that are more detailed. First the plan recognizes \$152 million received as part of DSRIP. Those funds are above the line in the grant section of the plan part of the receipts and are no longer carried below the line. Historically, DSRIP was projected at \$400 million per year over a five year period. Included in the current plan is a \$2 billion receipt net receipts of \$1.3 billion including the Interim Access Assurance Fund (IAAF) through 2020. Therefore, the totals are \$1.5 billion in receipts less \$250 million projected expenses. The second item is the MetroPlus enrollment projected to increase to 1 million enrollments by June 2020. Currently, MetroPlus membership totals 470,000 and the projected increase for that initiative is expected to increase business to HHC. It is HHC's expectations that these corrective actions are all achievable.

Mr. Page commented that the additional HHC and the state and federal actions are a significant amount and asked what was included in those numbers.

Mr. Covino stated that the current HHC actions of \$200 million for FY 15 includes revenue process transformation projected at \$72 million; \$75 million for the right-sizing of the staff based on workload initially projected at \$53 million but expect that half of that amount will be achieved. The state and federal actions are still in the planning and development stages.

Mr. Rosen stated that overall it is a good plan; however, as an observation, generally there are no corrective actions in the current FY which would not be needed but would be for the out years. In terms of how all financial plans are developed it is important for people to understand the assumptions that are reflected as part of that plan based on what HHC expects to transpire over the years.

Ms. Zurack stated that the goal was to imbed the vision going forward and also focus on some of the comments from the Committee that would be less technical and more strategic and focused on HHC's vision.

Mr. Page added that the FTE effort is more encompassing and focused on the issues.

**Medical & Professional Affairs / Information Technology Committee –
March 12, 2015 - As reported by Dr. Vincent Calamia**

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

HHC Accountable Care Organization (ACO) Updates

The HHC ACO Board of Directors recently endorsed a finalized distribution plan for shared savings generated by the ACO's strong 2013 Year 1 performance. For this first distribution, the portion of savings allotted to our ACO's primary care physicians will be spread evenly based on FTE. Going forward, the ACO will continue to refine the incentive model as part of a broader savings reinvestment plan to advance the population health goals of HHC and the HHC ACO.

As part of a strategic planning process conducted by the ACO in the Fall of 2014, eight domains of strategic priority were identified: Population Management, Network Development, Financial Sustainability, Rewarding Excellence, Advanced Leveraging of Data & Technology, HHC-Affiliate-Physician Alignment, National Policy & Thought Leadership, and Strong Governance. The ACO is now developing work plans for each domain, with a focus on Network Development and growth potential. ACO Quality Reporting for 2014 performance is nearly completed, involving HHC-wide mobilization of electronic and manual performance data in partnership with facility Quality Management teams, IT, and ACO leadership.

Office of Population Health

In coordination with the Chief Nursing Officer's office, nurse educators from every facility were trained on Patient-Centered Medical Home, in order to strengthen the role of the RN in this team based care model. HHC is renewing an Memorandum of Understanding with the NYC Department of Health and Mental Hygiene (NYC DOHMH) which would continue supporting some public health activities at HHC, including the point-of-care Nicotine Replacement Therapy distribution program and Treat-to-Target blood pressure program. HHC will be launching HHCYouthHealth.org at the end of this month, a website to promote the adolescent health services offered by HHC. To coincide with the launch of the website, there will be a community kick-off event, social media and press outreach, and promotion thru community-based organizations. Next month, HHC will be hosting a conference to explore on integration models for behavioral health services into primary care, for adolescents.

Care Management

As a culmination of NYS Hospital-Medical Home Demonstration Program reporting, each of our hospitals—in collaboration with their D&TCs—submitted a final report to the State in February that summarized and analyzed their participation in the two-year program. Our facilities described success in transforming care through the support of the Program, especially in improving the patient-centered medical home, expanding and enhancing residency training opportunities, improving access to ambulatory care, integrating depression management in primary care, and improving quality and safety in select inpatient initiatives. On March 3rd, 2015, the NYS Office of Mental Health conducted a site visit to Bellevue Hospital Center to examine our Care Plan Management System (CPMS). CPMS successfully met the registry requirements for our facilities which have been approved for participation in the NYS Medicaid Collaborative Care for Depression Program. Dr. Dave Chokshi, AVP for Care Management in M&PA, served as an investigator in a recently-published study entitled, "Convenient Care: Retail Clinics and Urgent Care Centers in New York State." The study examined proliferation of convenient care nationally, the distribution of these providers in New York State, and their potential impact on two special populations—the medically underserved and children. The study was sponsored by the United Hospital Fund and is available at: <https://www.uhfnyc.org/publications/881033>.

Laboratory Services

General

System-wide effort continues as the HHC laboratories work together to plan for the implementation of a standardized Cerner laboratory computer system for HHC laboratories. Focus has been to verify the appropriateness of the future HHC Rapid lab test menu. Efforts are now underway to standardize the Anatomic Pathology and Microbiology test menus, equipment and related processes.

NorthShore-LIJ (NSLIJ) Reference Testing

Management oversight continues both by NSLIJ and HHC laboratory leadership to ensure that expected levels of service and financial performance are met. Results are reviewed monthly at a corporate and facility level. Planning is underway to coordinate the review of quality metrics during the HHC Chief of Pathology/Laboratory Directors Council meeting.

Equipment

Critical laboratory equipment replacement is in progress. Chemistry, hematology and POC middleware software is undergoing user evaluation which includes assessments by the vendors as well as site visits by HHC staff. Included in the process is participation by all HHC laboratories to ensure we are working towards equipment standardization during the replacement process. Project planning is underway for implementation of 4th generation (increased sensitivity and specificity) HIV testing at four (4) HHC laboratories. A 90 day implementation plan is currently in development for the four facilities. There will be a possible joint presentation at another MPA/IT meeting with Lab and IT.

Office of Patient Center Care

Some of the presentations scheduled in the next few weeks:

April 7 - presenting regarding Lessons learned during Hurricane Sandy at the Healthcare Organizations Emergency Preparedness Seminar in Virginia; April 8 - presenting on the HHC Ebola experience at the MedAssets National Client Conference in Las Vegas, NV; and May 4 - presenting at the GHX national conference regarding Nursing and Procurement partnering during Ebola

Office of Emergency Management

NYC HHC continues to collaborate with FDNY on EVD preparedness. To that end, we've conducted facility familiarization walkthroughs at our 11 acute care facilities during which FDNY EMS and Hazardous Materials leadership meet with Central Office and facility leadership to prepare for the unlikely event of a patient with a fever and travel history to one of the affected West African countries who is in extremis and requires transportation to a 911-receiving facility. From there the groups are conducting

tabletop exercises to discuss the clinical and operational elements of such a response. It is important to note that to see, there have been so such critically ill fever and travel history patients transported by FDNY EMS and that every effort would be made to transport such patients to a designated treatment facility such as Bellevue.

The HHC Emergency Management Council continues to bring external partners to each month's meeting. In January, NYPD's Counter-terrorism Bureau offered an overview of the current international, national and local threats. In February, NYC DOHMH Emergency Preparedness leadership provided the group with their current priorities and in March, NYC Emergency Management will give us their insights into their Health and Medical Group. Future invitees include NYSDOH, FEMA Region 2, UCLA Emergency Management and Denver Health Authority's Health and Safety group.

IMSAL

On March 10, 2015, in the Critical Care and Trauma Unit (CCT) of the King's County Hospital Center (KCHC) Emergency Department (ED) the first "In-situ simulation", a team-based training technique conducted in patient care units, commenced. This research is collaboration between HHC's Simulation program, the Institute for Medical Simulation and Advanced learning (IMSAL), and KCHC ED. In-situ simulation is a novel training tool with potential to improve teamwork and clinical outcomes.

In preparation for this initiative, all members of the healthcare team including Ward Clerks in the unit have undergone simulation training in the simulation center environment and structured training in teamwork and communication using TeamSTEPPS-based training.

The objectives of the study are to assess the effect of the proposed intervention, an additional program of regular in situ simulations and debriefings, on:

- a) Teamwork and communication skills occurring in the unit.
- b) Staff satisfaction in the unit.
- c) Selected indicators of clinical care (stroke and sepsis) occurring in the unit.

The target population for the intervention is teams of emergency medicine physicians (attending and resident), nurses, patient care associates, patient care technicians and clerical staff.

The project intervention will include implementation of regular, brief simulations, occurring at least twice per week, conducted over a 6 month intervention period. Each simulation will be followed by a 10 minute debriefing session. Debriefings will be conducted by a simulation faculty member, trained in debriefing using the techniques of 'debriefing with good judgment' and 'advocacy and inquiry' to explore frames pertaining to teamwork, communication, and clinical performance. Cases will be designed to require teamwork and communication and will include cases of sepsis and stroke.

Several trained observers have observed 30 actual patient presentations pre-intervention and will observe 30 more post intervention. Group teamwork and communication skills were assessed using a Emergency room team performance tool. The tool has been previously validated and the same tool will be used for the post intervention. Items evaluated include; team structure, leadership, situation monitoring, mutual support and communication. The tool uses a Likert scale (1-5) for rating of each component. Overall scores will be calculated as a mean of individual item scores. Staff satisfaction will be measured using a staff satisfaction questionnaire which has been administered to unit staff during pre-intervention time and will be administered following the intervention.

DSRIP Update

The HHC-led Performing Provider System (PPS; now known as OneCity Health) continues its preparation for implementation of Delivery System Reform Incentive Payment (DSRIP) Program projects and programs.

Because our DSRIP success depends significantly on partners who share our patients, we continue in our collaborations with partners and other PPSs in order to develop simple, unified protocols for each of our projects. We have launched project implementation planning to develop a standardized approach across our four PPS hubs, and are using the input of HHC and partner clinical and operational experts to help define clinical guidelines and workflows. In April, we expect to begin local planning, which will include HHC facilities and local partners who will work together to design the projects in a way that is patient-centered and feasible.

For DSRIP Program valuation, we expect to learn our potential 5-year award in late March, and while no firm date is yet known, the NYS DOH estimates the first payment will be distributed in mid-April. It is important to remember that to earn the full potential award amount, our PPS must satisfy reporting and performance requirements as set forth by NYS DOH.

Additional to DSRIP funds, NYS made \$1.2B available statewide for PPSs to implement capital projects intended to enable and help sustain DSRIP transformation. On February 20, OneCity Health (the HHC-led PPS) submitted capital applications totaling \$760M, representing asks from HHC and all partners. HHC's portion of that total request was approximately \$435M, divided nearly equally between facility-based projects intended to further our access, care coordination, and primary care and behavioral health integration efforts; and IT-focused projects intended to provide connectivity and a population-health focused platform for HHC and its partners. We will be able to do modifications to the State capital application submission. State requirements can't make modification.

MetroPlus Health Plan, Inc.

Arnold Saperstein, MD Executive Director, MetroPlus Health Plan Inc. Presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of February 1, 2015 was 466,261. Breakdown of plan enrollment by line of business is as follows:

Medicaid	409,748
Child Health Plus	12,078
Family Health Plus	7
MetroPlus Gold	3,420
Partnership in Care (HIV/SNP)	4,836
Medicare	8,599
MLTC	824
QHP	26,001
SHOP	736
FIDA	12

Despite open enrollment being almost two months shorter, with much less publicity for this period, Metro Plus marketing staff submitted approximately the same number of applications for health insurance this year when compared to last, approximately 32,000. Two thirds of these applicants were for Medicaid and one third qualify for QHP. Further while most of these are MetroPlus applications, our staff is required to submit applications for those who choose other plans.

I would like to inform this committee of a few new regulations from the New York State of Health.

First, the Open Enrollment period was extended to February 28th, 2015, for the persons who were unable to complete the enrollment process before the February 15th deadline. Plan facilitated enrollers are allowed to complete the applications via telephone. Effective date for the individuals enrolling during this extended period will be April 1, 2015.

Second, New York State of Health announced a Special Enrollment period (SEP) for individuals and families who had to pay a federal penalty for 2014 and had not been aware of or understood that they would have to pay a penalty for not having health insurance coverage. The SEP will start on March 1st and end on April 30th, 2015. Consumers who do not enroll during this period and do not meet the criteria for other SEPs will not be able to purchase coverage for the remainder of 2015 and may be subject to a federal tax penalty when they file their 2015 federal income taxes.

The State also proposed to include in the NYSOH application language emphasizing the importance of selecting a PCP for Medicaid Managed Care (MMC) and Child Health Plus (CHP) with a hyperlink to the plan's provider network page. PCP selection would not be possible at the time of application, but would be prompted once the member is enrolled and becomes active.

In addition, the Affordable Care Act calls for a new product called the Basic Health Plan (BHP). This new line of business is applicable only to the Aliessa population starting in April 2015 (the Aliessa decision made the full range of New York's Medicaid program available to all lawfully present legal immigrants) and it provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from zero to 200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage. States operating a BHP enter into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he/she were to receive coverage from a QHP through the marketplace. A state that operates a BHP will receive federal funding equal to 95% of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals.

Enrollment in BHP will be open all year. Applications for BHP coverage in 2016 will be processed starting October 1, 2015. Federal regulations require that BHP enrollees have a choice of insurance plan in each county of the state. Applicants will have the ability to choose to participate in the commercial QHP Individual market, Small Business Market, or the BHP, or any combination. The Aliessa population will have additional benefits for non-emergency transportation, non-prescription drugs, orthotic devices, orthopedic footwear, and vision care. Adult benefits will be available to BHP as follows: immigrants at or below 138% who previously qualified for Medicaid will receive additional dental benefits through BHP, and all other enrollees will be able to purchase stand-alone dental plans.

Starting July 1, 2015, plans will be expected to contract for urgent and routine primary care with School Based Health Center (SBHC) sponsoring entities. SBHC sponsors will have to contract with the Plan's oral health and behavioral health vendors in addition to the Plan. Reproductive Health Services would remain carved out of the SBHC. Providers will bill fee-for-service if the primary visit is for reproductive health.

Regarding transgender related benefits and care, the Department of Health is proposing the following new services: cross-sex hormone therapy and surgical gender reassignment, including post-transition care. These benefits apply to the Medicaid population, while approval for the CHP population is pending.

Information Items:

Eileen O'Donnell, Assistant Vice President Enterprise of Enterprise Information Technology, presented to the Epic Implementation to the Committee.

The objectives are to demonstrate to clinical workgroup members, through a series of scenarios, major workflows that span multiple clinical settings; to provide clinical workgroup members with a final opportunity; and to provide comments on system design after build completion and before moving on to testing.

Only Subject Matter Experts (SMEs) who have been involved with clinical workgroups are invited to attend. Sessions are tentatively scheduled for May-June, 2015. Sessions will take place at the acute care hospital of each network and Health & Home Care Manhattan office to accommodate and minimize the disruption of SMEs' schedules. Representatives from each application team will be stationed outside of the sessions to document comments from the attendees about the demonstrated workflows. Comments will be categorized: Patient Safety, Regulatory Requirements, Workflow-Critical, Future State, Nice-To-Have and triaged accordingly. A sample Scenario was given and the preliminary schedule was provided.

Next Steps will be to finalize locations, dates and times by late March. Send out invitations to workgroup members by early April. Finalize presentations and workflows by mid-April. Conduct dress rehearsals by late April. Testing to start late summer, tool has to support team - nurses must be involved, this should not be restricted to subject matter experts only and there should be pre-presentation.

Strategic Planning Committee – March 10, 2015 **As reported by Josephine Bolus, RN**

Senior Vice President Remarks

FEDERAL UPDATE

Ms. LaRay Brown reported on the following key issues:

Ebola Funding

Ms. Brown reported that, on February 20, 2015, HHS had announced that New York City (NYC) would be awarded \$21.7 million for Ebola related expenses. New York State was awarded \$7.5 million in HHS funding. The NYC funding would include reimbursement for the costs that Bellevue Hospital incurred for treating the one Ebola patient. With the support of Senator Schumer, HHC is seeking funding for Bellevue's designation by the U.S. Department of Health and Human Services (HHS) as the Region II Ebola and Other Special Pathogen Treatment Center. Ms. Brown added that this designation will require that Bellevue accept all patients within HHS Region II for any treatment related to infectious diseases. This designation requires specific levels of personnel and non-personnel readiness. Support from HHS in the amount of \$3 million per year would be required. Ms. Brown informed the Committee that HHC's Washington staff is working with Senator Schumer's office and the HHS Office of the Assistant Secretary for Preparedness and Response on this critical issue. Ms. Brown commented that HHC was very grateful for the Mayor's support on this issue.

Sustainable Growth Rate

Ms. Brown reported that the Sustainable Growth Rate (SGR) - otherwise known as the “Doc Fix” deadline is March 31, 2015. She explained that this is the rate that Medicare uses to reimburse physicians for medical procedures. Without the fix, Medicare physician payments will fall by 21% in 2015. A one year fix would cost about \$16 billion. Ms. Brown informed the Committee that, in 1997, Congress had crafted the SGR formula, which tied Medicare payment rates for doctors to the projected growth of the national economy. She explained that healthcare spending had quickly outpaced economic growth, opening a multibillion-dollar gap in funding for Medicare payments to physicians. Lawmakers had placed the first temporary patch on the SGR in 2003, and the quest for a permanent Medicare “doc fix” has become an annual ritual ever since.

Ms. Brown reported that Congress had passed 17 temporary “patches” over these years. The latest SGR patch which Congress adopted last winter after failing to agree on financing a bipartisan SGR repeal-and-replacement deal, at a cost of \$128 billion, is set to expire on March 31, 2015. Congress is wrestling with how to pay for the SGR. Options explored often spell trouble for safety net hospitals as “pay-fors” often target public hospitals that treat the most vulnerable populations.

Ms. Brown stated that a long-term fix would cost approximately \$170 billion, a 9-month patch would cost approximately \$12 billion and a 6-month patch would cost approximately \$8-9 billion. Ms. Brown stated that there was strong reason to fear that any patch or long term solution would target Hospital Outpatient Department (HOPD) Medicare Evaluation and Management (E/M) Services, which could cost HHC \$186 million over 10 years or about \$18 million yearly. Ms. Brown informed the Committee that other options that have been raised to pay for the SGR fix have also included restructuring GME/IME and pushing Medicaid DSH further into the out-years.

Supreme Court Hearing Regarding ACA Subsidies

Ms. Brown reported that last week, the Supreme Court of the United States had heard arguments in *King vs. Burwell* in which plaintiffs challenge the Obama Administration regarding the Affordable Care Act (ACA). Ms. Brown stated that the question before the court is whether the language of the ACA limits health care subsidies to enrollees who reside in states that have established their own health care exchanges. The plaintiffs argue that the “plain language” of the ACA states that subsidies are only available in states that have exchanges that are “established by the state.” Ms. Brown reported that as many as 7.5 million persons could lose their health care subsidies if the plaintiffs prevail.

Ms. Brown informed the Committee that thirty-four (34) states have not established their own exchanges with enrollees in these states using the Federal Exchange that is accessible through the website healthcare.gov. She added that, while this case can greatly cripple the ACA, some Republicans realize that they need to have a “Plan B” in case the court rules that these subsidies are beyond the scope of the ACA. Ms. Brown added that lower courts were divided on the issue. Ms. Brown promised to keep this Committee apprised on this issue going forward.

Mr. Rosen, Board Member, asked when the *King vs. Burwell* case would be argued. Ms. Brown responded that arguments concerning this case started last week. President Raju added that a decision would be made by the Supreme Court by the end of June.

Federal District Court Blocks President Obama’s Immigration Actions

Ms. Brown reported that following President Obama’s Immigration Policy announcement in November 2014, twenty-six (26) states across the country had filed a lawsuit in a Texas Federal District Court to try to keep the changes from going into effect. Ms. Brown stated that the Texas federal district court had decided that the initiatives announced by President Obama, known as expanded Deferred Action for Childhood Arrivals (DACA+) and Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) would be temporarily blocked from going forward. Ms. Brown added that the court had based its decision on an argument that the federal government did not comply with rulemaking procedures under federal law.

Ms. Brown informed the Committee that the court indicated that the strongest argument that the states filing the suit had presented related to the costs that the State of Texas would incur to provide driver’s licenses to recipients of expanded DACA and DAPA. Missing from the court’s analysis are the benefits to the state economy that providing DACA and DAPA to currently undocumented individuals would provide, including increased state income and property tax revenues.

Ms. Brown reported that the first phase of President Obama’s executive initiatives which would affect undocumented immigrants who came to the United States as children was scheduled to be implemented beginning on February 18, 2015. In addition, applications for the Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA) initiative are scheduled to go into effect in May.

Ms. Brown stated that many state and local officials have filed amicus briefs in district courts that highlight the benefit that the immigration initiatives will bring to communities and the economy. Twelve states, the District of Columbia, 33 cities, 27 police chiefs, along with nonprofit organizations have filed briefs with the court emphasizing the benefits of the Obama Administration's immigration initiatives. In addition, a request by the Justice Department for an emergency order to allow the Federal Government to issue work permits and provide legal protections to hundreds of thousands of undocumented immigrants, while it appeals the Judge's ruling to halt the programs to a Federal Appeals Court, had been rejected by the District Court. Ms. Brown's stated that she would keep the Committee apprised of new developments concerning this case.

STATE UPDATE

Budget Update

Key Issues Important to HHC

Ms. Brown reported that, on March 9, 2015, each house had introduced their budget proposals. These proposals are the starting point for a series of budget negotiations. Ms. Brown stated that, based on the Consensus Revenue forecast agreed-upon last week, the Legislative proposals would contain \$200 million in additional revenue above and beyond what was included in the Governor's Executive Budget. HHC staff is currently analyzing the Governor's proposals as well as the two spending bills that were introduced yesterday by each house.

Ms. Brown reported that, while there are many specific budget issues that would impact HHC, some of the key issues that HHC was focusing on are the following:

- Medicaid funding increased by 3.6% from \$58.752 billion to \$62.046 billion
- Global Cap on Medicaid funding
- Savings Allocation Plan
- Global Cap "dividend"
- Basic Health Plan
- Medicaid for new immigrants
- HHC Upper Payment Limit (UPL)
- Charity Care funding
- Capital Restructuring Financing Program -\$700 million targeted to Brooklyn
- Vital Access Provider Funding (Important to all safety nets including HHC)
- Hospital Quality Pool
- Value Based Payments
- Other Policy Changes

Ms. Brown reported that she and Dr. Raju visited Albany last week to meet with the Health Committee Chairs and other key legislators and focused most of their attention on two issues – HHC's Upper Payment Limit and the distribution of Charity Care funding. Ms. Brown stated that overall it was a very successful trip. They were asked to propose charity care language for inclusion in the Senate and Assembly Budget proposals. Ms. Brown added that HHC got very positive responses from most downstate legislators. Ms. Brown added that they also discussed the importance of Upper Payment Limit (UPL) and that language remains in the Assembly and the Senate budgets.

Behavioral Health Rates in Managed Care

Ms. Brown informed the Committee that, although it is not currently a budget issue, they spoke to legislators about the proposed premiums for Behavioral Health Services in managed care. Ms. Brown reminded the Committee that she had raised this emerging issue last month. Ms. Brown reiterated that the premiums that the State is providing for Medicaid patients who are transitioning from fee-for-service into managed care are too low because the State is basing those premiums on Medicaid fee-for-service rates, which have historically underfunded/not funded the cost of behavioral health care. The current underfunding is approximately \$120 million.

Update on State Legislative Actions

Ms. Brown stated that, although Albany is focused on the State Budget, there were state legislative actions that were of importance to HHC. Ms. Brown stated that the perennial introduction of language in the budget season usually surfaces around nurse staffing ratios, medical malpractice and HHC-specific legislation. Ms. Brown informed the Committee that Senator Lanza has put forward a bill that would require HHC to financially support hospitals on Staten Island. This bill was reported out of the Senate Cities Committee and is now poised to pass the Senate. Ms. Brown stated that, although Assemblyman Cuisack had introduced the bills in the Assembly, no action was expected on it in that house. Ms. Brown informed the Committee that her

staff would continue to monitor these bills as well as other emerging issues that could affect HHC. Ms. Brown shared with the Committee that recently a letter was written to the Brooklyn Delegation and to the Mayor requesting support for the emergency rooms for the Staten Island hospitals.

CITY UPDATE

Ms. Brown reported that nearly all the Community Advisory Boards have hosted legislative forums. Ms. Brown explained that Legislative Breakfasts are important events that HHC Community Advisory Boards (CABs) hold each year to highlight new initiatives and to educate elected officials and their community about key legislative and budgetary issues. Over the last month, Ms. Brown and Mr. John Jurenko have been presenting at these forums, most recently at Bellevue and Coney Island Hospitals on March 6th. Ms. Brown stated that there was a very good turnout of local, state and federal elected officials and their representatives. Ms. Brown added that Mrs. Bolus had attended many of them and had spoken at some and exhorted community members in those forums to continue to be active in a civic way and to bring their message to their legislators. Ms. Brown reiterated that these forums have been very well attended and folks have been very engaged.

Ms. Brown announced that HHC was expected to provide testimony at the NYC Council Health Committee's March 23rd Preliminary Budget Hearing. She informed the Committee that each year, facilities ask their Council Members and their Borough Presidents for capital funding. IGR coordinates these requests and works with Council Finance and key staff on maximizing these requests. In addition, IGR staff continues to work with facilities on capital requests that they make to the City Council and Borough Presidents.

Information Item:

Mayor's Management Report - Dona Green, Senior Assistant Vice President, Corporate Planning Services

Ms. Brown stated that, for many years, the Mayor's Management Report (MMR) had included an insert from HHC. She commented that, while each Mayor wanted to put their own highlights into the MMR, oftentimes, the Mayor's Office of Operations' staff work with city agencies to produce this report. Ms. Brown informed the Committee that it was important for the Strategic Planning Committee to present an overview of that report and educate Board Members about what story the MMR entails. In addition, since the report is made public, the Board Members will be able to see the report and understand the type and the meaning of the data collected within HHC.

Ms. Dona Green, Senior Assistant Vice President of Corporate Planning Services greeted Committee members and invited guests and thanked them for the opportunity to present The Mayor's Management Report (MMR).

Ms. Green began her presentation with an overview of the MMR. She explained that the MMR served as a public report card on City services affecting New Yorkers since 1997. It was mandated by the New York City Council. She added that the final reports are submitted twice a year to the New York City Council for its review and are available online at <http://www.nyc.gov/html/ops/html/data/mmr.shtml>.

Ms. Brown reported on the report specifics. She stated that the preliminary reports covered the first four (4) months of the current fiscal year (July-October) and had to be submitted no later than January 30th of the current fiscal year to the City Council. The full fiscal year report covers the full fiscal year (July-June) and is submitted no later than September 30th of the subsequent fiscal year to the City Council. Ms. Green informed the Committee that Corporate Planning Services captures data from various Central Office divisions and enters data on the NYC Performance Management Application web site.

Ms. Green reported that HHC reported on 15 indicators which are categorized into the following four areas:

1. **Goal 1a:** Improve access to outpatient services – reducing costly and unnecessary emergency department use and making sure that their illnesses can be managed before they progress to acute stages.
2. **Goal 1b:** Expand enrollment in insurance programs – reduce the number of patients that delay care and reduce the number of uninsured patients using our services
3. **Goal 1c:** Achieve/surpass local and national performance standards for specific health interventions and efficient delivery of health services – quality and making sure that provided services are appropriate for the patients
4. **Goal 1d:** Reduce unnecessary emergency room visits and re-hospitalizations – care coordination and management

Ms. Green reported that, as a public report card, the use of the MMR was consistent with a management tool known as a **balanced scorecard**. She explained that, in a balanced scorecard, a set of measures, aligned with the organization's goals and mission, provides the organization with a fast and yet comprehensive perspective on its performance. In addition, it also provides a feedback loop to enable improvement and the development of strategies to initiate change.

Ms. Green reported that HHC’s immediate initiative is to make sure that the MMR is aligned with HHC’s strategic priorities. Ms. Green cited HHC’s strategic priorities listed on the right side of the table below and showed how they were aligned with the Mayor’s Management Report Indicators on the left.

Mayor’s Management Report Indicators (MMR)	HHC’s Strategic Priorities
<ul style="list-style-type: none"> • Prenatal care patients retained in care through delivery • MetroPlus Medicaid, Child Health Plus and Family Health Plus enrollees • Total Medicaid Managed Care, Child Health Plus and Family Health Plus enrollees 	Grow market share
<ul style="list-style-type: none"> • % ER revisits by adult asthma patients • % ER revisits by pediatric asthma patients • Adult psychiatric patients 30 day readmission rate • HIV patients retained in care • Clinic cycle time (Adult, Pediatrics and Women’s Health): Non-clinical patient time (minutes) • Mammography screening • Percent of two-year olds immunized 	Expand access to care: Right service; right place; right time
<ul style="list-style-type: none"> • Total Uninsured patients served (Expand enrollment in insurance programs) • Days in accounts receivable (net) • General Care ALOS 	Stabilize HHC’s Financial Health
n/a	Focus on Workforce Development

Ms. Green explained that one of HHC’s immediate strategic priorities related to the Delivery System Reform Incentive Payment (DSRIP) and its link to the MMR. She reminded the Committee that the DSRIP Program is a healthcare reform initiative aimed at reducing unnecessary emergency room utilization; reducing unnecessary hospitalizations for conditions treatable in primary care settings; improving the healthcare experience through the coordination of healthcare providers across the continuum; and increasing primary care access. She stated that many of the MMR indicators aligned with DSRIP goals.

Ms. Green reported on the alignment of MMR with DSRIP as outlined on the chart below:

Mayor’s Management Report Indicators (MMR)	DSRIP Goals
<ul style="list-style-type: none"> • Total uninsured patients served (Expand enrollment in insurance programs) • Prenatal care patients retained in care through delivery • MetroPlus Medicaid, Child Health Plus and Family Health Plus enrollees • Total Medicaid Managed Care, Child Health Plus and Family Health Plus enrollees • Mammography screening • Percent of two-year olds immunized 	Increase primary care access
<ul style="list-style-type: none"> • % ER revisits by adult asthma patients • % ER revisits by pediatric asthma patients • HIV patients retained in care 	Reduce unnecessary emergency room utilization
<ul style="list-style-type: none"> • Adult psychiatric patients 30 day readmission rate • HIV patients retained in care 	Reduce unnecessary hospitalizations

Mayor's Management Report Indicators (MMR)	DSRIP Goals
<ul style="list-style-type: none"> General Care ALOS Clinic cycle time (Adult, Pediatrics and Women's Health): Non-clinical patient time (minutes) Mammography screening Percent of two-year olds immunized 	Improve the healthcare experience
<ul style="list-style-type: none"> Days in accounts receivable (net) 	N/A

Ms. Green reported on a summary of current indicators for **Goal 1a: Improve Access to Outpatient Services**. She informed the Committee that there are five indicators as listed in the first column of the chart below:

Indicator Name	Owner	Data availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparables
Prenatal patients retained in care through delivery (%)	CPS	Quarterly & annually	88.8%	90%	Up	Up	None
HIV patients retained in care (%)	CPS	Annually	86.8%	90%	Up	Up	69.8% NYS 2009
Cycle Time Adult (Min)	M&PA	Quarterly & annually	45	30	Down	Change in formula	30 IHI Goal
Cycle Time Pediatrics (Min)	M&PA	Quarterly & annually	43	30	Down	Change in formula	30 IHI Goal
Cycle Time Women's Health (Min)	M&PA	Quarterly & annually	44	30	Down	Change in formula	30 IHI Goal

Ms. Green explained that Owner referred to the HHC Division charged with providing performance data for that indicator. Ms. Green explained that "Data Availability" referred to the time frame for which the data is collected. For instance, data is collected quarterly and annually for all indicators with the exception of the "% of HIV patients retained in care" indicator. Data for that indicator is provided on an annual basis.

Ms. Green informed the Committee that Corporate Planning Services (CPS) is the owner for the "Prenatal Care" indicator. She explained that for this indicator, the numerator is the number of patients who delivered in an HHC facility and the denominator is the number of women with two or more prenatal visits in a quarter.

Ms. Green reported on another indicator owned by CPS, HIV-Retained in Care-Indicator. She explained that the numerator for that indicator is, of the number of patients in the denominator, those who had at least one visit in each half of the calendar year and the denominator the number of patients with an HIV visit. Ms. Green explained that this indicator is also a NYS HIV monitoring indicator. She highlighted that the data for this indicator is collected over a full 12 months because the definition of "retained in care" is an HIV patient who had at least one visit in the first six months of the calendar year and at least one visit in the last 6 months of the calendar year. Therefore, Ms. Green underscored that one could not run that indicator for only 4 months and adhere to the present definition. For that reason, N/A or non-applicable is noted in the columns titled, "4-month actual" on the Preliminary MMR Report. Mrs. Bolus recommended that Ms. Green should include this explanation as part of her presentation. Both Ms. Brown and Ms. Green agreed to include these explanations as a footnote.

Mr. Robert Nolan, Board Member, asked if 86.8% of the HIV patients have made the required two visits during the course of the year. Ms. Green responded affirmatively. Ms. Brown added that this was an indicator that these HIV patients are being retained in care. Mr. Rosen asked if "retained in care" means that these patients are coming to HHC's clinics. Ms. Brown answered that it

means that there are coming back to HHC's facilities to be treated for HIV. Mr. Nolan asked who came up with the requirement that the visit should be twice a year. Ms. Brown responded that the AIDS Institute of the New York State Department of Health (NYSDOH) had established that standard. She clarified that the visits were not twice a year but rather once in every half of the year. Again, Mrs. Bolus suggested to include these explanations in the PowerPoint document.

Ms. Green reported that the Cycle Time indicators for Adults, Pediatrics and Women's Health were owned by the Office of Medical and Professional Affairs (M&PA). Ms. Green explained that, in the past, the definition for Cycle Time was "time of registration to the time of discharge." Ms. Green explained that the recently adopted definition is "scheduled appointment time until time actually seen by provider." Ms. Green underlined that the target for this new definition is **30 minutes**. She informed the Committee that CPS will notify the MMR's staff regarding this new change in time for the full Fiscal Year 2015 Report. In addition, the indicator will be collected via Sorian. Ms. Green informed the Committee that, in the near future, the indicator will go back to full cycle time.

Mr. Nolan asked Ms. Green to clarify the meaning of "Cycle Time." Ms. Green explained that "Cycle Time" means the time that the patients come into the facility until the time that they leave or until the time they see a provider. Ms. Green remarked that the purpose of these indicators is to identify the patients' non-value added time during their appointments. Ms. Green added that, if patients are waiting an inordinate amount of time in the waiting room before seeing a provider, it gives you an opportunity to do some improvements on that. She clarified for Mr. Nolan that 45 minutes on the chart indicated that the patients waited 45 minutes before they could see a provider. She emphasized that the goal is to get it down to 30 minutes. Mrs. Bolus asked if the cycle time also included the registration of vital signs and all the other activities done in between. Ms. Green responded affirmatively. She reiterated that it is the time the patients come into the facility until they see a provider. Mr. Rosen asked how realistic is the goal of 30 minutes cycle time.

Ms. Brown answered that there is an expected standard from the Institute for Health Improvement (IHI) and others stating that with the help of certain systems and processes, people should be able to see their doctors in a half an hour of their presenting in a clinic or a doctor's office. Dr. Raju clarified for Mr. Rosen that it can be done. Dr. Raju underscored one of the major concerns is that some patients are not following their scheduled times. He mentioned that, with the notion of first come, first serve in mind, some show up well ahead of their time and end up waiting for a long time. Dr. Raju commented that, for this indicator to be successful, patients need to show up at their scheduled time. In addition, Dr. Raju stated that a large number of "no show" rates do not help the cycle indicators. He stated that there is a lot of work to be done to educate the providers as well as the patients.

Ms. Brown added that there has been a huge body of work several years ago and most recently the ambulatory care redesign project most recently under M&PA, Dr. Christina Jenkins, with consultants on improving access. There are certain systems that you have to put in place. For example, when the person comes in, the provider team should already know that the person is coming and that all lab results are already made ready for the patient. In addition, the team must show up on time so that when the patient comes in they are already there for them; patients do not have to wait and the visit itself is the most productive. Ms. Brown reiterated Dr. Raju's comments stating that, if the new patients coming in through the Affordable Care Act experience frustration and long waits, they are going to go elsewhere. As such, Ms. Brown stated that it would defeat HHC's goals to increase its market share, and its other goal to improve the patient's experience. Ms. Brown remarked that's why it is all connected and it is called the balanced score card. Mrs. Bolus commented that patients need to be educated because they tend to feel that they would be seen earlier if they come earlier. With this mentality, on-time patients become frustrated as they experience an excessive amount of wait time. Mrs. Bolus referred to some TV commercials advertising "no wait times" for their services.

Mr. Rosen summed that the point that Ms. Brown is making is to ensure that all the prep work that need to be done by members of the team, other than the physicians, are in place before the scheduled time of the patient. Ms. Brown added that improvements are needed from both the healthcare team's behavior and the patients' behavior.

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Ms. Green reported on the current indicators of **Goal 1b: Expand Enrollment and Insurance Programs** as presented on the chart below:

Indicator Name	Owner	Data Availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparables
Uninsured Patients Served	Finance	Annually	469,239	A target for this indicator will be set once there is sufficient data about the implementation of the NYS Healthcare Marketplace and its impact on HHC's uninsured population.			None
# of Medicaid Managed Care, Child Health Plus and Family Health Plus enrollees	Finance	Quarterly & annually	532,910	513,400	Up	Down	None
# of MetroPlus Medicaid, Child Health Plus and Family Health Plus enrollees	Finance	Quarterly & annually	411,385	446,932	Indicator Name	Down	None

Ms. Green reported that the “Uninsured Patients Served” indicator is owned by Finance. She noted that the most current number of uninsured patients is 469,239. A target has not been set for this indicator because there is a lot going on with the healthcare exchange and we want to look at that a little bit longer before establishing a target. There are no comparables. Ms. Green stated that the final two indicators: the # of Medicaid Managed Care, Child Health Plus and Family Health Plus and the # of MetroPlus Medicaid, Child Health Plus and Family Health Plus enrollees are both owned by Finance. Data captured quarterly and annually from managed care reports.

Ms. Green highlighted the chart below and reported on the current indicators for **Goal 1c: Achieve/Surpass Local and National Performance Standards for Specific Health Interventions and Efficient Delivery of Health Services.**

Indicator Name	Owner	Data Availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparables
% of two-year olds immunized (with 1 visit prior to 2 nd birthday)	M&PA	Annually	95%	98%	Up	Down	76.2 ^a
Mammography screening (women with a primary care visit at HHC within the past 2 years, aged 40-70)	IT	Quarterly & annually	74.9%	70%	Up	Down	81.1% target Healthy People 2020
General care avg LOS	Finance	Quarterly & annually	5.1	4.7	Down	Up	6.06 ^b

Indicator Name	Owner	Data Availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparables
Net days of revenue in A/R	Finance	Quarterly & annually	55.44	56	Down	Down	50.2 ^c

Ms. Green stated that the “% of Two –year olds immunized” indicator is owned by the Office of Medical and Professional Affairs (MPA) based on a three-month sample from the Board Report. She explained that with an achievement of 95% and a target of 98%, HHC is very far above the comparable of 76.2%.

Ms. Green stated that the Information Technology Department (IT) is the owner for the Mammography screening data. She noted that this indicator is collected quarterly and annually. She added that the numerator is the number of those patients in the denominator with a Mammogram in the past two years and the denominator is the number of those female patients age 40-70 on their last visit in Medicine or GYN during the reporting period. Ms. Green explained that, while the most recent achievement of 74.9% exceeded the target of 70%, it was still below the 81.1% target that was established by Healthy People 2020. Ms. Green explained that Healthy People 2020 is a national organization that does a lot of research in healthcare to look at what should be happening across the nation in terms of the goal of achieving a healthy population.

Mr. Nolan asked, of the 74.9% of women who do get mammography screenings, what is the percentage of the women from the Bronx. Ms. Green responded that the data was collected on a per facility basis and that she would provide Mr. Nolan with the data for the Bronx facilities.

Ms. Green reported on the “General Care Average LOS” indicator. She stated that Finance was the owner of this indicator and that the data was collected quarterly and annually. The most recent performance is 5.1 and the target was 4.7. While the desired direction is down, the recent performance was up. Ms. Green explained that the comparable NYS ALOS for 2011 was 6.06. Ms. Green stated that HHC had done a lot of work to reduce one day stays. By doing so, HHC has reduced those one-day stays that are bringing the length of stay down, which cause us to creep up. Ms. Green highlighted that that HHC’s performance is still below the state average.

Ms. Green reported on the “Net Days of Revenue in A/R”, an indicator owned by Finance. She explained that the most recent performance went down to 55.44 and the target is 56. She highlighted that the 50.2 comparable was taken from Standard & Poor (S&P) data and that HHC was moving towards it.

Ms. Green reported on the current indicators of **Goal Id: Reduce Unnecessary Emergency Room Visits and Re-hospitalizations**. See below:

Indicator Name	Owner	Data Availability	Most Recent Data	Target	Desired Direction	Recent Direction	Comparables
% of ER revisits for Adult Asthma patients	M&PA	Quarterly & annually	6.9%	5.0%	Down	Up	None
% of ER revisits for Pediatric Asthma patients	M&PA	Quarterly & annually	2.9%	3.2%	Down	Down	None
Adult psych 30 day readmission rate	M&PA	Quarterly & annually	7.4%	5.0%	Down	Up	21.6% Medicaid Pts ^a

Ms. Green stated that all three indicators were owned by the Office of Medical and Professional Affairs (M&PA) and that data were collected quarterly and annually. Ms. Green highlighted that the 6.9 % of ER revisits for adult Asthma patients must be reduced to achieve the target of 5.0%. She also stated that the % of ER revisits for pediatric Asthma patients decreased to 2.9% and exceeded the target of 3.2%. However, the adult psych 30-day readmission rate indicator needs to be improved because it exceeds the target of 5.0%. Ms. Green stated that the comparable performance for Medicaid patients is 21.6%.

Dr. Raju commented that this adult psych 30-day readmission rate indicator needs to be correlated with the length of stay as sometimes readmissions looks smaller and lengths of stay are higher. He explained that HHC’s performance is still good compared to the state. He stated that there is a need to bring down the length of stay for behavioral health patients even though that number has significantly gone down compared to the past. It is to be noted that HHC serve special needs patients that require longer lengths of stay. Mrs. Bolus asked why the comparable were Medicaid patients. Ms. Green responded that it is Medicaid patients only because it is the data that was available.

Ms. Green shared with the Committee an example of the Preliminary and the Full Fiscal Year 2014 HHC MMR as presented below:

Example – Preliminary Fiscal Year 2014-HHC MMR

Service 1: Provide medical, mental health and substance abuse services to New York City residents regardless of their ability to pay.

Goal 1a: Improve access to outpatient services.

Performance Indicators	Actual			Target		4-Month Actual	
	FY11	FY12	FY13	FY14	FY15	FY13	FY14
★ Prenatal patients retained in care through delivery (%)	86.4%	85.8%	83.0%	90.0%	90.0%	89.8%	84.2%
★ HIV patients retained in care (%)	87.4%	87.4%	84.3%	85.0%	85.0%	NA	NA
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Adult medicine	61.0	75.0	69.0	60.0	60.0	72.0	72.0
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Pediatric medicine	60.0	59.0	61.0	60.0	60.0	63.0	64.0
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Women's health	61.0	75.0	67.0	60.0	60.0	81.0	70.0

★ Critical Indicator "NA" - means Not Available in this report ◀ ▶ shows desired direction

Example-Full Fiscal Year 2014 HHC MMR

Goal 1a Improve access to outpatient services.

Performance Indicators	Actual					Target		Desired Direction	5yr Trend
	FY10	FY11	FY12	FY13	FY14	FY14	FY15		
★ Prenatal patients retained in care through delivery (%)	86.5%	86.4%	85.8%	83.0%	81.4%	90.0%	90.0%	Up	Neutral
★ HIV patients retained in care (%)	87.1%	87.4%	87.4%	84.3%	86.6%	85.0%	85.0%	Up	Neutral
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Adult medicine	59.0	61.0	75.0	69.0	77.0	60.0	60.0	Down	Up
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Pediatric medicine	58.0	60.0	59.0	61.0	60.0	60.0	60.0	Down	Neutral
★ Average time spent by patient for a primary care visit at hospitals and diagnostic and treatment centers (minutes) - Women's health	61.0	61.0	75.0	67.0	73.0	60.0	60.0	Down	Up

★ Critical Indicator "NA" - means Not Available in this report ◀ ▶ shows desired direction

Ms. Green informed the Committee that the MMR is available on line. She cautioned that the MMR is a very big report and that a couple of boxes can direct them to the HHC sections.

Ms. Green concluded her presentation by sharing with the Committee that Corporate Planning Services (CPS) worked with multiple divisions to capture the data for the MMR. She added that a majority of the MMR indicators are reported monthly or quarterly on the Citywide Performance Report (data is available to the public). In addition, any new indicator required 3-5 years of prior data in order to establish the foundation for patterns and projections. Ms. Green informed the Committee that moving forward, CPS would be monitoring the MMR metrics and work with senior leadership to ensure that the MMR will continue to be aligned with HHC's Guiding Principles and strategic priorities as presented below:



Committee member Robert Nolan, asked if there were any new indicators that were added or dropped during the transition from the Bloomberg to the DeBlasio Administration. Ms. Green answered that indicators may have been changed not dropped because they do or do not align with HHC's strategic priorities. She emphasized that indicators have not changed because the Administration has changed but that the indicators have to reflect the goals of the agency. Ms. Brown added that the body of work that was done to communicate HHC's goals and Dr. Raju's priorities and why we would propose to continue to have some, to modify others in terms of what the individual metrics were took place early on in the Administration and these indicators were accepted.

Mr. Nolan asked how flexible the Mayor's Office of Operations is. Ms. Brown answered that they are very reasonable but cautioned that they have rules. If HHC needs to make a change, HHC must show prior data for 5 years. In the event that you do not have an information system that collected the data, then, you do not have that five years prior data available.

Mrs. Bolus asked how to inform the public about HHC's goal to cut down the waiting time to 30 minutes. She asked what is being done to inform the public that these issues are being addressed. Ms. Brown stated that the HHC Insider has included featured stories on HHC's access work over the last couple of years. She assured Mrs. Bolus that this information has been shared with the CAB reports and all the facilities. In addition, Ms. Brown explained that, when the facilities have their annual public meetings, (separate and apart from their legislative forums), the leadership of the facilities talk about the initiatives they have worked on that year and, often time, as they are reporting out to the community, they share their goals in terms of access, waiting time and ER utilizations among many other issues. Ms. Brown commented that how often that information is shared, is facility specific or neighborhood specific but those are some ways in which folks are informed about the things that we are reporting. Ms. Brown underscored that some of this data is not just reported to the MMR, but is also reported at other venues and the facilities' leadership use that information to inform the public not only on what is being done at the facilities but also report on their achievements when they have their public meetings.

Mrs. Bolus commented that it is imperative for the public to be aware that HHC is working on the waiting time problem. She re-stated that the television commercials that promote "no waiting time" stay in people's minds. Committee member Anna Kril, commented that she has been showing up unannounced with patients at various HHC facilities and had been very impressed and proud of the facilities and the staff members try very hard to move the patients with their appointments. She added that she had also observed and admired their courtesy and consideration for the patients. She agreed that there are snafus everywhere but stated that she truly felt that overall the services at the facilities were better than the private hospitals.

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SUBSIDIARY BOARD REPORTS

HHC Accountable Care Organization (ACO) – February 25, 2015

As reported by Dr. Ramanathan Raju

Dr. Raju requested an update regarding the status of an ACO Director to be named by the New York University School of Medicine (“NYU”). Dr. Wilson stated that the Board previously passed a resolution to add an NYU Director, pending approval from the NYC Health & Hospitals Corporation (“HHC”) and the Centers for Medicare & Medicaid Services (“CMS”). Such approval has since been obtained and NYU designated Dr. Andrew Brotman as its representative.

NEW BUSINESS

The next agenda item was a report from Dr. Wilson, Chief Executive Officer of the ACO. Dr. Wilson discussed the performance payment earned by the ACO as a result of achieving savings in its first Medicare Shared Savings Program (“MSSP”) performance year. As discussed and agreed upon at the November 3rd Board meeting, a portion of the savings were to be distributed to primary care physicians through their affiliate employers, according to a formula based on CMS guidance and set forth in agreements between the ACO, HHC, and affiliates. The distribution amount would be weighted by the volume of ACO patients served. This model resulted in disparities across facilities and employers.

Distribution was delayed due to negotiations with Doctors Council, which resulted in a revised payment methodology for 2013. Rather than pay primary care physicians variable amounts, the new model provides for even distribution, prorated based on the individual physician’s full-time equivalent (“FTE”) status in 2013. Only physicians currently employed are eligible for a distribution. HHC agreed to pay its employed physicians the same amount that affiliate employed physicians would receive, with such funds to come from HHC’s savings share.

Dr. Wilson read a resolution authorizing the ACO to distribute savings according to the new model, and to amend the ACO agreements with HHC and affiliates. A motion was made and duly seconded to adopt the resolution identified as number two on the agenda:

Authorizing the CEO of the ACO to execute amendments to the ACO’s agreements with the New York City Health & Hospitals Corporation (“HHC”); and Coney Island Medical Practice Plan P.C.; Downtown Bronx Medical Associates P.C.; Harlem Medical Associates P.C.; Metropolitan Medical Practice Plan P.C.; Physician Affiliate Group of New York; Icahn School of Medicine at Mount Sinai, doing business as The Mount Sinai Services Queens Hospital Center; Mount Sinai Elmhurst Faculty Practice Group, doing business as Mount Sinai School of Medicine; and New York University School of Medicine (collectively the “Existing Non-Corporation Shared Savings Distributees”), related to the distribution of Medicare Shared Savings Program (“MSSP”) Performance Payments, as set forth in Exhibit A annexed hereto;

AND

Authorizing the CEO of the ACO to distribute the 2013 MSSP Performance Payment as described in Exhibit A annexed hereto, subject to agreement by the ACO, HHC and the Existing Non-Corporation Shared Savings Distributees.

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

MetroPlus Health Plan, Inc. – March 10, 2015

As reported by Mr. Bernard Rosen

Chairperson’s Remarks

Chair Rosen welcomed everyone to the MetroPlus Board of Directors meeting of March 10th, 2015. Mr. 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 one resolution presented at the meeting and Dr. Saperstein would present MetroPlus’ strategic plan.

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Executive Director's Report

Total plan enrollment as of February 1, 2015 was 466,261. Breakdown of plan enrollment by line of business is as follows:

Medicaid	409,748
Child Health Plus	12,078
Family Health Plus	7
MetroPlus Gold	3,420
Partnership in Care (HIV/SNP)	4,836
Medicare	8,599
MLTC	824
QHP	26,001
SHOP	736
FIDA	12

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

Despite open enrollment being almost two months shorter, with much less publicity for this period, Metro Plus marketing staff submitted approximately the same number of applications for health insurance this year when compared to last, approximately 32,000. Two thirds of these applicants were for Medicaid and one third qualify for QHP. Further while most of these are MetroPlus applications, our staff is required to submit applications for those who choose other plans.

I would like to inform this committee of a few new regulations from the New York State of Health.

First, the Open Enrollment period was extended to February 28th, 2015, for the persons who were unable to complete the enrollment process before the February 15th deadline. Plan facilitated enrollers are allowed to complete the applications via telephone. Effective date for the individuals enrolling during this extended period will be April 1, 2015.

Second, New York State of Health announced a Special Enrollment period (SEP) for individuals and families who had to pay a federal penalty for 2014 and had not been aware of or understood that they would have to pay a penalty for not having health insurance coverage. The SEP will start on March 1st and end on April 30th, 2015. Consumers who do not enroll during this period and do not meet the criteria for other SEPs will not be able to purchase coverage for the remainder of 2015 and may be subject to a federal tax penalty when they file their 2015 federal income taxes.

The State also proposed to include in the NYSOH application language emphasizing the importance of selecting a PCP for Medicaid Managed Care (MMC) and Child Health Plus (CHP) with a hyperlink to the plan's provider network page. PCP selection would not be possible at the time of application, but would be prompted once the member is enrolled and becomes active.

In addition, the Affordable Care Act calls for a new product called the Basic Health Plan (BHP). This new line of business is applicable only to the Aliessa population starting in April 2015 (the Aliessa decision made the full range of New York's Medicaid program available to all lawfully present legal immigrants) and it provides a new option for states to offer health coverage for individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from zero to 200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage is in lieu of Marketplace coverage. States operating a BHP enter into contracts to provide standard health plan coverage to eligible individuals. Eligible individuals in such a state could enroll in BHP coverage and would not have access to coverage through the Health Insurance Marketplace. The amount of the monthly premium and cost sharing charged to eligible individuals enrolled in a BHP may not exceed the amount of the monthly premium and cost sharing that an eligible individual would have paid if he/she were to receive coverage from a QHP through the marketplace. A state that operates a BHP will receive federal funding equal to 95% of the premium tax credit (PTC) and the cost-sharing reductions (CSR) that would have been provided to (or on behalf of) eligible individuals.

Enrollment in BHP will be open all year. Applications for BHP coverage in 2016 will be processed starting October 1, 2015. Federal regulations require that BHP enrollees have a choice of insurance plan in each county of the state. Applicants will have the ability to choose to participate in the commercial QHP Individual market, Small Business Market, or the BHP, or any combination. The Aliessa population will have additional benefits for non-emergency transportation, non-prescription drugs, orthotic devices, orthopedic footwear, and vision care. Adult benefits will be available to BHP as follows: immigrants at or below 138% who previously qualified for Medicaid will receive additional dental benefits through BHP, and all other enrollees will be able to purchase stand-alone dental plans.

Starting July 1, 2015, plans will be expected to contract for urgent and routine primary care with School Based Health Center (SBHC) sponsoring entities. SBHC sponsors will have to contract with the Plan's oral health and behavioral health vendors in addition to the Plan. Reproductive Health Services would remain carved out of the SBHC. Providers will bill fee-for-service if the primary visit is for reproductive health.

Regarding transgender related benefits and care, the Department of Health is proposing the following new services: cross-sex hormone therapy and surgical gender reassignment, including post-transition care. These benefits apply to the Medicaid population, while approval for the CHP population is pending.

After Dr. Saperstein's report, Mr. Martin stated that he thought it would be appropriate for the Board to discuss the 2015 Strategic Plan and how realistic it is and how MetroPlus plans to get to the numbers presented in the plan.

Information Item

Dr. Saperstein presented the Board with MetroPlus' 2015 Strategic Plan.

There was a discussion regarding the methods that the Plan will use to reach the membership targets of 520,000 members by the end of 2015 and one million members by the end of 2020. Dr. Jenkins asked that since these targets are so ambitious and there are so many methods to try, how the Plan will know what to try first and where to focus. Dr. Saperstein commented that the question was a very good one and that there has been so many different things implemented by the State that the Plan is being pulled in many directions. Dr. Saperstein stated that the Plan will do its best to meet all the new requirements and its top priority will be to grow membership while staying fiscally sound.

Mr. Dan Still stated that it's true that a company that is in the insurance business has to grow but to keep in mind that MetroPlus did grow pretty fast for a number of years and the membership has leveled off partly due to market saturation. Mr. Still stated that the Plan was also able to maintain fiscal integrity and that has markedly benefited HHC. There was a brief discussion regarding MetroPlus' current network and access issues.

Mr. Lloyd Williams suggested that a separate Board meeting should be held to address in specific detail how the Board can assist in aiding MetroPlus to meet and surpass their strategic plan goals and come up with "out of the box" ideas. Mr. Martin stated that he would like to see a work plan on a monthly basis showing how the Plan is doing in relation to achieving its target goals. Dr. Jenkins stated that if this is something that will turn into a 5 year plan then it should be facilitated by someone not on the Board. Dr. Saperstein stated that Mr. Kelii Opoluho, MetroPlus' Director of Training and Organizational Development would be the perfect person to facilitate this plan.

Dr. Christina Jenkins suggested for the separate Board Meeting, that an outside expert facilitate the meeting.

Action Item

The resolution was introduced by Mr. Dan Still.

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") negotiate and execute a contract with Buck Consultants, LLC to provide actuarial and managed care consulting services for an amount not to exceed \$2.5 million per year for the first three years and \$2.75 million per year and for a 4th and 5th year option, respectively.

Mr. John Cuda explained to the Board the need for actuarial consultants are necessary to assist MetroPlus for the creation of financial bids for both Medicare and the New York State of Health Marketplace. In addition to the evaluation of financial risk due to on-going changes in its lines of business and the need to evaluate fiscal issues related to regulation and budget mandates for managed care plans.

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

Medical Director's Report

Update on FIDA

As of February 2015, the FIDA product lines has 13 Opt in members. Three (3) Opt in for January and ten (10) for February 2015. We are expecting an additional four (4) Opt in for the month of March and in April 2015 seventy (70) passive enrollees. The biggest challenge for FIDA Care Management is that providers do not want to take part in the Interdisciplinary Team (IDT) Meetings. MetroPlus has been utilizing **Doctor on Call** to serve as the provider's designee. Another great challenge is that it

takes the Care Manager about an hour to an hour and half to train each individual that will serve in the IDT Meeting for each member.

The reporting requirement for this product line is very heavy and challenging with a dashboard due biweekly on the following:

- IDT Meetings held
- Comprehensive Assessment completed
- Enrollment

We are also required to submit a monthly dashboard by various areas at MetroPlus in addition to the FIDA medical management reporting requirements.

Update: Behavioral Health Services

MetroPlus' delegation of all Behavioral Health (BH) and Substance Use Disorder services to Beacon Health Strategies began on January 1st when Beacon began managing the FIDA line of business. All other lines of business went live on February 1st. Beacon and MetroPlus held HHC specific Clinical Orientation Sessions in all four boroughs for all Psychiatric Directors, Assistant Directors, BH Central Office Staff and other staff delegated by the Psych Directors. Beacon also held ongoing web based trainings for their entire MetroPlus provider network. All training was completed prior to go-live. The Network was very prepared as evidenced by a day one census of over 200 acute care cases from all segments of the provider network. Currently Beacon manages close to 300 acute level cases daily. On the ambulatory level, approximately 100 non-par providers have asked for and received transitional care authorizations for membership in ongoing care. Call Center operations are currently well within targets for all service metrics. By all accounts this has been a very smooth transition for MetroPlus membership and providers.

Related to Beacon's contract with the HHC System; Beacon and HHC were unable to execute a contract prior to the go-live date. Consequently, MetroPlus holds the paper on which the contract is written and delegates the administrative services to Beacon. This relationship is expected to last for the first 90 days of delegation during which time HHC and Beacon will continue to strive for a fully executed contract.

MetroPlus is continuing ongoing meetings with State liaisons to help achieve all HARP readiness initiatives. Readiness review seminars and in-person meetings at the OMH Field Office take place every other week. Meetings at DOH-MH take place monthly. Meetings with HPA and Manatt take place sporadically. Internally, MetroPlus continues its work on the infrastructure to make both the carve-out to Beacon and the new HARP line of business fully operational.

MetroPlus' Behavioral Health Director serves as a member of the HHC/McKinsey BH Consultancy Steering Committee. He is participating as a liaison to the transformation team on all four pilot projects. He also participates on calls with the non-pilot sites to help with their preparation for future transformation projects.

Health Plan Accreditation

The Affordable Care Act requires every health plan participating in the Exchange to be accredited by an HHS-approved accrediting body by 2016. HHS has approved Utilization Review Accreditation Commission (URAC), National Committee for Quality Assurance (NCQA) and Accreditation Association for Ambulatory Health Care (AAAHC) as accrediting bodies for health plan participating in the Exchange.

We have decided to pursue URAC accreditation. URAC has accredited or in the process of accrediting 44 health plan around the country. URAC provides cutting-edge quality measures and data analytics capabilities that minimize the burden and cost of data reporting while providing a level of analysis not available in other accreditation programs, flexible design allows incorporation of state-specific standards and measures, collaborative educational approach helps guide health plans in achieving accreditation, provisional accreditation is available for new health plans, and pricing based on health plan size.

There is a five step accreditation process.

1. Review the URAC standards and then conduct a self-assessment process to compare our current operations with those required by URAC's standards.
2. Complete the application. URAC accreditation reviewers are available to answer questions about application process and interpretation of the standards.
3. Desktop Review of MetroPlus policies and procedures.
4. On-Site review
5. Committee review

It usually takes 4-6 months to complete the process of accreditation once URAC receives our application. The amount of time it will take for MetroPlus to prepare the application may vary, depending on whether we have the appropriate policies and procedures in place.

Quality Management

The Quality Management Department requests an exception to policy to enter into a sole source contract with Krames StayWell (KSW) for health brochure services. KSW was selected in June 2012 through a competitive RFP. They were selected based on understanding of work and soundness of approach; technical qualifications; vendor’s experience, client references; and cost of the proposal.

MetroPlus entered into an agreement with Krames StayWell on March 1, 2013 to provide health education brochure services for the MetroPlus Health Plan for one year (March 1, 2013 to February 28, 2014) with an option to renew for an additional year (March 1, 2014 to February 28, 2015) at the discretion of MetroPlus. The contract amount was not to exceed \$200,000.00 for the total term of the contract.

Krames StayWell developed the content and designed templates for the health education brochures which were approved by MetroPlus. Krames StayWell owns the content and MetroPlus needs to contract with them to gain access to the health education brochures. The brochures are available in English, Spanish, Haitian French Creole, Bengali and Urdu. The health brochures are branded with the MetroPlus Logo and are sent to our members. MetroPlus does not own the health education content. From March 1, 2013 through February 28, 2015, MetroPlus spent \$135,680.00 for 51,108 health brochures.

The specific brochures included in this fulfillment agreement are as follows:

- Managing Diabetes
- What is Diabetes
- High Blood Pressure
- Cold and Flu
- Healthy Eating
- Childhood Obesity
- Living with Asthma
- Family Planning
- Prenatal Care
- Domestic Violence
- Postpartum
- HIV/AIDS
- STDs (Sexually Transmitted Diseases)
- Lead Screening
- Vaccination Cards
- Things to Know about Depression
- Antidepressants
- Counseling
- Healthy Teeth
- Managing Depression
- Vaccination Card
- Colon Cancer
- Breast Cancer
- Cardiovascular Diseases
- Glaucoma
- Pap Test/Cervical Cancer
- Preventing Falls
- Smoking Cessation
- Vision Care
- Skin Cancer
- Substance Abuse
- Early Intervention
- Parenting: Early Years
- Parenting: Later Years
- Older Adults

KSW hosts a web portal on iStore website, specifically branded for MetroPlus to facilitate the ordering of health education brochures. The iStore website includes an order form that captures all necessary pertinent information required to fulfill the order and to generate any required reporting such as the number of health education brochures order in each category.

Fulfillment Fees are the same as the original contract. The Print-on-Demand rate is as follows:

Quantity Per Title	Cost Per Unit
25	\$ 1.75
50	\$ 1.07
100	\$ 0.74
150	\$ 0.63
200	\$ 0.57
250	\$ 0.54
300	\$ 0.52
400	\$ 0.49
500	\$ 0.47
600	\$ 0.46
700-899	\$ 0.45
900+	\$ 0.44

The not-to-exceed amount per year for this contract will be \$75,000.

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

RAMANATHAN RAJU, MD
HHC PRESIDENT AND CHIEF EXECUTIVE OFFICER
REPORT TO THE BOARD OF DIRECTORS
MARCH 26, 2015

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

ROMA TORRE - PUBLIC CHAMPION OF COLON CANCER AWARENESS

Today I am delighted that we are joined by New York 1 news anchor Roma Torre. She's been the face of NY 1 for 23 years. Last year, Roma underwent a routine colonoscopy screening and was diagnosed with colon cancer. Now cancer-free, Roma and NY 1 have joined forces with the Health and Hospitals Corporation and members of the Citywide Colon Cancer Control Coalition (C5) to promote colon cancer awareness, an effort the Health and Hospital Corporation has spearheaded for over a decade.

Roma has publicly shared her colon cancer diagnosis, surgery, and recovery in a compelling public service announcement. NY 1 has also been airing a series of very moving personal video journals Roma filmed during her treatment.

I wanted to take just a few moments today to watch Roma's important public service announcement, which promotes the benefits of colon cancer screening, prevention and early detection. [Show the video]

Please join me to thank Roma and NY1 for unwavering support of an issue that means so much to the patients we serve. We are happy to present her with these small tokens of our appreciation.

DSRIP UPDATE

Capital requests from our PPS, OneCity Health, totaling \$742 million were submitted to the State on February 20. Funding will be available sometime in June, at the earliest.

OneCity Health is producing clinical guidelines that will guide DSRIP projects. Our implementation plan, which helps define milestones toward our goals, will be submitted to the state Health Department on April 1. We look forward to launching hub-based planning in April.

As part of engaging our partners on cultural competence, we had a very helpful interactive partner webinar on February 27th.

FEDERAL UPDATE

Sustainable Growth Rate (SGR) Advances

The House of Representatives has passed legislation to permanently replace the Medicare physician sustainable growth rate (SGR) formula, which if not fixed before March 31st, would result in a 21 percent cut in Medicare payments to doctors. The legislation also includes language which would extend the Children's Health Insurance Program for two years.

The House legislation also includes changes to the current schedule and amount of Disproportionate Share Hospital (DSH) cuts. Current law has DSH cuts starting in FFY 2017 and extending through FFY 2024. The House legislation would postpone the initiation of the DSH cuts

until FFY 2018 and extend the DSH cuts through FFY 2025 with more aggressive reductions in funding over the last three years, than what is in current law.

As a result of advocacy by the hospital community, the House bill did not include language concerning: reductions to Hospital Outpatient Department (HOPD) payments, cuts to Indirect Medical Education (IME), or immediate implementation of the Medicare Two-Midnight Rule. Proposals for site-neutral HOPD payments would have resulted in cuts to HHC of \$19 to \$23 million per year. Proposals for a 10 percent reduction in IME payments would have cost HHC \$10 million per year. The House bill delays implementation of the Medicare Two-Midnight Rule until FFY 2016. Implementation of this rule would have cost HHC an estimated \$23 to \$38 million in Medicare revenue each year.

HHC Pushes CMS for ACO Rule Interpretation

A rule of the Centers for Medicare and Medicaid Services (CMS) has resulted in unintended consequences for our six Elected Teaching Amendment (ETA) hospitals. Many of the patients they serve will no longer be counted toward their Accountable Care Organization (ACO) numbers. On April 1, this anomaly will result in these patients being automatically reassigned to other entities.

We have established an ACO that treats a large number of the most vulnerable ---dual-eligible--- patients. Using CMS metrics, our ACO was among the best performing Medicare Shared Savings Programs (MSSP) in 2013. During the past year, however, the number of patients attributed to our ACO according to CMS has undergone a precipitous decline.

Health and Hospitals Corporation urgently seeks an updated methodology in order to allow ACOs that include Elected Teaching Amendment (ETA) facilities to continue their participation in the MSSP.

The New York State Department of Health and CMS recently began a Fully Integrated Dual Advantage (FIDA) demonstration program that will passively enroll Medicare-Medicaid beneficiaries into managed FIDA plans starting April 1. Once patients are enrolled in FIDA, they are no longer eligible for ACO attribution.

We are working closely with the State and CMS to rectify this situation, so that the patients we are servicing as part of our ACO are not deleted permanently from our attribution and automatically-assigned elsewhere.

STATE UPDATE

The Governor and Legislature are busy negotiating the details of the State Budget, which must be passed by next Wednesday, April 1.

The Senate and Assembly agreed to the Governor's proposal to modify the way the State distributes the Upper Payment Limit (UPL) for Health and Hospitals Corporation. These changes will allow us to receive more than \$1 billion in outstanding payments for services provided in 2011-2014.

Both houses have agreed to extend the current methodology for distributing Charity Care funding for three years. However, there continues to be disagreement about providing the State flexibility to revise the distribution if federal Disproportionate Share Hospital (DSH) funding cuts are implemented. That flexibility is important to protect Health and Hospitals Corporation from absorbing a disproportionate amount of the cuts.

We strongly believe that charity care dollars should go to those providers who are providing care to uninsured people. We continue to vigorously advocate for this position in Albany.

HHC TESTIMONY AT CITY COUNCIL HEARING

This Monday I appeared before the City Council to testify at the City's Preliminary Budget Hearing. I outlined our top priorities and spoke in some detail about the challenges we face in meeting them. I spoke about our five-year financial plan, the large deficits we face, and corrective actions that we are taking to address them. I also spoke of the recent designation of our diagnostic and treatment centers as a Federally Qualified Health Center look-alike, and our significant efforts, together with our many partners, to support healthcare delivery reform through the ongoing development of OneCity Health.

I also addressed our ongoing capital improvements, particularly at Gouverneur Health, North Central Bronx Hospital, and Elmhurst Hospital.

Finally, I shared details of the recently announced FEMA award of \$1.7 billion to partly rectify the damage caused to HHC hospitals by Hurricane Sandy. We are working closely with the Mayor's Office of Recovery and Resiliency to monitor the work that we need to complete.

Council Member Corey Johnson, Chair of the Health Committee voiced strong support for Health and Hospitals Corporation at the council hearing. We appreciate Council Member Johnson recognition of our essential role in New York City's overall health and wellness.

CONEY ISLAND HOSPITAL EARNS KUDOS FROM JOINT COMMISSION

I am very happy to report that -- not only did Coney Island Hospital sail through a full Joint Commission survey last week with flying colors -- it managed this while being inspected by a number of other regulators like College of American Pathologists (CAP), the Accreditation Council for Graduate Medical Education (ACGME), and the Joint Commission's Detox team during the same timeframe.

Arthur Wagner and his team deserve our strong thanks. They have set a high standard for other HHC facilities to meet.

REDUCING ANTI-PSYCHOTIC MEDS HELPS THREE HHC NURSING HOMES EARN TOP FIVE-STAR RANKINGS FROM CMS

Our nursing homes at Gouverneur, Sea View and McKinney have all earned the top five-star national rating from the federal Centers for Medicare & Medicaid Services (CMS), due in part to our leadership's work to reduce the use of anti-psychotic medications.

LINCOLN MEDICAL CENTER EARNS BABY-FRIENDLY STATUS

Congratulations to Lincoln Medical Center, which has become the first hospital in the Bronx to be designated "Baby-Friendly." This status was earlier awarded at Harlem and Queens hospitals. We are grateful for this international acknowledgement of our commitment to better health for mothers and their babies through strong breastfeeding support.

The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) has designed the Baby-Friendly initiative to promote breastfeeding. It recognizes birth facilities worldwide that offer mothers the information, confidence and skills needed to successfully initiate and continue breastfeeding their babies. The prestigious "Baby-Friendly" designation is given only after a rigorous on-site survey is completed, and is then reviewed every five years.

HHC TOMORROW CONVERSATION ON APRIL 7TH

As the end of my first year as President of Health and Hospitals Corporation draws to a close, we are taking an opportunity on April 7th to review where we have been as an organization, and to chart a course for what lies ahead. I've invited leaders from our facilities and departments, and outside guests, to join me at John Jay College to talk about how we will thrive in the post health care reform era. I look forward to seeing many of you there.

HHC HOSPITALS CONTINUE TO KEEP PATIENT SAFETY FIRST

This month we observed Patient Safety Awareness week -- recognition of the extraordinary level of patient safety protocols and activity we build into our work every day.

I was thrilled to see so much excitement and enthusiasm during this year's Patient Safety Jeopardy battle. Obviously we've made tremendous progress in our work to avoid errors and in keeping patients safe.

The next frontier is translating this degree of patient safety excellence to outpatient care, so that we continue to keep patients safe, while we also keep them out of the hospital.

The President Choice Patient Safety Champion Award went to the staff of Harlem Hospital Center's Pharmacy Department, for tirelessly working to reduce errors and risk. Congratulations to them and congratulations to all HHC Patient Safety Champions. And thank you especially to SVP Caroline Jacobs and her team for pulling this event together and doing a phenomenal job.

HHC HOSPITALS CELEBRATE NATIONAL SOCIAL WORK MONTH

March is National Social Work Month, a time to recognize the important role that HHC's dedicated social workers play in providing truly patient-centered and holistic care. Their commitment to compassionate care is evident in every patient interaction, counseling session, discharge plan, and linkage to a service.

We know that social workers are indispensable members of multidisciplinary care teams across the system. Whether it's arranging for child care for a parent in need or connecting a patient to a better housing option, social workers have the expertise to leverage NYC's resources and do everything they can to make our patients healthier and safer. This month, and all year round, let's remember to appreciate and honor their contributions.

HHC FEATURED PROGRAM: PALLIATIVE CARE PROGRAM

As you know, each month we highlight programs that demonstrate the compassion, heart and soul that is the Health and Hospitals Corporation.

Today I call your attention to our Palliative Care Program. I couldn't be prouder that our corporation has been at the forefront of the Palliative Care evolution taking place across the medical field. We've been very much out front on this. We've lead many of our competitors in recognizing how palliative care enables our patients to make the most of life---and maximize the gift that is every day.

Since launching our initiative in 2005, we've embraced a philosophy which, at its core, is about empowering patients *and their families* to take control of debilitating symptoms and pain, often at the end of life. This allows them to focus on what matters most.

Palliative care is not about giving up. It's about offering a lifeline of medical and psychological support, comfort and compassion to patients during the last part of their lives when they need it most. Our palliative care teams exemplify the kind of culturally competent, patient-centered, family-oriented health care that is Health and Hospitals Corporation.

A team of people have worked very hard to make this happen. I particularly want to thank Donna Leno-Gordon, RN, and Dr. Susan Cohen, Co-Chairs of our Palliative Care Council, for spearheading our efforts over the long term. Congratulations.

HHC FEATURED INDIVIDUAL: MONICA RODRIGUEZ, PATIENT NAVIGATOR

As you know, we use this portion of each board meeting to shine a spotlight on an employee or volunteer who is doing something outstanding on behalf of our patients.

Someone who is going the extra mile, extending themselves to patients beyond their duties, to deliver the quality and compassionate care that we are all about. This month I would like to introduce you to Monica Rodriguez.

Six years ago Monica had a close family friend who was struck with breast cancer. Monica spent a lot of time visiting and doing what she could to make her friend more comfortable and less anxious. At the time she learned first-hand how the American Cancer Society and Queens Hospital staff helped her friend pull through, both physically and emotionally. Monica resolved that she wanted do this sort of work herself. And without blinking an eyelash, she set about getting the proper training and qualifications to work in the field.

For the past five years Monica has worked as a patient navigator at the Queens Cancer Center, where she excels at what she does. She serves as an indispensable source of comfort, information, advocacy and guidance for her patients.

Please join me in recognizing Monica Rodriguez today and in thanking her for a job well done.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

New York Ebola Survivor Says He Was Unfairly Cast as a Hazard and a Hero, NY 1 News, Bellevue

Fit Kids: Program Gives Low Income Moms Tools to Prevent Childhood Obesity, NY1 News, Bellevue: Dr. Mary Joe Mossito

Bronx Hospital Midwifery Program, News 12 Bronx, NCBH: Dr. Michael Zinaman, Chairman of Obstetrics & Gynecology, North Bronx Healthcare Network; Susan Papera, CNM, Director of Midwifery Services; Belinda Parisi, RN

Hand Washing Demonstration for Patient Safety Week, News 12 Bronx, Jacobi

Home Visiting Service, NY 1 News, Harlem: Marcia Pierre, Nursing Asst. Director, Tiffany Reid, RN

76-Year-Old Harlem Shooting Victim Speaks Out, WABC, Harlem

Kings County Sleep Clinic, News12 Brooklyn, Kings County: Samir, Fahmy, MD, Medical Director, Sleep Diagnostic Center; Josianne Regis, Associate Respiratory Therapist, Polysomnographer

Colon Cancer Screenings Still a Reach for City's Uninsured, NY 1 News, Woodhull: Barbara Blase, Patient Navigator

Lincoln Medical Center attains 'baby friendly' designation, News 12 Bronx, Lincoln

City Hospitals Help Patients Screen Risks with Colonoscopies, NY1 News, Woodhull: Dr. Harry Winters, Chief of Gastroenterology

Print

On the Use of Antipsychotics for Dementia Patients, The New York, Times, Dr. Ram Raju, HHC President

Having and Fighting Ebola — Public Health Lessons from a Clinician Turned Patient, New England Journal of Medicine, Bellevue

Doctor who survived Ebola Says he Was Unfairly Cast as a Hazard and a Hero, The New York Times, Bellevue

Kennedy Airport passenger does not have Ebola virus, officials say, AMNY, Bellevue

H.H.C. facing a \$753 million deficit, Capital New York, Dr. Ram Raju, HHC President

HHC votes to renew Sandy contract, Capital New York, HHC, Marlene Zurack, Senior Vice President

Cuomo's quiet health care-funding challenge, Capital New York, HHC

Health reform: 'The challenge of moving to scale so quickly', Crain's Health Pulse, HHC

HHC goes to Albany, Crain's Health Pulse, HHC: Dr. Ram Raju

UHF Grants, Crain's Health Pulse, HHC

Coney Island Rebuilds, Crain's Health Pulse, HHC, Coney Island

Medicaid Managed Care, Crain's Health Pulse, MetroPlus

Many New Yorkers Can STILL Sign up for Health Coverage Due to Special Enrollment Period (March 1 Through April 30), Reuters, MetroPlus: Seth Diamond, COO

Medicaid/Medicare Patients Rely on MetroPlus, Queens Tribune, MetroPlus: Seth Diamond, COO; Roger Miliner, Deputy Executive Director, Marketing

New Executive Director at HHC Metropolitan Hospital Center, Manhattan Times, Dr. Ram Raju, Anthony Rajkumar, Executive Director, Metropolitan

Anthony Rajkumar named executive director of HHC Metropolitan Hospital Center, Amsterdam News

39 HHC health centers and clinics join together, become community health center, Nurse.com, Dr. Ram Raju; Dr. Walid Michelen, Gotham Health CEO

Top hospital inspector spent 7 years investigating a single case, New York Post, Coney Island

Suspended guard who punched Obama impersonator paid \$240K, New York Post, HHC, Jacobi

City HR honcho accused of using power to hire six family members, New York Post, HHC

Medical and dental residents reach tentative agreement with the city, Amsterdam News, Dr. Ram Raju

NYC Councilmember Eugene presents \$2.8 M to Kings County Hospital for new PET/CT scanners, Brooklyn Daily Eagle, Kings County: Ernest Baptiste, Executive Director

My Patient Doesn't 'Do' Vaccines, The New York Times, Bellevue: Dr. Danielle Ofri, Internist

Growing number of city hospitals offer premature babies donated breast milk, New York Daily News, Bellevue

Free Seminars on Colon Cancer at Coney Island Hospital, Bensonhurst Bean, Coney Island

SNUG Program to Stem Soundview Violence, The Bronx Times Reporter, Jacobi: Noe Romo, MD, SUV Medical Director; Erika Mendelsohn, Stand Up to Violence (SUV) Program Director

The Secret to Successfully Quit Smoking: Support and Gradual Cessation are Essential, Bronx Free Press, Lincoln: Akinola Fisher, MD

City Council Slams Rikers Medical Provider at Hearing, DNAinfo, HHC

Honors for Women's History, Queens Chronicle, Elmhurst: Atiya Butler, Director of External Affairs and Marketing

Queens Hospital Center: Improving Patient Services, Queens Tribune, Queens: Pam Rios, Associate Director; Dr. Farshid Radparvar, Director of Cardiology; Dr. Edouard Belotte

Elmhurst Hospital: An Outline For Achieving Preventive Care, Queens Tribune, HHC, Queens, MetroPlus Elmhurst: Claire Patterson, Senior Associate Executive Director, Queens Health Network

Physician Residency Training Gets Boost from Quality Improvement Clinics, The Hospitalist, Harlem: Maurice Wright, MD, Medical Director; Paroma Mitra, MD

Brooklyn BP Adams presses hospitals to open borough's first burn unit, Metro NY, Jacobi, Harlem

RESOLUTION

Authorizing the President to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation (“HHC” or the “Corporation”) and Base Tactical Disaster Recovery, Inc. (“Base Tactical”) to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency (“FEMA”) for expenses incurred by the Corporation in connection with damages caused by Super Storm Sandy. The extension will be for a term of 12 months commencing August 1, 2015 through July 31, 2016, for an amount not to exceed \$2,500,000.

WHEREAS, on October 29, 2012 Super Storm Sandy caused substantial damage to numerous HHC facilities, which required the evacuation of all patients and staff from Bellevue Hospital Center and Coney Island Hospital; and

WHEREAS, the President of HHC issued a Declaration of Emergency and directed that repairs and replacement of facility assets necessary to have the facilities resume providing medical care to their respective communities be carried out immediately; and

WHEREAS, a Request for Proposals was issued November 23, 2012 and Base Tactical was the highest rated respondent and was awarded the contract for the period of February 1, 2013 through July 31, 2014; and

WHEREAS, said contract was extended for the period of August 1, 2014 through July 31, 2015; and

WHEREAS, said contract is expiring and a change of vendors at this time would jeopardize the Corporation’s ability to fully recoup its expenses and to maximize its mitigation funding for the facilities impacted by Super Storm Sandy; and

WHEREAS, the extension of the Base Tactical contract will enable the Corporation to secure FEMA obligations, identify appropriate solutions to harden HHC facilities’ physical structures so that they can resist future storms and proceed with their reconstruction; and

WHEREAS, the Executive Vice President and Chief Operating Officer of the Corporation shall be responsible for the overall management, monitoring and enforcement of the contract extension.

NOW, THEREFORE be it

RESOLVED, that the President be and hereby is authorized to negotiate and execute a contract extension between the New York City Health and Hospitals Corporation and Base Tactical Disaster Recovery, Inc. to provide expert consulting services for disaster recovery, project management, and filing claims for reimbursement from the Federal Emergency Management Agency for expenses incurred by the Corporation in connection with damages caused by Super Storm Sandy. The extension will be for a term of 12 months commencing August 1, 2015 through July 31, 2016, for an amount not to exceed \$2,500,000.

RESOLUTION

Authorizing the President to negotiate and execute a contract between the New York City Health and Hospitals Corporation (HHC or Corporation) and Arcadis-U.S., Inc. and Parsons Brinckerhoff, Inc. to provide professional architectural and engineering services to assist in the recovery, reconstruction and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital and other HHC facilities, which were damaged as a result of the Super Storm Sandy disaster. The Contract will be for a term of 12 months commencing October 1, 2015 through September 30, 2016 in an amount not to exceed \$5,000,000.

WHEREAS, on October 29, 2012 Super Storm Sandy caused substantial damage to numerous HHC facilities, which required the evacuation of all patients and staff from Bellevue Hospital Center and Coney Island Hospital; and

WHEREAS, the President of HHC issued a Declaration of Emergency and directed that repairs and replacement of facility assets necessary to have the facilities resume providing medical care to their respective communities be carried out immediately; and

WHEREAS, a Request for Proposals was issued on February 15, 2013 seeking the services of a professional architectural and engineering services to assist in the recovery, reconstruction and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital and other HHC facilities; and

WHEREAS, the contracts with Parsons Brinckerhoff, Inc. and Arcadis-US, Inc., will expire as of September 30, 2015; and

WHEREAS, said contract is expiring and a change of vendors at this time would jeopardize the Corporation's ability to fully recoup its expenses and to maximize its mitigation funding for the facilities impacted by Super Storm Sandy; and

WHEREAS, the extensions of these contracts will enable the Corporation to continue to secure FEMA obligations of funds, proceed with reconstruction, and execute appropriate solutions to harden HHC facilities so that they can resist future storms.

WHEREAS, the Senior Vice President for Finance and Chief Finance Officer of the Corporation shall be responsible for the overall management, monitoring and enforcement of the contract.

NOW, THEREFORE be it

RESOLVED, that the President be and hereby is authorized President to negotiate and execute a contract between the New York City Health and Hospitals Corporation (HHC or Corporation) and Arcadis-U.S., Inc. and Parsons Brinckerhoff, Inc. to provide professional architectural and engineering services to assist in the recovery, reconstruction and hazard mitigation of Bellevue Hospital Center, Coler Rehabilitation and Nursing Care Center, Coney Island Hospital, and Metropolitan Hospital and other HHC facilities, which were damaged as a result of the Superstorm Sandy disaster. The Contract will be for a term of 12 months commencing October 1, 2015 through September 30, 2016 in an amount not to exceed \$5,000,000.

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

WHEREAS, the President of New York City Health and Hospitals Corporation (the "Corporation") has issued that certain Operating Procedure (40-58 Debt Finance and Treasury) (the "Operating Procedure") relating to the delegation of certain powers for the incurrence of debt for equipment financing to the Corporation's Chief Financial Officer by resolution to be adopted by the Board of Directors of the Corporation; and

WHEREAS, the Board of Directors of the Corporation, and the Finance Committee of such Board, pursuant to Section 4(f)(i) of the Operating Procedure, have determined that it is necessary and desirable to increase the authorization previously approved by the Board of Directors on July 25, 2013 for the incurrence of debt for equipment financing from an aggregate amount from time to time not exceeding \$40,000,000, to an aggregate amount from time to time not exceeding \$60,000,000, in the form of tax-exempt or taxable loans borrowed by the Corporation from time to time from one or more lenders (the "Lenders"), to provide funds to finance, refinance and reimburse the Corporation for the costs of equipment and various related capital projects and expenditures at the Corporation's facilities, and to carry out the purposes permitted by law and set forth herein and consistent with the Operating Procedure;

NOW, THEREFORE, BE IT RESOLVED, AS FOLLOWS:

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

Section 102. Principal Amount. The incurrence of debt is hereby authorized in the aggregate principal amount of not more than \$60,000,000, from time to time, for the purpose of financing equipment and various related capital projects and expenditures at the Corporation's facilities. Such debt may take the form of borrowings, loan agreements, installment purchase agreements or lease agreements, all as contemplated by the Operating Procedures.

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

Section 104. Authorization of Related Documents. The Corporation is authorized to enter into one or more debt contracts, such as loan agreements, notes, bonds, installment purchase agreements, rental arrangements or lease agreements. The form, terms and provisions of the debt contracts, between the Corporation and a Lender, providing for the incurrence of such debt, shall be approved by an Authorized Officer (defined below) of the Corporation, as evidenced by his or her signature thereon. The President, the Senior Vice

President of Finance/Chief Financial Officer or any other authorized officer of the Corporation under the by-laws of the Corporation (each an “Authorized Officer”) is authorized and empowered for and on behalf of the Corporation to execute, acknowledge and deliver the debt contracts, and the Secretary or any other Authorized Officer of the Corporation is hereby authorized and empowered to affix the seal of the Corporation and to attest to the same for and on behalf of the Corporation.

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

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

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

April 14, 2015 Finance Committee of the Board of Directors

EXECUTIVE SUMMARY

Amending a Previously Adopted Resolution to Increase the Authorization for One or More Borrowings to Finance Various Capital Projects in an Aggregate not-to-exceed Amount from \$40,000,000 to \$60,000,000

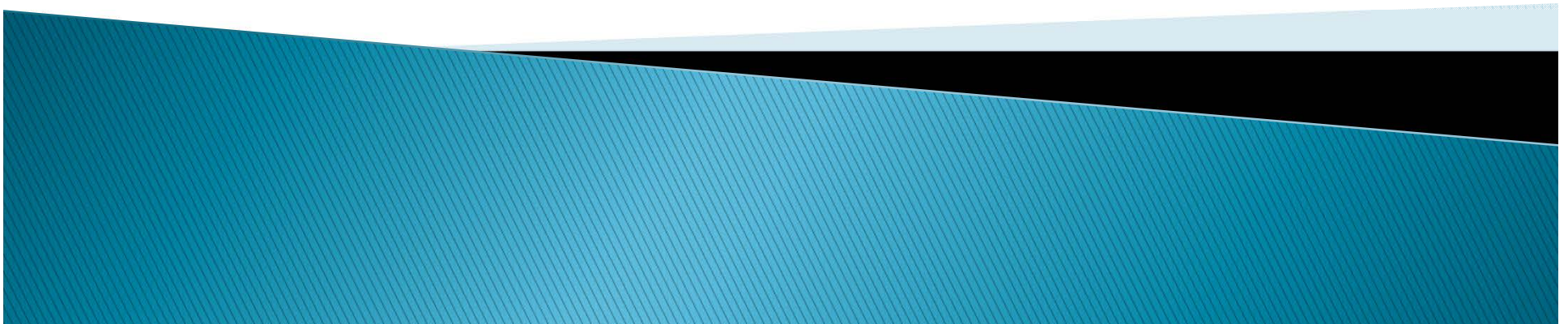
The resolution amends a resolution adopted on July 25, 2013 that authorized the Corporation to borrow from one or more lenders, from time to time an aggregate not-to-exceed amount of \$40 million. This resolution increases that not-to-exceed amount to \$60 million. The overall negotiation, execution, and management of the borrowing under this resolution are delegated to the Corporation's Chief Financial Officer (CFO). Any borrowing under this resolution will be reported quarterly by the CFO to the Finance Committee as described in Operating Procedure 40-58 (Debt Finance & Treasury), Section 4. F. (Equipment Financing)

The Corporation funds the vast majority of its major capital expenditures with the proceeds of tax-exempt bonds issued by the Corporation or the City of New York. Because bonds proceeds are best suited to finance assets with longer useful lives, the Corporation has determined that it is more suitable to finance assets with shorter useful lives, such as equipment, with loans provided by banks and/or leasing companies. This type of borrowing allows the Corporation to borrow in smaller amounts, as the need arises, incur minimal cost of issuance and minimizes investment risk on borrowed proceeds.

Since FY 2000, HHC's average annual capital equipment expenditures are approximately \$40 million, with useful life typically ranging from 5 to 10 years. The types of equipment the Corporation is expecting to purchase are primarily medical and laboratory equipment (including but not limited to anesthesia machines, adult/neonatal ventilators, blood gas analyzers, blood pressure monitors, blood culture system, bone densitometry machine, breast biopsy system, chemistry analyzers, CT scanner, dental X-ray machine, digital mammography machine, digital X-ray machine, EKG/EEG machines, hematology analyzers, IV pumps, infant incubators, infant warmers, feeding/infusion/IV pumps, fetal monitors, gamma camera, microscopes, MRI machine, operating room tables, patient beds, patient room pressure monitors, ultrasound machine, urine analyzers, etc.) and certain information technology purchases (including but not limited to computer servers, network switches, radiology information system, etc.).

Equipment Financing Program

Board of Directors Meeting
April 30, 2015



Equipment Financing Program

▶ Goal

- Establish a routine mechanism to secure access to capital financing for HHC's equipment needs with one or more banks over multiple years.

▶ Board of Directors authorization

- In July 2013 the CFO was authorized to incur up to \$40 million of debt to finance already identified equipment needs.
- We are currently asking to increase that authorization to \$60 million to meet anticipated equipment financing needs through Fiscal Year 2016.



Equipment Financing Program

▶ Secondary Lien Structure

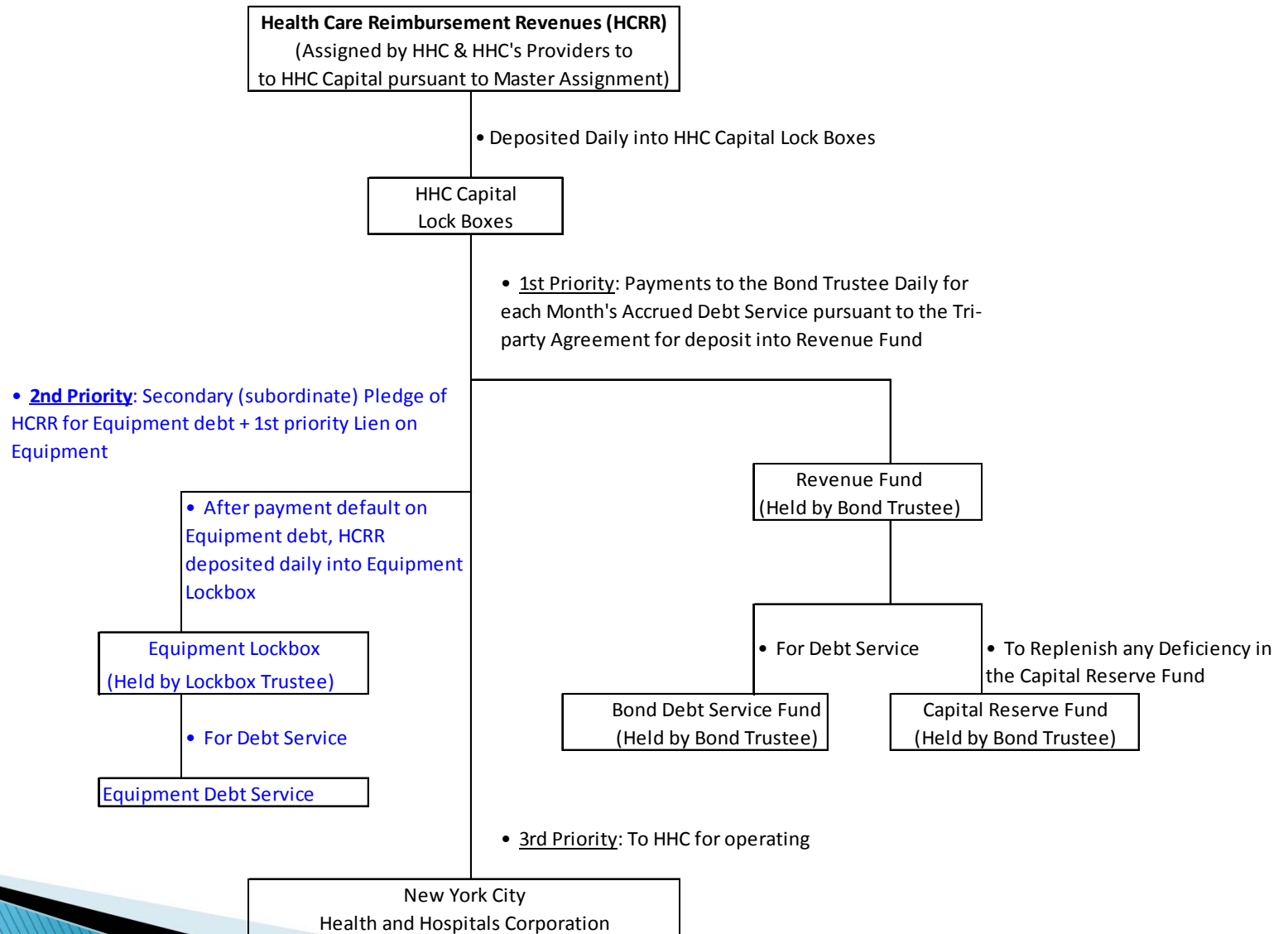
- After unsuccessfully attempting to secure traditional equipment financing, a secondary Health Care Reimbursement Revenue lien security structure was developed, which has generated interest from lenders.

▶ Current Status

- HHC recently signed a term sheet with JPMorgan to provide up to \$60 million of tax-exempt financing for equipment purchases.
- Documents are being finalized by counsels for HHC and JPMorgan.
- Financing is expected to close by late April or early May 2015.



Equipment Financing Security Structure



JPMorgan Transaction

- ▶ HHC Debt Finance worked with Bond Counsel and the Financial Advisor to structure an equipment financing with JPMorgan.
 - Size: Up to \$60 million
 - Uses: Upgrade, purchase and install of medical equipment and information technology systems; cover costs of issuance
 - Security: (A) a first lien security interest in equipment; (B) a secondary pledge of Health Care Reimbursement Revenues. In the event of a payment default, a requirement for revenues to be deposited into a daily lockbox will be triggered.
 - Term: 12 month drawdown period at a variable rate, converting to a six year fixed rate loan
 - Provides maximum drawdown flexibility
 - Minimizes negative arbitrage on borrowed, but unspent proceeds
 - Example* Interest Rates:
 - Drawdown Period: 0.9249%
 - Fixed Loan: 1.7062%
 - Rates set by formula. (*Example rates based on index rates as of 3/30/15.)

Next Steps

▶ Additional Capacity

- This structure provides a framework for additional borrowing capacity with other lenders. Discussions are currently underway with other banks.
- Securing additional financing agreements in the near term will give the Corporation flexibility in financing projects within existing Board authority, and will eliminate delays in meeting future equipment financing needs.
- Total actual outstanding debt will never exceed amounts authorized by the Board.

▶ Reporting to Finance Committee

- Per HHC's operating procedures for Debt Finance and Treasury (OP 40-58), the CFO will report to the Finance Committee on all borrowing activity under these authorizations on a quarterly basis.

RESOLUTION

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

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

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

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

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

NOW THEREFORE, be it

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

EXECUTIVE SUMMARY

3M Software Licenses and Maintenance: Coding and Reimbursement Services

3M's Health Information Systems will provide HHC with a suite of software for abstracting International Classification of Diseases (ICD), Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes at acute and long-term care facilities. The 3M suite of products aids selection of codes, maintains a database of patient information, groups codes for validation and provides these codes to financial systems. The contract is for three years with two options to renew, each for one-year. The not to exceed amount for the full term of the agreement is \$13,510,101 which includes a contingency of \$643,338.

Public solicitation through a Request for Proposal is not in the best interest of the Corporation. The support of proceeding with a sole source procurement from 3M Health Information Systems is based on:

- 1) 3M is the only provider of New York State groupers that the Corporation must use;
- 2) HHC's 3M coding software system is integrated with Soarian Financials, HHC's new revenue cycle system. Changing coding software at mid-deployment will endanger the roll-out of Soarian in 2015;
- 3) Changing coding providers creates unacceptable risk to HHC's readiness for ICD-10 implementation on October 1, 2015 ; and
- 4) Reconfiguring hardware to another provider is cost prohibitive.

The majority of inpatient claims processed by HHC are for payers that must use the 3M owned grouper; the APR-DRG grouper (Medicaid and Medicaid managed care). NYS mandates use of the 3M APR-DRG for all Medicaid, Workers Compensation and No-Fault discharges. Moreover, as the State has rolled out its healthcare reforms it has relied exclusively on 3M software. HHC must purchase the APR-DRG grouper from 3M.

The Corporation has invested over \$230,000 in interfaces between 3M and the Corporation's two financial information systems in operation in 2015. Interfaces are already built between 3M and Unity and Soarian. Claims are routed to the correct system depending on the system originating the input to 3M. Building a new set of interfaces with this capability will delay the Soarian deployment.

The Corporation continues to devote significant resources to Health Information Management employee training using 3M. Coders use the 3M system as they practice coding cases in the ICD-10 code set. 3M was upgraded in 2014 to prepare for ICD-10 implementation. On October 1, 2015 Centers for Medicare and Medicaid is mandating the nation switch from the ICD-9 to the ICD-10 code set. ICD-10 implementation is a substantial change to coding operations. HHC's 3M system is ICD-10 ready and has tested successfully with Unity and Soarian to produce compliant bills.

HHC has invested significantly in 3M hardware for the deployment of an enterprise wide version of 3M. Installing a new system will necessitate creating a duplicative system for an extended period.

Since the advent of DRG (Diagnosis Related Groups) based reimbursement, almost all acute hospital and long-term care billing operations use software to support abstracting. HHC has held an agreement with the 3M Health Information Systems to provide these services since 1984. For HHC's coders, 3M supports the process of selecting the correct codes, assigning them to patients, storing data for audits, medical reporting and transmission to financial systems. 3M is the owner of the proprietary software and maintenance contractor for the software and interfaces for which this agreement is required. It is the only source able to provide and maintain the software in a timely, reliable, and efficient manner.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: 3M Coding and Reimbursement Services

Project Title & Number: Provides software licenses, maintenance and support for 3M's Coding and Reimbursement suite of products including interfaces with financial systems.

Project Location: 55 Water St., New York, NY 10041

Requesting Dept.: EITS

Successful Respondent: <u>3M Health Information Systems</u>
Contract Amount: <u>\$13,510,101 with all renewal options exercised</u>
Contract Term: <u>Three years (FY 2016 to FY 2018) with two one-year renewal options. There is a contingency of \$643,338</u>

Number of Respondents:
(If sole source, explain in background) One (1) section)

Range of Proposals: \$ N/A to \$ _____

Minority Business

Enterprise Invited: Yes If no, please explain: This is a sole source agreement.

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

Method of Payment: Lump Sum Per Diem Time and Rate
 Other: explain: Licensing software based on HHC patient volume. Paid monthly

EEO Analysis: Pending

Compliance with HHC's:
McBride Principles? Submitted. Pending approval.

Vendex Clearance? Submitted. Pending approval.

(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.)

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):

3M's Health Information Systems will provide HHC with a suite of software for abstracting ICD, Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes at acute and long-term care facilities. The 3M suite of products aids selection of codes, maintains a database of patient information, groups codes for validation and provides codes to financial systems. The work includes software licenses, support, maintenance and administrator training on all products.

The Corporation needs to continue its software license, maintenance and support services agreement in order to protect its investment in the 3M Coding and Reimbursement Information System. 3M is the owner of the proprietary software and maintenance contractor for the software and interfaces for which this agreement is required. 3M is the only source able to provide maintain the software in a timely, reliable, and efficient manner. The Corporation uses the Coding and Reimbursement System in daily patient record management and has invested in interfaces between 3M and the Corporation's two financial information systems in operation in 2015. In addition, the Corporation continues to devote significant resources to Health Information Management employee training using 3M. Coders use the 3M system as they practice coding cases in the ICD-10 code set. 3M was upgraded in 2014 to prepare for ICD-10 implementation.

CONTRACT FACT SHEET (continued)

Contract Review Committee

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

The proposed contract was presented to the CRC on March 18, 2015.
Approval was provided.

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:

Yes. The scope of work and budget changed since the presentation on March 18th. The CRC presentation included 3M providing components for Epic. These elements were removed. 3M could not provide proposed language acceptable to HHC. This reduced the budget by \$3,470,405.

CONTRACT FACT SHEET (continued)

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

Public solicitation through a Request for Proposal is not in the best interest of the Corporation. The support of proceeding with a sole source procurement from 3M Health Information Systems is based on:

- 1) 3M is the only provider of New York State groupers that the Corporation must use;
- 2) HHC's 3M coding software system is integrated with Soarian Financials, HHC's new revenue cycle system. Changing coding software at mid-deployment will endanger the roll-out of Soarian in 2015;
- 3) Changing coding providers creates unacceptable risk to HHC's readiness for ICD-10 implementation on October 1, 2015 ; and
- 4) Reconfiguring hardware to another provider is cost prohibitive.

The majority of inpatient claims processed by HHC are for payers that must use the 3M owned grouper; the APR-DRG grouper (Medicaid and Medicaid managed care). NYS mandates use of the 3M APR-DRG for all Medicaid, Workers Compensation and No-Fault discharges. Moreover, as the State has rolled out its healthcare reforms it has relied exclusively on 3M software.

HHC is deploying new revenue management software in 2015. Interfaces are already built between 3M and both the legacy Unity and the new Soarian systems. Claims are routed to the correct system depending on the system originating the input to 3M. Building a new set of interfaces with this capability will delay the Soarian deployment.

On October 1, 2015 Centers for Medicare and Medicaid is mandating the nation switch from the ICD-9 to ICD-10 code set. The deadline was delayed twice, as the change is significant for both HIM and information systems. ICD-10 is a significant modification of the existing code set. HHC's 3M system is ICD-10 ready. It has successfully tested with Unity and Soarian to produce compliant bills.

HHC has invested significantly in 3M hardware for the deployment of an enterprise wide version of 3M. Installing a new system will necessitate creating a duplicative system for an extended period.

Since the advent of DRG (Diagnosis Related Groups) based reimbursement, almost all acute hospital and long-term care billing operations use software to support abstracting. HHC has held an agreement with the 3M Health Information Systems to provide these services since 1984. For HHC's coders, 3M supports the process of selecting the correct codes, assigning

CONTRACT FACT SHEET (continued)

them to patients, storing data for audits, medical reporting and transmission to financial systems.

Contract Negotiation Members included:

- Maxine Katz, Senior Assistant Vice President, Finance/Revenue Management
 - Laura Free, Assistant Vice President, Finance/ Managed Care
 - Brenda Schultz, Assistant Vice President, EITS
 - Robert Melican, Senior Director, Finance/ Managed Care
 - Elaine Chapnik, Senior Counsel, Legal Affairs
-

Scope of work and timetable:

The 3M software has four basic components; a database, coding software, DRG groupers and interfaces to fiscal systems. The four components are a unified system. 3M's Health Record Management database stores all coded patient records. The database supports discharged not final billed management, physician research, data management for New York State and others on care practices. 3M's Coding and Reimbursement Plus software aids selection of ICD-9, ICD-10, HCPCS and CPT codes. 3M will provide a suite of DRG grouping services to HHC for Medicaid and Medicare patients. Grouping software will be integrated and work seamlessly with coding services and the Health Record Management Software. The interfaces move data from 3M to the appropriate financial system, either Unity or Soarian depending on the originating system.

Services will continue with no interruptions. The contract begins July 1, 2015

This is a three year contract, with two one-year renewal options.

Cost/Benefit:

HHC requires 3M software to produce ICD, HCPCS and CPT codes required for reimbursement. Deriving these required codes without support of 3M is not possible, it will place all HHC patient revenue in jeopardy.

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

HHC does not have the capability of producing its own coding and reimbursement software.

CONTRACT FACT SHEET (continued)

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?

This contract will not produce artistic/creative/intellectual property.

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

Sal Guido, Interim, Chief Information Officer is responsible for the contract.

The project managers are Janet Karageozian, Interim AVP for Business Applications, EITS and Robert Melican, Senior Director, Finance/ Managed Care.

CONTRACT FACT SHEET (continued)

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):

EEO process is pending.

Received By E.E.O. _____
Date

Analysis Completed By E.E.O. _____
Date Name

Sole Source Contract with 3M Health Information Systems

Board of Directors Meeting
April 30, 2015

Elements of 3M Contract

- **Coding & Reimbursement components:**
 - Encoder – software that guides coders through a series of questions to provide a pathway to an appropriate ICD code
 - Database – stores all coded case information for reporting
 - Groupers – assembles individual ICD codes into the correct Diagnostic Related Group (DRG)
 - Interfaces – custom connections to Unity and Soarian financial systems
- **Function as a unified system for Health Information Management (HIM)**

Why 3M?

- 3M developed the Medicaid groupers with NYS in 2009 and is the only provider of the product
 - All software providers in NYS have to purchase these groupers from 3M
- 3M can operate simultaneously with Unity & Soarian financial systems
 - In next 12 months all facilities are moving to Soarian
 - Managing this transition and a change of coding creates unacceptable level of risk
- Migrating to Enterprise version of 3M in next 4 months

3M History with HHC

- First contract in 1984 – 6 renewals
- Terms for 7th renewal are 3 year contract with two one-year renewal options

5 Year	FY '04	FY '05	FY '06	FY '07	FY '08		
Coding & Reimbursement Services	1,131,074	1,217,994	1,234,707	1,258,630	1,308,975		
7 Year	FY '09	FY '10	FY '11	FY '12	FY '13	FY '14	FY '15
Coding & Reimbursement Services	2,022,671	2,042,806	2,104,233	2,167,504	2,232,676	2,299,804	2,368,947
Proposal							
5 Year	FY '16	FY '17	FY '18	FY '19	FY '20		
Coding & Reimbursement Services	2,423,514	2,496,219	2,571,106	2,648,239	2,727,686		
Includes Negotiated Annual Increases of 3%				Total Contract	12,866,763		
				Contingency of 5%	643,338		
				Total Amount	13,510,101		

RESOLUTION

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

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

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

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

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

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

NOW, THEREFORE, be it:

RESOLVED, THAT THE President of New York City Health and Hospitals Corporation be and hereby is authorized to purchase storage hardware, software, and associated maintenance from various vendors via Third Party Contract(s) to support the Epic implementation in an amount not to exceed \$13,220,000 over a one year period.

**Executive Summary –
Purchases for Epic Storage Hardware, Software, and Maintenance via
Third Party Contracts**

The accompanying resolution requests approval to purchase storage hardware, software and associated maintenance from various vendors via Third Party Contract(s) in an amount not to exceed \$13.22 million for the EPIC Electronic Medical Record (EMR) program. This purchase is included in the EPIC EMR clinical budget.

A Storage Area Network (“SAN”) is a dedicated network that provides access to consolidated, block level data storage. SANs are primarily used to make storage devices, such as disk arrays, tape libraries, and optical jukeboxes, accessible to servers so that the devices appear as locally attached devices to the end user.

HHC previously purchased storage for the EPIC project under a single vendor architecture. All of this storage equipment has been installed at both data centers and is active in the development and testing environments.

Predicted and budgeted storage requirements are now needed to complete the Epic production installation including specifications required for the Epic software upgrades, virtual desktops to meet future growth.

The announcement by EPIC of a 2015 version upgrade contained specifications requiring the predicted increase in the size and capacity of the storage systems needed to support the implementation and deployment. Further increase in the EMR storage requirements derives from the need to support the new virtual desktop environment for EPIC. Lastly, predicted storage is now required to support multiple EPIC related applications such as the Enterprise Content Management system.

These purchases will allow the Corporation to add the necessary storage to meet its EMR related demands.

Due to changes in technology and pricing, the Corporation’s storage needs can be satisfied through multiple vendors. By using multiple vendors, the Corporation can achieve significant savings. Purchasing from multiple vendors will also protect the Corporation from being reliant upon one vendor’s storage prices in the future.

Under this request, solicitations are being conducted from vendors available through Federal General Services Administration and the New York State Office of General Services (“Third Party Contracts”) to procure storage equipment for the Corporation’s EPIC SAN’s. Enterprise Information Technology Services will solicit manufacturers and authorized resellers via Third Party Contracts. These contracts allow the Corporation to receive discounts beyond what is available on the open market. For example, a recent purchase of EMC storage equipment realized a 50% discount off of the list price. A minimum of three resellers will be solicited for each purchase. A purchase order will be issued to the lowest responsive bidder for each purchase.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: Storage Hardware, Software, and Maintenance for Epic
Project Title & Number: Electronic Medical Record
Project Location: Enterprise-Wide
Requesting Dept.: Enterprise IT Services

Successful Respondent: Multiple Vendors via Third Party Contracts
Contract Amount: \$13,220,000
Contract Term: 12 months

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

Range of Proposals: \$ Not Applicable to \$

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

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

Method of Payment: Lump Sum Per Diem Time and Rate
 Other: explain Upon acceptance

EEO Analysis:

Compliance with HHC's McBride Principles? Yes No N/A

Vendex Clearance Yes No N/A

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

CONTRACT FACT SHEET (continued)

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

EITS needs to purchase storage hardware, software and associated maintenance necessary for the EPIC Electronic Medical Records (“EMR”) implementation and deployment.

A Storage Area Network (“SAN”) is a dedicated network that provides access to consolidated, block level data storage. SANs are primarily used to make storage devices, such as disk arrays, tape libraries, and optical jukeboxes, accessible to servers so that the devices appear as locally attached devices to the end user.

HHC previously purchased storage for the EPIC project under a single vendor architecture. All of this storage equipment has been installed at both data centers and is active in the development and testing environments.

Predicted and budgeted storage requirements are now needed to complete the EPIC production installation including specifications required for the EPIC software upgrades, virtual desktops to meet future growth.

The announcement by EPIC of a 2015 version upgrade contained specifications requiring a dramatic increase in the size and capacity of the storage systems needed to support the implementation and deployment. Further increase in the EMR storage requirements derives from the need to support the new virtual desktop environment for EPIC. Lastly, additional storage is required to support multiple EPIC related applications such as the Enterprise Content Management system.

These purchases will allow the Corporation to add the 3 Petabytes (equivalent to about 3 times the data volume of Facebook’s Photo Storage) necessary to meet its EMR related storage demands.

Contract Review Committee

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

CRC approved this submission on April 1, 2015.

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

N/A

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):

Process used to select the proposed contractor –

Under this request, solicitations are being conducted from vendors available through Third Party Contracts. Conducting solicitations via Third Party contracts will ensure that HHC is promoting competition as well as receiving the best price for the required equipment. Third party contracts offer discounted pricing compared to the market price for such equipment.

The selection criteria –

Enterprise IT Services will solicit manufacturers and authorized resellers via Third Party contracts. A minimum of three resellers will be solicited for each purchase. A purchase order will be issued to the lowest responsive and responsible bidder for each purchase.

The justification for the selection –

A purchase order will be issued to the lowest responsive and responsible bidder for each purchase.

Scope of work and timetable:

Vendors will provide Storage Equipment for the Corporation's Epic storage projects. The anticipated project duration for these purchases is one year.

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

No services will be included in these purchases. Software, hardware, and maintenance will be purchased off of Third Party Contracts, which offer discounted pricing compared to the market price for such equipment. For example, an EMC storage system was recently purchased for a price of \$46,300 via NYS OGS contract. This represents a 50% savings off of the list price of \$92,600. By soliciting vendors via Third Party Contracts, the Corporation can obtain potential savings of approximately 50% off list pricing for storage hardware and software purchases.

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

FY15: \$2.3 million to date

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

Not applicable. These purchases are for Storage Hardware, Software and Maintenance.

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

No.

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

Sal Guido, Assistant Vice President/ Interim Corporate CIO.

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

Received By E.E.O. _____ **Not Applicable**
Date

Analysis Completed By E.E.O. _____
Date

Name



Purchases for EMR Storage Hardware, Software and Maintenance

Board of Directors Meeting

April 30, 2015

EMR Storage Hardware, Software & Maintenance Purchases – Background



Enterprise IT Services (EITS) is seeking \$13.22 million in spending authority to purchase storage hardware, software and maintenance for the EPIC EMR program.

Previously purchased storage for the EPIC program has been installed at both data centers and is active in the development and testing environments.

The predicted and budgeted cost of storage equipment that will be purchased is needed to complete the production installation and includes:

- **Requirements for EPIC software upgrades**
- **Support for virtual desktops**
- **Capacity for future growth**
- **Epic related application installations and projects**

EMR Storage Hardware, Software & Maintenance Purchases – Procurement Process



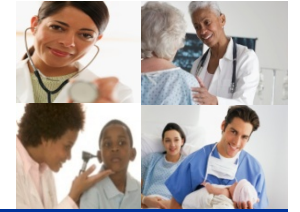
Purchases will be made via Third Party Contracts to procure storage equipment.

EITS is soliciting manufacturers and authorized resellers using Third Party Contracts. A minimum of three resellers are being solicited for each purchase.

A purchase order will be issued to the lowest responsive and responsible bidder for each purchase.

Third Party Contracts offer discounted pricing. The Corporation can obtain a potential savings of approximately 50% off list pricing for storage hardware and software purchases.

Questions



Questions?

RESOLUTION

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

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

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

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

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

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

NOW, THEREFORE, be it

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

EXECUTIVE SUMMARY

CONSTRUCTION SERVICES INDEFINITE QUANTITY CONSTRUCTION CONTRACTS (IQCC)

GENERAL CONTRACTING (GC) – VASTECH CONTRACTING CORPORATION AND RASHEL CONSTRUCTION CORPORATION

- OVERVIEW:** The Corporation seeks to execute two (2) Indefinite Quantity Construction Contracts for a term of two years each, for individual amounts not-to-exceed \$6,000,000, to provide professional construction services on an as-needed basis at any HHC facility. The total authorized to be spent under these contracts is \$12 Million.
- The method of requirements contract proposed starts with fixed prices for thousands of materials utilized in a typical construction project. The prices are derived from widely published construction reference works to which HHC subscribes that are updated at frequent intervals. The contractors awarded requirements contracts under the proposed resolution are later invited to submit proposals for particular projects. The requirements contractors submit proposals based upon acceptance of the fixed material prices and a multiplier based on such material costs to determine their labor cost proposals. For example, if a material to be installed is priced at \$10.00, and the contractor's labor multiplier to install that material is 1.0, the cost of that material and labor is \$10.00, inclusive of overhead and profit. If the multiplier is 1.2, then the cost of that material and labor is \$12.00, inclusive of overhead and profit.
- This format has been used in previous HHC requirements contracts, and continues to be used by the New York City School Construction Authority, the Dormitory Authority of the State of New York State, the New York City Department of Design and Construction, the New York City Department of Environmental Protection, the United States Postal Services and others. The program was developed by the Department of Defense and has been in existence for more than twenty years.
- NEED:** The various facilities of the Corporation are likely to require GC services that vary in frequency, size and urgency, which cannot be timely and cost effectively completed through a dedicated design, bid and award process.
- TERMS:** The construction services will be provided via a work order system within a two (2) year period, each for an amount not to exceed \$6,000,000.
- COSTS:** Not-to-exceed \$6,000,000 over two years, for each of the two (2) contracts for a total of \$12 Million.
- FINANCING:** Requirements contracts provide a pre-qualified approved mechanism for Networks to access construction services. Networks establish funding sources such as capital funds from bond proceeds, grants or expense (Other Than Personnel Services - OTPS) funds.
- SCHEDULE:** Upon contract execution these contracts shall be in effect for two years or until funds are exhausted.

CONTRACT FACT SHEET

INDEFINITE QUANTITY CONSTRUCTION CONTRACTS (IQCC)

GENERAL CONTRACTING (GC)

RASHEL CONSTRUCTION CORPORATION

CONTRACT SCOPE: General Contracting Services

CONTRACT DURATION: Two (2) years

CONTRACT AMOUNT: \$6,000,000

ADVERTISING PERIOD: Advertised in City Record 11/25/14 - 12/16/14.

BIDS RECEIVED: 12 bid proposals received for consideration. Rashel Construction Corporation was recommended as lowest responsive bidder.

HHC EXPERIENCE: Requirements Contract: Various Facilities. Completed in 2014.

VENDEX: Approved.

EEO: Approved.

CONTRACT FACT SHEET

INDEFINITE QUANTITY CONSTRUCTION CONTRACTS (IQCC)

GENERAL CONTRACTING (GC)

VASTECH CONTRACTING CORPORATION

CONTRACT SCOPE: General Contracting Services

CONTRACT DURATION: Two (2) years

CONTRACT AMOUNT: \$6,000,000

ADVERTISING PERIOD: Advertised in City Record 11/25/15 – 12/18/14.

BIDS RECEIVED: 10 bid proposals received for consideration. Vastech was recommended as lowest responsive bidder.

HHC EXPERIENCE: Requirements Contracts: Various Facilities. Completed in 2009 and 2012.


VENDEX: Pending. Documents have been submitted to the Office of Legal Affairs.

EEO: Approved.

Office of Legal Affairs

MEMORANDUM

To: Clifton McLaughlin
Office of Facilities Development

From: Karen Rosen 
Assistant Director

Date: March 12, 2015

Subject: VENDEX Approval

For your information, on March 12, 2015 VENDEX approval was granted by the Office of Legal Affairs for the following company:

Rashel Construction Corp.

cc: Norman M. Dion, Esq.

30452H

Manasses C. Williams
Senior Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

O: Clifton S. Mc Laughlin
Sr. Management Consultant
Central Office – Office of Facilities Development

FROM: Manasses C. Williams 

DATE: April 1, 2015

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Vastech Contracting Corp., 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 City-Wide

Contract Number: IQCC-GC-3

Project: Provide Indefinite Quantity Construction 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
Senior Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: Clifton S. Mc Laughlin
Sr. Management Consultant
Central Office – Office of Facilities Development

FROM: Manasses C. Williams

DATE: April 1, 2015

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Rashel Construction Corp., 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 City-Wide

Contract Number: IQCC_GC1

Project: Provide Indefinite Quantity Construction 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: