AGENDA

FINANCE COMMITTEE

MEETING DATE: FEBRUARY 9, 2016
TIME: 9:00 A.M.
LOCATION: 125 WORTH STREET
BOARD ROOM

BOARD OF DIRECTORS

CALL TO ORDER	**BERNARD ROSEN**
ADOPTION OF THE JANUARY 12, 2016 MINUTES	
SENIOR VICE PRESIDENT'S REPORTS	**P.V. ANANTHARAM**
• **CASH FLOW**	**JULIAN JOHN**
KEY INDICATORS REPORT	**KRISTA OLSON**
CASH RECEIPTS & DISBURSEMENTS REPORT	**FRED COVINO**
INFORMATION ITEM	
QUEENS HEALTH NETWORK GLOBAL FTE STATUS REPORT	**WAYNE ZIMMERMAN** **BRIAN STACEY**
OLD BUSINESS **NEW BUSINESS** **ADJOURNMENT**	**BERNARD ROSEN**

MEETING DATE: JANUARY 12, 2016

FINANCE COMMITTEE

BOARD OF DIRECTORS

The meeting of the Finance Committee of the Board of Directors was held on January 12, 2016 in the 5th floor Board Room with Bernard Rosen presiding as Chairperson.

ATTENDEES

COMMITTEE MEMBERS

Bernard Rosen
Ramanathan Raju, MD
Lilliam Barrios-Paoli
Josephine Bolus, RN
Mark Page
Emily Youssouf

OTHER ATTENDEES

J. Cassidy, Analyst, NYC OMB
K. Cherny, Unit Head, OMB
T. DeRubio, Analyst, NYC OMB
M. Dolan, Senior Assistant Director, DC 37
E. Eng, Finance Analyst, NY City Council
C. Francisco, Unit Head, Finance, NY City Council
D. Gilliam, Director, State Comptroller's Office
L. Garvey, Cerner Regional Executive, Cerner Corporation
M. Hecht, Analyst, NYC Comptroller's Office
E. Kelly, Analyst, IBO
C. Uber, Senior Budget Analyst, PAGNY

HHC STAFF

P. Albertson, Senior Assistant Vice President, Corporate Operations
S. Alexander, Executive Director, Bellevue Hospital Center
M. Allen, Senior Assistant Vice President, Medical & Professional Affairs
J. Amora, Director, Corporate Supply Chain Strategy
P.V. Anantharam, Senior Vice President/CFO, Corporate Finance
M. Beverley, Assistant Vice President, Corporate Finance
M. Brito, CFO, Coler/Hank Carter Specialty Hospital & Skilled Nursing Facility

J. Bender, Assistant Director, Media, Corporate Communications
G. Calliste, Executive Director, North Central Bronx Hospital
T. Carlisle, Associate Executive Director, Corporate Planning Services
D. Collington, Associate Executive Director, Coney Island Hospital
F. Covino, Corporate Budget Director, Corporate Budget
L. Dehart, Assistant Vice President, Corporate Reimbursement Services
V. Fleming, Director, Corporate Office of Medical Affairs
R. Fischer, Associate Executive Director, Bellevue Hospital Center
L. Free, Assistant Vice President, Corporate Managed Care
J. Font, Director, EMR Clinical Information, Corporate IT
G. Guilford, Assistant Vice President, Office of the Senior Vice President/Finance/Managed Care
K. Garramone, CFO, North Bronx Health Care Network
T. Green, CFO, Metropolitan Hospital Center
C. Hercules, Chief of Staff, Board Affairs
L. Johnston, Senior Vice President, Medical & Professional Affairs
M. Katz, Senior Assistant Vice President, Corporate Revenue Management
B. Keller, Deputy Counsel, Officer of Legal Affairs
J. Linhart, Deputy Corporate Comptroller, Corporate Comptroller's Office
P. Lockhart, Secretary to the Corporation, Office of the Chairman
P. Lok, Director, Corporate Reimbursement Services/Debt Financing
F. Long, Acting Executive Director, Coler/Henry J. Carter
N. Mar, Director, Corporate Reimbursement Services/Debt Financing
A. Marengo, Senior Vice President, Corporate Communications/Marketing
R. Mark, Chief of Staff, Office of the President
A. Martin, Executive Vice President/COO, Office of the President
D. Moskos, Director, Office of Facilities Development
K. Olson, Assistant Vice President, Corporate Budget
P. Pandolfini, CFO, Staten Island /Southern Brooklyn Network
C. Parjohn, Director, Office of Internal Audits
K. Park, Associate Executive Director, Elmhurst Hospital Center
A. Rajkumar, Executive Director, Metropolitan Hospital Center
A. Rossano, Deputy Executive Director, Health & Home Care
C. Samms, CFO, Generations Plus/Northern Manhattan Network
A. Saul, CFO, Central Brooklyn Health Care Network
B. Stacey, CFO, Queens Health Network
M. Sullivan, Executive Director, Gouverneur Healthcare Services
U. Tambar, Chief Transformation Officer, Office of the President
S. VanOrden, Assistant Vice President, Corporate Comptroller's Office
J. Wilson, Senior Director, Corporate Strategic Sourcing
R. Wilson, Senior Vice President/Chief Medical Officer, Medical & Professional Affairs
J. Weinman, CFO, South Manhattan Network
O. Worthy, CFO, Gotham Health

CALL TO ORDER **BERNARD ROSEN**

The meeting of the Finance Committee was called to order at 9:05 a.m. The minutes of the December 1, 2015 meeting were approved as submitted.

CHAIR'S REPORT **BERNARD ROSEN**

SENIOR VICE PRESIDENT'S REPORT **P.V. ANANTHARAM**

Mr. Anantharam informed the Committee that the reporting would include the status of Health + Hospitals' (H+H) cash balance as of December 31, 2015 and that Julian John, Corporate Comptroller would report on that status. Since last month, H+H has received an update from the State that was very positive. Dr. Raju has been involved in getting the State and Federal governments to address the approval of H+H's UPL and DSH payments and it is expected that there will be some positive movement on this issue. Ms. Dehart would update the Committee on the status of the DSH/UPL payments. The utilization reports have been changed to reflect a better comparison of the actual data and would be reported by Ms. Olson. Mr. Covino would update the Committee on the November Plan and some positive news regarding the shift in FTEs.

Cash Update

Mr. John reported that through December 2015, H+H cash balance was $203.5 million or 15 days of cash on hand and assuming that all the actions reflected in the current cash flow occur as projected, the year-end cash balance is projected at $104.3 million or 6.5 days of cash on hand. DSH payments totaling $531 million are expected to-date and $401 million in UPS payments are expected in February 2016. In January 2016, $172 million in UPL payments scheduled for receipt in December 2015 but was deferred to January 2016.

Mr. Anantharam added that all of the pending payments put H+H in a better cash position.

State/Federal Update

Ms. Dehart stated that as reported by Mr. John and Mr. Anantharam H+H continues to make progress with the UPL calculations with the State and CMS. $172 million is expected during the month of January 2016 and has been fully approved to be processed for payment to H+H within the week. An additional $401 million is expected in February 2016 and in total for the remainder of the first quarter, $564 million is expected in UPL payments that includes an additional $73 million for prior year outpatient funds; $250 million of 2015 inpatient; $63 million 2015 nursing home; $32 million for three prior year D&TCs UPL and $146 million for 2015 outpatient payment is expected in March 2016.

Mr. Page asked if the 2015 was fiscal or calendar year. Ms. Dehart stated that it is calendar year. Mr. Page asked how fast H+ H could reapply for a period. Ms. Dehart stated that H+H expects to use that calculation and to apply trending on some volume adjustments for 2016. Theoretically the intent was to catch-up; in that 2015 would have been completed by January 2016 and H+H would have received some prospective payments for 2016. In the plan and the cash flow H+H has been extremely cautious and assumed that the "spend up" will not occur but it remains a possibility. The DSH of $531 million is

expected to-date with an additional $2 million immediately following and $291 million scheduled for year-end. As previously reported there are some risks relative to the receipt of those DSH funds in terms of both the magnitude and the timing. The source of that risk has to do with two factors. One being an over estimate in the State's prior year UPL payments to the voluntaries which was a swop of DSH for the voluntaries that created room for payments to H+H. A reduction of $51 million in DSH has been received with an additional $187 million being at risk and is currently being discussed with the State regarding the timing and ways of mitigating the takeback of those funds.

Ms. Youssouf asked for clarification of the risk to H+H. Ms. Dehart explained that due to the cash cap on the amount of DSH payments that can be made in a federal year; in order for the State to make those additional payments to the voluntaries cut off funds to make available for H+H. By law the State is required to make those adjustments; therefore, the state will need to address this issue in some fashion by spreading that adjustment over multiple federal years. There are some suggestions on how that takeback can be done that would minimize the impact to HHC which is a very high risk at this point.

Mr. Page asked what drives the timing of when the State makes the payment to the voluntaries. Ms. Dehart stated that it is in part negotiations with those hospitals with cash flow issues and the trade associations have been involved and their awareness of H + H cash flow issues and balancing all that with the federal cash caps.

Mr. Rosen asked what the funding sources are for the UPS and DSH. Ms. Dehart stated that in terms of the share it is 50/50, 50% Federal and 50% City. There are no State funds. The bulk of the DSH is the same with some minor pools such as the indigent care pool which the State pays the local match and H+H received approximately $100 million from that pool and the remainder of the DSH funding which is in excess of $1 billion.

Ms. Youssouf asked what the size of the pool is from which H+H receives the $100 million. Ms. Dehart stated that the pool is split and there is a voluntary portion of that and public hospitals' portion which is $139 million of which H+H receives $100 million. The voluntary portion is approximately $35 million.

Ms. Youssouf asked if that was statewide to which Ms. Dehart replied in the affirmative.

Mr. Anantharam added that there is a historical basis for the formulation of those pools in the 80's. There was a certain amount of pool for the bad debt and charity care (BDCC) funding and if available would be distributed on a formula basis, some for the public and the remainder for the voluntaries hospitals. Those funds were distributed based on the City, State and Federal. As H+H has tried to maximize the amount of DSH or BDCC that is received from the federal government, the City has stepped up indicating that there is a lot more room to collect federal DSH funding and the State has been reluctant to put in dollars for that basis. All of the funds that H+H received beyond the $100 million pool are all City and Federal shares.

Ms. Youssouf asked how the split between the voluntary and public was determined and whether it can be changed. Ms. Dehart stated that it is NYS statutory. In the last Governor's budget there was a proposal to give the State Health Commissioner the authority to adjust that split in the event that the

ACA DSH cuts were enacted. The State legislature did not address that issue at the time given that the cuts were not eminent.

Dr. Raju added that H+H has advocated for this change on an ongoing basis that recently included a trip to Albany to suggest a different methodology given that in the out years H+H will lose a significant amount of DSH if the change was not considered.

Mr. Rosen asked if the DSH was extended. Dr. Raju stated that the charity care law was extended for three years with the same methodology; however, H+H is requesting that there be another review of this issue.

Ms. Youssouf commented that to get a higher share is essential for H+H financial stability. Dr. Raju stated that this has been a major part of H+H's advocacy with its labor partners in support of this issue.

Financial Plan

Ms. Covino stated that the November 2015 Plan included the City's transfer of collective bargaining (CB) funds for carpenters, sheet metal workers of $3.9 million beginning in 2016 growing to $5 million by 2020. There was a significant transfer of CB for pensions for all of the prior settlements of approximately $43.9 million for FY 16 growing to $97.5 million in 2020. During the adoption phase the City transferred $28 million on behalf of FY 15.

Mr. Page asked if there is a commitment from the City to continue to cover those expenses for H+H as part of the incremental cost of the CB.

Mr. Anantharam stated that in as much as it is included in the City's financial plan.

Mr. Covino stated that in addition to the CB funding the City transferred $1 million for City Council funded items that included colonoscopy screening funding of $650,000; $3,000,000 for immigrant health and FY 16 restored intracity of $1.2 million that included, cure the violence plan of $5 million and ACS detention center programs of $1.5 million.

Ms. Youssouf asked what the total amount for those adjustments was to which Mr. Covino stated that the total was $60 million increasing to $102 million by 2020.

Mr. Rosen asked if H+H finance was working on a new January Financial Plan. Mr. Covino responded in the affirmative adding that it is scheduled for release shortly.

Mr. Rosen asked when the City's financial plan is scheduled for release to which Mr. Anantharam replied that it is scheduled to be release in the next ten days.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS **KRISTA OLSON/FRED COVINO**

Ms. Olson stated that the FY 16 utilization thru November 2015 as previously noted by Mr. Anantharam a methodological change was made to the outpatient utilization that included a switch in posted visits to date of service and with the current month reports, open visits were added to both the baseline and the current year in order to normalize the data between the two years that provides a clearer picture of workload than previously documented.

Ms. Youssouf asked for clarification of open visits. Ms. Olson stated that they are visits that have occurred during that month but were not closed or billed during the period.

Ms. Katz added that a patient came in for service that was not properly coded in addition to the clinical documentation are all required in order to close the visit in order for it to be properly billed.

Ms. Youssouf asked what percent of the utilization do open visits represent. Ms. Olson stated that information was not readily available but would report back to the Committee on that data. Ms. Katz added that it is usually not a large percentage; however, due to recent change in behavioral health regulations and substance abuse, there are issues associated with that. In addition to the conversion to ICD-10 there were some code changes that increased the volume of the open visits. There has always been a certain amount but usually within three days from the date of service those visits are closed.

Ms. Youssouf asked what percentage of H+ H visits the open visits represents. Ms. Olson stated that it varies by facility and facilities improved with the adjustment compared to last month with some hospitals improving significantly more than others.

Ms. Youssouf added that based on the responses it would appear that it is yet to be determined whether this is a major problem or not.

Dr. Raju stated that it is monitored on a daily basis by Ms. Katz's office and a report is issued on all of the open visits to ensure that visits are properly closed. There are a number of factors that contribute to the open visits issue one being, pending lab results that would allow the physician to make a final diagnosis. On the ambulatory care side the physicians are the providers and also code the cases as opposed to the inpatient side and in some instances it is difficult to find the appropriate codes which delays the process of closing the visits.

Ms. Katz added that another factor is that the services provided by the residents requires the sign-off of the attending physician.

Ms. Olson continuing with the reporting stated that corporate wide there has been a 1% improvement in the non-outpatient utilization. Acute visits are up by 1.5%; D&TCs were down by 3.1%. Discharges were down by 3.2%; nursing home days were down by 1.1%. The ALOS comparison, Coney Island remained above the corporate average by 7/10% greater than the average. The CMI was up by 3% over last year.

Ms. Youssouf asked what the issue was with the decline at Jacobi. Ms. Olson explained that the decline related to the increase in discharges at NCB due to the reopening of their labor and delivery unit and that shift offset the other.

Mr. Covino further explained that the services were transferred to Jacobi and subsequently moved over to NCB. When that service was closed at NCB services were shifted to Jacobi. Last year Jacobi was up by a very similar amount and the comparison net between the two facilities cancels out. Continuing with the reporting as part of the cash receipts and disbursements, Mr. Covino reported that the global FTEs base period as of FY 15 as 48,406 compared to 49,409 as of November 2015, a net increase of 1,003. The increase is predominately in full time staffing in the following categories

tech/specs 286; housekeepers/environmental hotel 179; 149 aides and orderlies/pcts; 157 in RNs; 105 clericals; 122 managers; 59 residents; and 11 physicians. FTEs are up across the system but there has been a decrease in the FTE count as of December 2015 compared to the increase through November 2015 of 2,103 above the target of June 13, 2016. This is a considerable reduction that must be achieved by June 30, 2016.

Mr. Page asked what the attrition rate is for H+H. Mr. Covino stated that it is about 6% annually which is the standard.

Mr. Rosen asked if the hospitals failed to achieve their FTE target but achieved the dollar target reduction would that be acceptable. Mr. Covino stated that there are reductions in other areas such as allowances.

Ms. Youssouf asked whether the staff currently being hired is being done to reduce overtime given that the conversion of overtime expenses was already included in the global target. Mr. Covino explained that it is included but Mr. Rosen was referring to the revenue as an offset to make-up the savings and the incentive to generate some savings in those areas. Additionally, there are some OTPS savings that are expected as well. In terms of the hiring to reduce overtime, it not clear whether that is being done across the system for that purpose; however, there has been a shift to reduce hourly and temporary employees but even with those efforts, the global FTE has increased substantially during the year. There have been discussions with the Networks regarding their plans for achieving the targets and each Network will present their plan status to the Committee.

Ms. Youssouf stated that the bottom-line is that full time staff is more productive than the hourly and whether those reductions or shifts would be sufficient to achieve the target.

Mr. Covino stated that it will be extremely difficult to achieve the target by 6/30/16. Moving back to the reporting, receipts were $23 million under collected compared to disbursements of $81 million over budget. Cash receipts and disbursements against the prior fiscal year for the same period, receipts were up by $446 million from last year; inpatient services were up by $21.2 million due to an increase in Medicaid and Medicaid managed care. Outpatient receipts were $18 million above the target due to Medicaid managed care as a result of the distribution of the MetroPlus risk pools. All other was up by $406 million primarily due to an increase in DSH and UPL payments up by $176 million.

Ms. Youssouf asked if those numbers were included in the budget and had those payments come in as expected would the numbers look much differently. Mr. Covino responded in the affirmative.

Mr. Page noted that since the FTE global target will not be achieved by the end of the fiscal year what steps are being take to address the issue.

Mr. Anantharam agreeing with Mr. Page stated that was concluded last month which as part of the next step action, Dr. Raju and Mr. Martin met with all of the hospitals' executive directors to strategize on minimizing hiring while maintaining quality and services. The FTEs are being monitored on a biweekly basis and a review of the details of all replacements and separations to determine where

those hires are occurring so that the appropriate discussions with those hospitals can be done regarding those changes.

Dr. Raju stated that there are some things that have occurred that have changed the dynamics of achieving the FTE target. For example, DSRIP requires the creation of more community initiatives; extra clinics to achieve that requirement along with other initiatives as well. The hospitals must be more cognitive of their hires. The targets as of now appear to be unattainable by year end; however, the goal was to get the hospitals to focus on changing the prior practices. There will always be initiatives that will require certain staffing levels; however, the way in which those staffing needs are addressed is the issue.

Mr. Page added that all initiatives should be address with an understanding that they should be cost free.

Dr. Raju stated that every effort is being made to review those initiatives but there are some operational realities that must be taken into account while maintaining quality care and meeting the requirements of the regulatory agencies.

Ms. Youssouf added that when H+H does get the money the deficit would be larger.

Mr. Covino stated that corporate finance has been addressing this issue with the City and trying to adjust the cash balances accordingly but not very easily achievable.

Dr. Raju stated that the operational cost and how much is being collected, the net would always show a gap due to the uninsured. The question has been how H+H compensates for that loss and whether there are ways of achieving those targets. Currently it is partially offset by the DSH/UPL but that is being done against an increasing demand for services for the indigent population. H+H patients are complex and in addition to their medical needs there are social needs that must be addressed in the emergency department, by ensuring that those patient get their medications.

Mr. Covino reported that expenses were $3.2 million over last year due to an increase in FTEs that was offset by a large retro payment that was paid last year for collective bargaining for DC 37, NYSNA and 1199. Fringe benefits were up by $13 million due to an increase in health insurances and welfare fund benefits. OTPS expenses were up by $28 million due to an increase in the number of days in accounts payable. Going forward those payments will be staggered to be more consistent with the prior year number from 53 days to 72-80 days. City payments were up by $309 million due to payments made on behalf of FY 14 for medical malpractice; debt services, health insurances payments and OTPS reimbursements. Affiliation expenses were up by $34.4 million based on collective bargaining for physicians and the new contracts that were initiated last year. A comparison of actual to the budget, receipts were basically unchanged, $1 million worse than budget compared to October 2015. YTD receipts were down by $24 million on the inpatient side; $27 million outpatient all other was up by $28 million. Expenses, PS and FB were up by $21.9 million and $3.5 million respectively due to an increase in FTEs. OTPS expense were $54 million over budget due to a reduction in the number of days in accounts payable in addition to an increase in spending in medical surgical supplies, up by $17 million, pharmaceuticals up by $16 million; other professional services up by $9.6 million. City payments and

bond debt were on budget and affiliation expenses were over budget by $1.9 million due to a prior year payment to PAGNY for the recruitment of physicians. The reporting was concluded.

INFORMATION ITEM
GLOBAL FTES NETWORK STATUS **STEVE ALEXANDER**

Mr. Alexander, Executive Director, Bellevue Hospital Center introduced the team representing the Network that included, Anthony Rajkumar, Executive Director, Metropolitan Hospital, Martha Sullivan, Executive Director, Gouverneur Healthcare Services, Floyd Long, Acting Executive Director, Coler/Carter Long Term Care/Chronic Care Services, and Jay Weinman, CFO, Bellevue Hospital Center. Mr. Alexander informed the Committee that the presentation would be presented by Mr. Weinman and that the Network plan would show the work that has been done consistently across the Network and each facility. The discussion by the Committee regarding the fiscal reality in which the hospital are attempting to operate. The strategic decision that was made to address the global target is of great concern and important to the hospitals in the sense of how the hospitals work together as acute care hospital, ambulatory care and long term care facilities. The type of work that has been done in the Network has been collaborative and has continued in different ways going forward. The targets were based on historical trends and performances that have changed in the past eighteen months that will be address by Mr. Weinman in the presentation relative to the actions that have been taken and continued in order to remain within the allocated resources.

Mr. Weinman stated that the presentation would show the Network's status against the global FTE target; what has contributed to the increase in FTEs and the plan to meet the target. The information shown reflected the data from the Key Indicators report as of November 2016. The Network's FTEs reduction of 220 or 2.7% over the targeted global FTEs and increased by 1.9% since June 2015. The utilization data showed that actual discharges were 185 above last year for the Network. The variances for patient days and visits were less than .5% variance from last year. One of the factors contributing to the Network's challenge relates to the average daily census that increased by 3.5%. Based on the discharges and the CMI adjusted discharges are up by 4.5%. This is due to a change in medical surgical and newborns due to more complex cases in neonatal ICU and psych. The CMI also increased at Coler/Carter. The inpatient psych census increased and the Article 28 survey at Coler/Carter that required an increase in resources in preparation for that survey. Coler/Carter has also been challenged with the demand for meeting the needs of the respiratory therapy coverage due to an increase in ventilator patients. The overall physical plants are aged and represent a challenge and upkeep and maintenance due to the aging of the overall plants. There are some technical issues that are being addressed with corporate finance.

Mr. Page asked what the increase in ventilator patients was attributable to. Mr. Long stated that at Coler/Carter Long Terms Care (LTC), at the Carter campus the patients are primarily ventilator patients in the LTC and a ventilator unit was opened in the nursing facility. There are an additional 20 certified beds that opened and is reflected in the CMI.

Mr. Page asked why had the use of those services increased.

Dr. Raju stated that those services have ranked very highly in terms of being one of the best in this area. These are patient who are on respirators that are eventually weaned off of the use of those respirators which is a unique service and process. These patients come from other H+H hospitals. It is considered to be one of the best service and it frees up beds at the acute care hospitals which from a revenue perspective is a major factor.

Mr. Page added that this is a great success and recognized service that is better for patients.

Mr. Alexander explained that the reason it was described as a challenge was because it is a needed service that has grown significantly and developed into a major function for the hospital while at the same time trying to stay within a limit and a headcount.

Mr. Weinman continued stating that besides those increases there are other improvements that are being addressed having to do with the expanded services in the outpatient clinics, Metropolitan, Bellevue and Gouverneur as part of improving access across the Network. The LGBT at Gouverneur services were expanded. There are revenue cycle committees at each hospital to address denials, and accounts receivable issues. Inpatient clinical documentation improvement at Bellevue, there was an increase in the CMI both from the clinical and patient mix those improvements were achieved. The MetroPlus collaboration at Gouverneur has opened some channels with the community relative to maintaining and improving MetroPlus retention which is extremely important so as not to lose business. Ongoing discussions with the affiliates on productivity standards and monitoring for controlling the FTEs. The rates at the LTC have improved at Coler/Carter as a way of increasing revenues. The Network process for managing the FTEs that include weekly meeting to review staffing needs relative to the needs and that the appropriate justification documents that are needed. Revenue generating positions are also reviewed in terms of return on investment and the alignment with the 20/20 vision.

Ms. Youssouf asked how the Network determines or reviews the ROI. Mr. Weinman in response stated that as an example, an increase in the neonatal unit, the census is reviewed closely as it relates to any significant change to the standard. In every investment that is made an analysis is done to ensure that there is a return on investment and whether it is sustainable.

Ms. Youssouf asked what type of ROI is being targeted and whether it is relative to a positive or a break even. Mr. Weinman stated that the focus was primarily a break even that would cover the cost. Additionally, the Network has standardized overtime to curtail the usage; biweekly JOC meetings with the affiliates are held; FTE monitoring reports are reviewed and those areas where there are overages are targeted for reductions. The NASH analytics are under review to take advantage of reducing nursing premium costs and where those opportunities exist.

Ms. Youssouf asked what NASH is. Dr. Raju asked Loren Johnston, Corporate Chief Nursing Officer to respond. Ms. Johnston stated that NASH is the firm that H+H contracted to review the utilization of the nursing staff to ensure that the appropriate utilization of staff based on those needs.
The presentation was concluded.

INFORMATION ITEM
CENTRALIZED PRUCHASING **PAUL ALBERTSON**

Before beginning the presentation, Mr. Covino informed the Committee that as part of the financial plan there are gap closing initiatives to general approximately $309 million in savings and included in those initiative is the centralized purchasing, supply chain group that will update the Committee on the status of that initiative.

Mr. Albertson, Senior Assistant Vice President, Corporate Supply Chain Services introduced the team that would be participating in the presentation, Jun Amora, Director, Supply Chain Strategy and Joe Wilson, Senior Director, Strategic Sourcing. The presentation would cover the status of the realized value for the Health + Hospitals. In 2013, at the request of Mr. Martin, the goal was to consolidate the eight local H+H purchasing office into a single supply chain office to take advantage of the quality savings and standardization benefits that many organizations such as H+H have realized across the country. Consequently, all of the eight local purchasing offices were centralized into a single purchasing team and all of the technology was also centralized into a single standard approach so as to simplify the selection of standard items that were contracted. Approximately 110,000 purchase orders are processed annually of which half are now selected from the item master that gets processed with 24 hours. The traditional work of the purchasing offices has been processing purchasing order (PO). The interest as an integrated delivery Network is moving to the next step which is to have a supply chain occur across the system in driving that automated standardization and move into strategic sourcing which the opportunity for being able to work with the vendor partners and stakeholder to be able to select the right product of good and services and equipment that is standardized across the system in order to get the best pricing. As routine transactions are automated, the ability to drive the healthcare transformation that provide a better quality in services and savings. The savings are being focused on in six natural groupings, med/surgical, pharmacy, radiology, labs, perioperative and business office related activities. In the five months of the current FY 16 the value that was realized in those categories has added up to $33 million which is related to the value of the contracts, rebates, cost avoidance, revenue that becomes additional across the period. There are a number of active projects that are being worked on to-date that are expected to generate additional savings by the end of FY 16.

Ms. Youssouf asked for clarification of cost avoidance. Mr. Wilson in response stated that it would fall into the world of capital purchases whereby the end users are reaching out taking a piece of capital equipment in conjunction with the H+H procurement team that would intervene using national bench

marketing companies, negotiate and take the prices that would have been submitted and pay less than that, the difference would be the cost avoidance.

Mr. Rosen asked if the first item as part of cost avoidance included as part of the med surgical contract amount of $6.1 million included the cost avoidance and revenue as part of the total savings.

Mr. Martin asked the group to explain the three categories, contract, COA, and revenue.

Mr. Wilson stated that as it pertains to med surgical contracting that is a different element. The contract is renegotiated or if the contract is expiring there will be a bid and that would be an apple to apple comparison in the pricing. The cost avoidance in the same area as it relates to the capital or in the event the supply chain is able to negotiate an enhancement for them to write off a cost; take away a charge such as freight charges; and revenues are the rebates and these are contracts that were written for keeping a certain market share that would be refunded to H+H in the form of a check or a rebate.

Mr. Rosen asked if the revenues were considered a discount. Mr. Wilson stated that it is somewhat of a reward for them keeping their market share with that category in the form of a check.

Mr. Page questioned the footing for the revenue columns that did not add properly. Mr. Albertson in response stated that it was an error and that the $7 million should have been included. A correction would be made to reflect that change but that it had been excluded per Mr. Covino. Ms. Olson added that there was a $7 million loss.

Mr. Rosen asked if the labs included the new restructuring in that area whereby H+H has a joint venture with NSLIJ.

Mr. Amora stated that particular dollar amount, $780,000 projected savings in the labs accounted for some of the routine supplies used internal within H+H. There are future savings that will close in the next sixty days that relate to some of the large negotiations with NSLIJ.

Mr. Rosen asked if the total savings of $33 million were representative of actual savings.

Mr. Albertson stated that the savings included all of the contracts that were renegotiated, all of the rebates, and the $7 million is largely comprised of funds that were received from the contracted pharmacies. All of the documentation is tracked in conjunction with Mr. Covino and Ms. Olson and reviewed so that it is appropriately documented as part of the savings. There is documentation for each of those numbers identified that are developed and validated with finance, Mr. Covino and Ms. Olson.

Ms. Youssouf asked if the $33 million in savings reflected a cost that had those actions described were not effectuated.

Mr. Wilson stated that some of those savings are but would have been an expense had those things not happened.

Mr. Albertson stated that two areas would be highlighted, pharmacy and the elements that make up those dollars, Mr. Wilson would address and Mr. Amora would expand more on the labs and future state.

Mr. Wilson stated that the $7.3 million reimbursement comes from the 400 pharmacies contracted with H+H for providing medications/drugs. Those savings are reflective of the reimbursement earned during the first five months of the FY 16 with an additional $16 million in reimbursement by the end of the FY 16. One of the primary distributors for pharmaceuticals for H+H is Cardinal and there was an opportunity to renegotiate the contract that allowed for a move from a single cost minus structure to a bifurcated cost minus structure, one for the GO account and one for the 340B that resulted in a 2.15% increase for the cost minus GPO, 2.4% for the 340B account. This resulted in a saving of $5.4 million within that number, a $1.6 million credit was negotiated for the forgiveness of all late charges. The supply chain is partnering with medical and professional affairs regarding the corporate formulary process that includes providing support for analytics, contracting to work in partnership to make better decisions around economies of scales having centralized contracts decision making within the division. The corporate procurement office has hired a pharm D and a foreign pharmacy graduate to do the analytics to provide the backup to Dr. Victor Cohen and Dr. Machelle Allen as part of that Committee.

Mr. Amora stated that in terms of the lab value analyses team, the focus is to look at the replacement of certain equipment throughout the hospitals. Also some of the agreements are being renegotiated. The $780,000 savings relate primarily to the routine reagents and the renegotiation of the Seamen's agreements for services reductions of 35% over the life of three years for the remaining equipment. The supply chain has closed out an agreement for the cost of whole blood with the NY Blood Center in partnership with Northwell. Soon to close will be large projects with Northwell around chemistry, hematology and tests sent out. In chemistry a 45% reduction is expected at the cost per test.

Mr. Rosen asked whether the savings for the joint venture with NSLIJ were included. Mr. Amora stated that the savings did not reflect the work that has been done with North Shore. However, in a future update those savings would be included. The joint lab with North Shore is not yet completed; however, some of H+H lab tests are being sent to the North Shore care lab. There will be a separate presentation on the lab project that will include the Cerner conversion and the paid response lab model.

Ms. Youssouf asked how the Surgical Solution contract fits into the procurement process relative to savings.

Mr. Amora stated that the Surgical Solutions is a contract that is managed by Joe Quinones, Chief Contracting Officer and that team is working on building relationships with the perioperative counsel and Dr. Wilson for standardizing and savings.

Mr. Martin added that it is expected to be incorporated into the supply chain counsel in the future. However, based on feedback from the hospitals, Surgical Solutions is working very well and the metrics are being achieved. At a later date Mr. Quinones can update the Committee on the status of that contract.

Mr. Albertson stated that there is a list of all of the projects that are being undertaken and scheduled for completion by fiscal year end. The diversity supplier's relative to the vision that has been established by Dr. Raju in concert with NYS requirements and involves a lot of work going forward. One of the challenges is the definition for minority women business enterprise and where they are contracted within H+H. To address this issue a diversity supplier manager was hired to reach out to the larger vendors to look at the subcontracts that are used by the primary vendors. Information on those subcontractors that are used by the primary vendors is not readily available to H+H. This is a major requirement as part of a NYS reporting on this data and engaging finance and IT to rollout the enterprise resource planning from a supply chain perspective.

Mr. Amora stated that in terms of the transformation with H+H system the strategic planning efforts through the development of a centralized technology and strategic sourcing team to allow for the negotiation of prices which represents half of the process. Controlling and managing how supplies are used and distributed are all key to the overall management process relative to utilization. By lowering the price and managing the utilization the cost can be controlled. As part of this effort and ERP system enterprise resource planning would be used which will allow for transparency across H+H for inventories patterns, ordering and stock outs. Using barcoding to order off of par levels based on demand. Finally to charge back those costs to the cost centers to determine and pinpoint usage and efficiencies.

Ms. Youssouf complemented the team on the work done as part of the transformation of that process which for H+H is a major accomplishment.

Mr. Page asked if H+H has any leverage in the generic drug pricing given its volume.

Dr. Wilson in response stated that H+H does not have any leverage. The provider system is in the hands of the suppliers in this area in driving the pricing.

Mr. Page asked if H+H is allowed to buy drugs outside of the US to which the response was no.

Mr. Martin added that in addition to the current saving of $33 million there is a total commitment of $75 million for the current FY 16.

Mrs. Bolus asked if IT was involved in the process given that oftentimes, the implementation of new initiatives has had some issues. Mr. Martin stated that with the ERP IT has been involved in ensuring that the appropriate training for the users is done and has been working very closely with procurement and finance to ensure that there is coordination. The presentation was concluded.

INFORMATION ITEM
QUARTERLY REPORTING SHORT TERM LEASES **LINDA DEHART**

Ms. Dehart informed the Committee that the reporting represented a new quarterly presentation on the status of H+H short term capital financing program. The Board authorized H+H's CFO to borrow up to $120 million to meet H+H equipment and short term financing needs. A secondary lien on H+H healthcare revenues that has facilitated the closing of two loans under the program. The first loan was with JP Morgan for $60 million which was in July 2015 and the second $60 million with Citibank closing in October 2015. The terms for those two loans include as approved by the Board include for the JP Morgan loan is a twelve month drawdown period which expires in July 2016 at that point it would convert to a six year fixed rate. It is a variable rate for the drawdown period. The current rate on the drawdown as of December 2015 was .9681%. The fixed loan rate as of January 2016 would be 1.7608%. Citibank is a revolving loan with a variable rate and a three year maturity. It is currently at 0.76% interest rate. The plan spending for the two loans under the JP Morgan loan is primarily for equipment and the Citibank loan is for IT and some infrastructure work which was additional flexibility that was not available on the JP Morgan loan. The current activity under each of the loans, there was an initial drawdowns of $10 million on each loan. As of December 2016 JP Morgan, $7.2 million was vouched as well as issuance cost of $187,000 with an unspent balance under the JP Morgan loan of $2.6 million outstanding encumbrances against this loan for $14.4 million and the Office of Facilities Development(OFD) has an additional $15 million for requests from the hospitals that is currently under review. Citibank, $150,000 has been vouched against the loan cost of issuance of $250,000; $9.6 million unspent balance.

Ms. Youssouf asked why the cost of issuance was greater for Citibank and greater than what has been drawn and whether that was a one-time cost.

Ms. Dehart stated that was a one-time cost. Ms. Youssouf asked if there will be any additional issuance costs when it converts. Ms. Dehart stated that there should not be any additional cost related to the conversion.

Ms. Youssouf asked that it be verified that there will not be any additional cost.

Ms. Dehart stated that she would confirm that understanding. Finalizing the presentation, for the Citibank loan the outstanding encumbrances are over $300,000 with additional requests totaling $5 million. The reporting was concluded.

ADJOURNMENT **BERNARD ROSEN**

There being no further business to discuss the meeting was adjourned at 10:35 a.m.

KEY INDICATORS/CASH RECEIPTS & DISBURSEMENTS REPORTS

KEY INDICATORS
FISCAL YEAR 2016 UTILIZATION

Year to Date
December 2015

NETWORKS	UTILIZATION						AVERAGE LENGTH OF STAY		ALL PAYOR CASE MIX INDEX	
	VISITS			DISCHARGES/DAYS						
	FY 16	FY 15	VAR %	FY 16	FY 15	VAR %	ACTUAL	EXPECTED	FY 16	FY 15
North Bronx										
Jacobi	208,119	212,546	-2.1%	8,977	9,729	-7.7%	6.0	6.3	1.0228	0.9689
North Central Bronx	105,565	102,641	2.8%	3,151	2,383	32.2%	4.6	4.8	0.6928	0.7698
Generations +										
Harlem	156,284	154,411	1.2%	6,025	5,691	5.9%	5.4	5.8	0.9367	0.9340
Lincoln	272,561	272,156	0.1%	11,030	11,757	-6.2%	5.1	5.4	0.8465	0.8079
Belvis DTC	28,235	27,149	4.0%							
Morrisania DTC	40,981	41,801	-2.0%							
Renaissance	21,236	20,997	1.1%							
South Manhattan										
Bellevue	301,558	294,444	2.4%	11,711	11,982	-2.3%	6.3	6.3	1.1465	1.0871
Metropolitan	198,101	200,560	-1.2%	5,025	4,508	11.5%	4.8	5.2	0.8174	0.8468
Coler				132,803	136,248	-2.5%				
H.J. Carter				56,712	57,518	-1.4%				
Gouverneur - NF				37,501	36,966	1.4%				
Gouverneur - DTC	124,635	129,403	-3.7%							
North Central Brooklyn										
Kings County	337,194	344,933	-2.2%	10,885	11,035	-1.4%	6.0	5.9	0.9786	0.9921
Woodhull	238,449	240,974	-1.0%	5,309	5,902	-10.0%	5.0	5.2	0.8728	0.8280
McKinney				56,728	57,033	-0.5%				
Cumberland DTC	36,189	40,222	-10.0%							
East New York	40,455	41,503	-2.5%							
Southern Brooklyn / S I										
Coney Island	179,352	161,111	11.3%	7,077	7,750	-8.7%	7.1	6.2	0.9971	0.9457
Seaview				54,735	54,794	-0.1%				
Queens										
Elmhurst	338,535	315,556	7.3%	9,530	10,310	-7.6%	6.0	5.6	0.9387	0.8860
Queens	213,749	212,356	0.7%	6,039	6,283	-3.9%	5.2	5.3	0.8216	0.7963
Discharges/CMI-- All Acutes				84,759	87,330	-2.9%			0.9451	0.9187
Visits-- All D&TCs & Acutes	2,841,198	2,812,763	1.0%							
Days-- All SNFs				338,479	342,559	-1.2%				

Utilization

Discharges: exclude psych and rehab

Visits: Beginning with the November 2015 Board Report, FY15 and FY16 utilization is now based on date of service, and includes open visits. HIV counseling visits that are no longer billable have been excluded. Visits continue to include Clinics, Emergency Department and Ambulatory Surgery.

LTC: SNF and Acute days

All Payor CMI

Acute discharges are grouped using New York State APR-DRGs version 32

Average Length of Stay

Actual: discharges divided by days; excludes one day stays

Expected: weighted average of DRG specific corporate average length of stay using APR-DRGs

KEY INDICATORS

FISCAL YEAR 2016 BUDGET PERFORMANCE ($s in 000s)

Year to Date December 2015

NETWORKS	GLOBAL FTEs			RECEIPTS		DISBURSEMENTS		BUDGET VARIANCE	
	Jun 15	Dec 15	Target	actual	better / (worse)	actual	better / (worse)	better / (worse)	
North Bronx									
Jacobi	4,189	4,241		$ 246,669	$ (11,733)	$ 328,894	$ (18,557)	$ (30,290)	-5.3%
North Central Bronx	1,391	1,435		82,311	1,623	101,254	3,046	4,669	2.5%
	5,580	5,676	5,612	$ 328,980	$ (10,110)	$ 430,148	$ (15,511)	$ (25,621)	-3.4%
Generations +									
Harlem	3,191	3,244		$ 167,802	$ 6,346	$ 216,832	$ (14,235)	$ (7,889)	-2.2%
Lincoln	4,197	4,390		256,474	9,630	286,399	520	10,150	1.9%
Belvis DTC	141	143		7,013	89	9,143	(65)	25	0.2%
Morrisania DTC	261	265		10,676	673	15,086	(1,298)	(625)	-2.6%
Renaissance	174	182		5,896	(486)	10,499	(163)	(649)	-3.9%
	7,964	8,224	7,362	$ 447,861	$ 16,252	$ 537,959	$ (15,241)	$ 1,011	0.1%
South Manhattan									
Bellevue	5,899	6,008		$ 359,537	$ (5,435)	$ 433,252	$ (26,935)	$ (32,370)	-4.2%
Metropolitan	2,709	2,747		140,121	2,848	173,939	(12,424)	(9,576)	-3.2%
Coler	1,224	1,222		47,149	1,694	69,673	(4,017)	(2,323)	-2.1%
H.J. Carter	972	1,023		55,028	(749)	74,579	(7,045)	(7,793)	-6.3%
Gouverneur	890	888		34,353	(8,837)	57,648	(170)	(9,007)	-8.9%
	11,694	11,888	11,601	$ 636,187	$ (10,479)	$ 809,093	$ (50,590)	$ (61,069)	-4.3%
North Central Brooklyn									
Kings County	5,559	5,528		$ 343,793	$ 2,071	$ 410,828	$ 7,846	$ 9,917	1.3%
Woodhull	3,148	3,170		182,711	7,896	219,007	(7,831)	65	0.0%
McKinney	467	471		18,665	(2,190)	23,904	484	(1,706)	-3.8%
Cumberland DTC	236	230		10,581	(872)	14,976	(2,997)	(3,869)	-16.5%
East New York	233	236		11,969	204	14,439	426	630	2.4%
	9,643	9,635	9,439	$ 567,719	$ 7,109	$ 683,152	$ (2,072)	$ 5,037	0.4%
Southern Brooklyn/SI									
Coney Island	3,229	3,365		$ 152,942	$ (16,078)	$ 226,822	$ (17,882)	$ (33,960)	-9.0%
Seaview	538	554		23,211	21	27,758	(2,952)	(2,931)	-6.1%
	3,767	3,919	3,466	$ 176,153	$ (16,057)	$ 254,580	$ (20,834)	$ (36,891)	-8.7%
Queens									
Elmhurst	4,492	4,519		$ 235,662	$ (15,015)	$ 306,746	$ (9,085)	$ (24,100)	-4.4%
Queens	2,918	3,001		150,950	(7,977)	227,921	(8,337)	(16,314)	-4.3%
	7,410	7,520	7,428	$ 386,612	$ (22,992)	$ 534,668	$ (17,422)	$ (40,414)	-4.4%
NETWORKS TOTAL	**46,058**	**46,862**	**44,908**	**$ 2,543,512**	**$ (36,278)**	**$ 3,249,600**	**$ (121,669)**	**$ (157,947)**	**-2.8%**
Central Office	770	784	770	400,396	8,569	160,243	1,949	10,519	1.9%
Care Management	518	514	518	12,853	(7,673)	21,886	(1,851)	(9,524)	-23.5%
Enterprise IT/Epic	1,060	1,153	1,110	5	(79)	72,933	11,409	11,329	13.4%
GRAND TOTAL	**48,406**	**49,313**	**47,306**	**$ 2,956,766**	**$ (35,460)**	**$ 3,504,662**	**$ (110,163)**	**$ (145,623)**	**-2.3%**

Global Full-Time Equivalents (FTEs) include HHC staff and overtime, hourly, temporary and affiliate FTEs. Enterprise IT includes consultants.

Care Management includes HHC Health & Home Care and the Health Home program.

New York City Health & Hospitals Corporation
Cash Receipts and Disbursements (CRD)
Fiscal Year 2016 vs Fiscal Year 2015 (in 000's)
TOTAL CORPORATION

	Month of December 2015			Fiscal Year To Date December 2015		
	actual 2016	actual 2015	better / (worse)	actual 2016	actual 2015	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 69,696	$ 66,429	$ 3,267	$ 448,817	$ 402,986	$ 45,832
Medicaid Managed Care	69,321	51,757	17,564	357,501	315,355	42,145
Medicare	61,263	56,365	4,899	290,819	294,079	(3,260)
Medicare Managed Care	29,460	37,222	(7,762)	137,979	176,627	(38,648)
Other	20,635	19,395	1,239	105,663	111,256	(5,593)
Total Inpatient	$ 250,374	$ 231,167	$ 19,207	$ 1,340,779	$ 1,300,303	$ 40,476
Outpatient						
Medicaid Fee for Service	$ 30,130	$ 11,254	$ 18,876	$ 88,554	$ 100,088	$ (11,534)
Medicaid Managed Care	46,831	125,755	(78,924)	244,137	284,548	(40,411)
Medicare	5,645	6,352	(707)	29,715	32,889	(3,174)
Medicare Managed Care	16,729	11,142	5,587	68,752	51,425	17,327
Other	8,886	26,543	(17,657)	69,314	86,495	(17,180)
Total Outpatient	$ 108,221	$ 181,046	$ (72,825)	$ 500,472	$ 555,445	$ (54,973)
All Other						
Pools	$ 12,292	$ 12,144	$ 148	$ 135,547	$ 136,642	$ (1,095)
DSH / UPL	-	-	0	607,345	430,887	176,459
Grants, Intracity, Tax Levy	13,758	10,091	3,666	331,518	132,652	198,866
Appeals & Settlements	(13,729)	(1,077)	(12,652)	1,131	(10,656)	11,787
Misc / Capital Reimb	4,673	5,583	(910)	39,973	29,022	10,950
Total All Other	$ 16,994	$ 26,741	$ (9,747)	$ 1,115,514	$ 718,548	$ 396,966
Total Cash Receipts	**$ 375,590**	**$ 438,954**	**$ (63,364)**	**$ 2,956,766**	**$ 2,574,296**	**$ 382,469**
Cash Disbursements						
PS	$ 311,045	$ 200,436	$ (110,609)	$ 1,443,449	$ 1,329,656	$ (113,793)
Fringe Benefits	62,113	57,257	(4,856)	415,635	397,731	(17,904)
OTPS	126,217	123,745	(2,472)	756,778	726,226	(30,552)
City Payments	-	-	0	309,405	-	(309,405)
Affiliation	106,076	92,789	(13,286)	538,455	490,797	(47,658)
HHC Bonds Debt	7,141	5,839	(1,302)	40,939	39,708	(1,231)
Total Cash Disbursements	**$ 612,592**	**$ 480,066**	**$ (132,526)**	**$ 3,504,662**	**$ 2,984,119**	**$ (520,543)**
Receipts over/(under) Disbursements	**$ (237,002)**	**$ (41,112)**	**$ (195,890)**	**$ (547,896)**	**$ (409,822)**	**$ (138,074)**

New York City Health & Hospitals Corporation
Actual vs Budget Report
Fiscal Year 2016 (in 000's)
TOTAL CORPORATION

	Month of December 2015			Fiscal Year To Date December 2015		
	actual 2016	budget 2016	better / (worse)	actual 2016	budget 2016	better / (worse)
Cash Receipts						
Inpatient						
Medicaid Fee for Service	$ 69,696	$ 84,075	$ (14,380)	$ 448,817	$ 456,133	$ (7,316)
Medicaid Managed Care	69,321	62,417	6,903	357,501	361,257	(3,756)
Medicare	61,263	58,796	2,467	290,819	280,210	10,609
Medicare Managed Care	29,460	29,810	(349)	137,979	149,032	(11,053)
Other	20,635	21,236	(602)	105,663	124,161	(18,497)
Total Inpatient	$ 250,374	$ 256,334	$ (5,959)	$ 1,340,779	$ 1,370,793	$ (30,014)
Outpatient						
Medicaid Fee for Service	$ 30,130	$ 15,112	$ 15,018	$ 88,554	$ 82,172	$ 6,382
Medicaid Managed Care	46,831	45,277	1,554	244,137	252,019	(7,882)
Medicare	5,645	7,494	(1,849)	29,715	36,779	(7,064)
Medicare Managed Care	16,729	17,346	(617)	68,752	71,047	(2,295)
Other	8,886	11,866	(2,981)	69,314	74,320	(5,006)
Total Outpatient	$ 108,221	$ 97,096	$ 11,125	$ 500,472	$ 516,336	$ (15,864)
All Other						
Pools	$ 12,292	$ 14,786	$ (2,494)	$ 135,547	$ 138,588	$ (3,041)
DSH / UPL	-	-	0	607,345	607,345	(0)
Grants, Intracity, Tax Levy	13,758	10,915	2,842	331,518	329,218	2,300
Appeals & Settlements	(13,729)	-	(13,729)	1,131	(4,674)	5,805
Misc / Capital Reimb	4,673	8,707	(4,034)	39,973	34,620	5,353
Total All Other	$ 16,994	$ 34,408	$ (17,414)	$ 1,115,514	$ 1,105,097	$ 10,417
Total Cash Receipts	**$ 375,590**	**$ 387,838**	**$ (12,248)**	**$ 2,956,766**	**$ 2,992,226**	**$ (35,460)**
Cash Disbursements						
PS	$ 311,045	$ 297,309	$ (13,735)	$ 1,443,449	$ 1,407,795	$ (35,654)
Fringe Benefits	62,113	61,624	(490)	415,635	411,656	(3,979)
OTPS	126,217	116,457	(9,760)	756,778	692,966	(63,812)
City Payments	-	-	0	309,405	309,405	0
Affiliation	106,076	101,329	(4,746)	538,455	531,788	(6,668)
HHC Bonds Debt	7,141	6,815	(326)	40,939	40,890	(49)
Total Cash Disbursements	**$ 612,592**	**$ 583,535**	**$ (29,057)**	**$ 3,504,662**	**$ 3,394,499**	**$ (110,163)**
Receipts over/(under) Disbursements	**$ (237,002)**	**$ (195,697)**	**$ (41,305)**	**$ (547,896)**	**$ (402,273)**	**$ (145,623)**

INFORMATION ITEM

NYC HEALTH+ HOSPITALS

Managing the Personal Services Global Cap

NYC Health + Hospitals / Queens

NYC Health + Hospitals / Elmhurst

NYC HEALTH+ HOSPITALS

Current PS Global Cap Performance:

NYC Health + Hospitals/Queens **NYC Health + Hospitals/Elmhurst**

- Through December, NYC Health + Hospitals/Elmhurst and NYC Health + Hospitals/Queens are both under the PS Global Cap by a combined $5.7 million.
- Both hospitals will have challenges to sustain these savings through the end of FY2016, and will continue to take action to control expenditures.

NYC HEALTH+ HOSPITALS

Global FTE Management Efforts:

NYC Health + Hospitals/Queens NYC Health + Hospitals/Elmhurst

Vacancy Control Board Meetings:

- Bi-weekly meetings to review all personnel actions, including vacancy backfill requests.
- Determine number of hires that can be approved at each VCB to remain under the cap.
- Complete justifications are required for any consideration of backfill requests, including utilization, patient safety, regulatory requirements, current staffing patterns, and return on investment.

NYC HEALTH+ HOSPITALS

Global FTE Management Efforts:

NYC Health + Hospitals/Queens NYC Health + Hospitals/Elmhurst

Joint Oversight Committee:

- Monthly meeting with Mount Sinai Affiliation leadership to discuss management of the Affiliation contract.
- Complete review of Mount Sinai's financial position.
- Similar to Hospital VCB, complete justifications are required for consideration of backfill requests.
- Requests for new positions require a full business plan, including ROI.
- New positions must be funded from existing contract funds by eliminating vacancies in other departments based on review of staffing and utilization.

NYC HEALTH+ HOSPITALS

Global FTE Management Efforts:

NYC Health + Hospitals/Queens NYC Health + Hospitals/Elmhurst

Overtime Review:

- Used Breakthrough A3 problem solving to work with Hospital Departments with high overtime expenses to evaluate strategies to reduce overtime.
- Engaged Hospital Departments outside of Value Streams to use Breakthrough methods to develop Overtime strategies
- Required pre-authorization process for high utilization departments.
- Overall PS spending has declined in the these key departments.

NYC HEALTH+ HOSPITALS

Global FTE Management Efforts:

NYC Health +Hospitals/Queens NYC Health + Hospitals/Elmhurst

Temporary Agency – Non-Nursing:

- Both hospitals conduct extensive review of every temporary agency staff for either elimination or conversion to full time status.
- Reduced temporary agency staffing by $1.4 million at NYC Health + Hospitals/Elmhurst as compared to last year, YTD December.
- Reduced temporary agency staffing by $1.3 million at NYC Health + Hospitals/Queens as compared to last year, YTD December.

NYC HEALTH+ HOSPITALS

Global FTE Management Efforts:

NYC Health +Hospitals/Queens NYC Health + Hospitals/Elmhurst

Nurse Staffing:

- Meet with Nursing Department each month to review staffing versus budget, including the Nash analytics model.
- Particular focus on reducing Nurse agency expense at NYC Health + Hospitals/Queens.
- Successful in reducing $344k in overtime for NYC Health + Hospitals/Elmhurst, YTD December. Moderate increase in nursing registry due to increase in 1:1s, LOAs and EPIC.
- Successful in reducing $368k for NYC Health + Hospitals/Queens, YTD December. This savings was achieved despite incurring additional EPIC-related Agency replacement costs of $150k in the period November/December.

NYC HEALTH+ HOSPITALS

Challenges Ahead Managing the PS Global Cap:

NYC Health +Hospitals/Queens

NYC Health + Hospitals/Elmhurst

- **Soarian Financials Implementation:** Implemented new Financial system at NYC Health + Hospitals/Elmhurst and Queens in August 2015.
- **ICD – 10 Implementation:** As of October 1, all hospitals were required to move from ICD- 9 to ICD – 10.
- **EPIC Implementation:** NYC Health + Hospitals/Elmhurst and Queens are the first 2 hospitals in our healthcare system to implement the EPIC clinical information system. This requires extensive training of all provider, nursing, and clinical support staff.