### Call to Order - 4 pm

1. Adoption of Minutes: November 20, 2014

#### Acting Chair’s Report

#### President’s Report

>>>Action Items<<

#### Corporate

2. **RESOLUTION:**

**DSRIP APPLICATION**

**Authorizing** the New York City Health and Hospitals Corporation (the “Corporation”) to (i) submit an application to the New York State Department of Health (“DOH”) to participate in the Delivery System Reform Incentive Payment program (“DSRIP”) pursuant to which the Corporation will establish a single Performing Provider System (a “PPS”) in collaboration with various health care providers (the “Participants”); and

**CONTRACTS WITH PPS PARTNERS**

**Authorizing** the Corporation to (ii) enter into agreements within the PPS structure with those Participants listed on the attached Schedule of Participants designated as “City Wide” and those Participants designated as “Hub-Based” in the attached Schedule of Participants subject to the addition of additional Hub-Based Participants or the removal of some Hub-Based Participants at the discretion of the Corporation President as he determines to be necessary or appropriate to respond to evolving DOH requirements, guidance and regulations, and the Corporation’s assessment of the ability of the Hub-Based Participants to perform as required for the DSRIP program; (iii) enter into such other and further ancillary contracts as are necessary or appropriate to carry out the purposes of the DSRIP program and to ensure the Corporation’s successful execution of its DSRIP projects using the structure diagramed in the attached Table of Organization; and

**HHC ASSISTANCE CORP TO FUNCTION AS CENTRALIZED SERVICE ORGANIZATION**

**Authorizing** the Corporation to (iv) cause the HHC Assistance Corporation (the “CSO”) to provide technical assistance to the PPS in the capacity of a centralized service organization; (v) nominate from among the officers and senior managers of the Corporation the directors of the CSO provided that the Corporation President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of the Corporation provided further that such outside directors never exceed 25% of the total of CSO directors; and

**PROCUREMENT, COMPLIANCE AND REPORTING**

**Directing** the Corporation to (vi) subject the activities of the CSO under the DSRIP program to the Corporation’s compliance and internal audit programs; (vii) requiring that all procurement contracts of the CSO be subject to the procurement rules applicable to the Corporation; and (viii) make regular, periodic reports to the Corporation’s Board of the progress of the DSRIP application and the implementation of the DSRIP projects including an overview of all contracts made by either CSO or the Corporation to carry out the DSRIP program.

*(Med & Professional Affairs/IT Committee – 12/11/2014)*
Queens Health Network

3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a five-year lease extension agreement with LSS Leasing Limited Liability Company for 5,120 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Women's Medical Center operated by Elmhurst Hospital Center at an initial rent of $225,280 per year or approximately $44 per square foot to increase at a rate of 2.75% per year for a five-year total of $1,190,079. (Capital Committee – 12/04/2014)

4. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a five-year sublease agreement with Pediatric Specialties of Queens for 2,560 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Subtenant’s pediatric program at an initial rent of $112,640 per year or approximately $44 per square foot to increase at a rate of 2.75% per year but in no event less than half of all of the Corporation’s occupancy costs at the premises. (Capital Committee – 12/04/2014)

MetroPlus Health Plan, Inc.

5. RESOLUTION reappointing Lloyd Williams as a member of the Board of Directors of MetroPlus Health Plan, Inc., a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York to serve in such capacity until his successor has been duly elected and qualified, or otherwise provided in the Bylaws. (MetroPlus Board – 12/09/2014)

Committee Reports

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

Subsidiary Board Reports

- HHC Capital Corporation
- MetroPlus Health Plan, Inc.

Facility Governing Body / Executive Session

- Bellevue Hospital Center
- Semi-Annual Report (Written Submission Only)
  - Jacobi Medical Center
  - North Central Bronx Hospital

> Old Business
> New Business

Adjournment
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

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

Dr. Jo Ivey Boufford
Dr. Ramanathan Raju
Mr. Steven Banks
Dr. Gary S. Belkin
Josephine Bolus, R.N.
Dr. Vincent Calamia
Ms. Anna Kril
Mr. Robert Nolan
Mr. Mark Page
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Patricia Yang was in attendance representing Deputy Mayor Lillian Barrios-Paoli, and Dr. Oxiris Barbot was in attendance representing Health Commissioner Mary Bassett, both in a voting capacity. Dr. Boufford chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on October 23, 2014 were presented to the Board. Then on motion made by Mrs. Bolus and duly seconded, the Board unanimously adopted the minutes.
1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on October 23, 2014, copies of which have been presented to this meeting, be and hereby are adopted.

**CHAIRPERSON’S REPORT**

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

Dr. Boufford noted that the schedule for the 2015 Board and Committee meetings was in the Board packages, and that the annual public meetings would be starting in the spring. She updated the Board on approved and pending Vendex.

On behalf of the Board, Dr. Boufford commended the HHC team in its handling of the events surrounding Ebola, not only on the care side, but in the role played in fighting the stigma through community education and outreach.

**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.

**ACTION ITEMS**

**RESOLUTION**

2. Authorizing the President of the New York City Health and Hospitals Corporation to implement the attached Operating Procedure 180-9 entitled “HHC’s Human Subject Research Program Policies and Procedures.”

After some discussion it was agreed that an annual report on all approved projects will be made to the Medical &
Professional Affairs/Information Technology Committee of the Board.

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

**RESOLUTION**

3. Authorizing the President of the New York City Health and Hospitals Corporation to execute one year extensions of existing agreements with six of the seven construction management services firms: Gilbane Building; HAKS; Hunter Roberts Construction Group; Jacobs Engineering; LiRo Program and Construction Management; and TDX Construction Corporation, to provide professional construction management services on an as-needed basis at various facilities throughout the Corporation at an additional aggregate not-to-exceed limit of $2.5 million.

Senior Assistant Vice President Roslyn Weinstein explained that this was a request to extend existing requirements contracts for one year while we negotiate a Project Labor Agreement. Deputy Counsel Jeremy Berman explained that a Project Labor Agreement with the construction trade unions will exempt HHC from the Wicks Law which otherwise prevents HHC from engaging a single contractor to coordinate all construction work on a project.

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

**RESOLUTION**

4. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable five-year license agreement with the Interboro Regional Health Information Organization (RHIO) for its use and occupancy of approximately 575 square feet of space on the third and fifth floors of the
Annex "G" Building at Elmhurst Hospital Center to provide technical and administrative services to the RHIO in which most of the Corporation's hospitals are participants with the occupancy fee waived as an in-kind contribution to the RHIO.

Al Marino, Director of the Interboro RHIO, explained its purpose and operations.

Ms. Youssouf moved the adoption of the resolution which was duly seconded and adopted by the Board by a vote of 12 in favor. Ms. Kril recused herself.

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 the Acting Chair at the Board meeting.

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 Harlem Hospital Center, received an oral report and written governing body submission and reviewed, discussed and adopted the facility's report presented; and 2) as governing body of Metropolitan Hospital Center, the Board received and approved its semi-annual written governing body submission.
ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 5:40 P.M.

Salvatore J. Russo
Senior Vice President/General Counsel
and Secretary to the Board of Directors
Ms. Youssouf then stated that this special meeting is convened to approve and release the audited financials. A large amount of time has been spent on the financial in prior meetings and there are a few changes that we are going to have KPMG highlight for us. She then turned the meeting over to Mr. Jay Weinman, Corporate Comptroller.

Mr. Weinman saluted everyone and said that since the October Audit Committee meeting, there have been three major changes and one minor change that I briefly want to discuss. I have handed out a one-page summary, along with the copies of financial statement pages for the balance sheet and income statements for you to follow along.

The first is KPMG did issue an unmodified opinion. That means that the financial statements were presented fairly in their opinion in all material respects. The following changes were made since the October meeting.

- An agreement with the City that HHC would not reimburse the City for the 2013 malpractice ($121.4 million) and debt service ($150.4 million) and other fringe benefits and expense payable ($28 million).
- $299.8 million reduction to Due to The City of New York.

Ms. Youssouf stated that that is really good news and we thank the City very much.

Mr. Weinman continued with the second major change:

- Funding from the City for collective bargaining settlements of $118 million

Mr. Weinman said that the third one is GASB 68 - I had mentioned in October that the new pension guidelines, actually impact the financial statement materially. There were a couple of changes; one is that we recorded a liability of $2.5 billion as of 2014 that is reflected as a newly disclosed liability. We never carried the liability before and the expenses were $229 million. This is slightly different than what we actually fund, so that is a change due to the GASB and is reflected on the balance sheet on page 15 with a new category called “Deferred Inflows”. This is a representative difference between what is earned on a pension fund and what was projected.

Mr. Weinman stated that lastly, there was a change in the recording for third-party liabilities. We previously netted them out; we have done this in the past to be more consistent with some of KPMG other clients. We separated the liabilities and recorded $182 million in the liabilities section rather than netting the receivables.

Ms. Marlene Zurack, Senior Vice President, Finance/Chief Financial Officer, added that KPMG had handed out a brief statement. Ms. Youssouf then asked the representatives to introduce themselves. They introduced themselves as follows: Maria Tiso, Engagement Partner and Joe Bukzin, Senior Manager.

Ms. Tiso stated that Mr. Weinman covered everything on page three, the audit update which discusses the three significant issues. On page four we put together a summary of significant subsequent adjustments and how they impacted each of the categories on the financial statements. On item 1, total assets was impacted by $183 million and that increased by moving the receivables down to liabilities. On total liabilities there was an increase of $2.3 billion that was the GASB 68 adjustment, a decrease due to the City in the collective bargaining adjustment and an increase to the third-party liabilities.

The deferred inflow of resources, a new line item on the balance sheet is $724 million. At the end of the day, the total net deficit position decreased by $2.8 billion which largely resulted from the GASB 68 adjustment. Total operating revenue increased by $390 million from the last the statement and is due to the appropriations from the City and the collective bargaining accrual. A total operating expense, which is good news, decreased by $234 million and that resulted from a decrease in the pension expenses from GASB 68.

Ms. Tiso added that we wanted to show at high level the unmodified opinion, and we worked diligently with the team of HHC as well as the team from the City of New York to implement the GASB 68. We had five days to have it implemented and HHC was the first in the country to have early adopted so kudos to HHC.

Ms. Zurack said that I would also like to give kudos to KPMG because they really pulled the resources on weekends and nights and made an effort to review a 318-page actuarial statement in a couple of days, and Mr. Weinman and his team as well had to do similar 11th-hour work and got it done on time, so kudos to all of them.

Ms. Youssouf remarked that I think this is great and helps our new-cash position.
Ms. Zurack added that two pieces help – the pension piece does not help. The pension change looks like an improvement, but from a cash perspective there is no difference.

Mr. Mark Page, Board Member said that the pension change is due to the way the actuarial funding works, if you make changes, it increases your liability. You basically borrow from the pension system an amount to cover the liability and you pay it back over a scheduled period of time and you pay back interest and principal to amortize the loan. This change is saying that you recognize as an expense the interest but you no longer recognize as an expense the payment of principal. So it changes what our inflow/outflow presentation is. It does not actually change how much money we are obliged to pay for this actuarial need.

Ms. Youssouf thanked the City for what they have helped us with, and extended thanks and appreciation to KPMG and especially HHC staff for getting the financial statement out in such a timely fashion given that it was a lot of additional work involved.

Ms. Youssouf asked for a motion to approve the financial statement, it was seconded and approved by the Committee.

**Capital Committee - November 6, 2014**
**As reported by Ms. Emily Youssouf**

**Senior Assistant Vice President’s Report**
Roslyn Weinstein, Senior Assistant Vice President, Office of the President, announced that Peter Lynch, former Assistant Vice President, Office of Facilities Development, had retired. She noted that he had expressed great pleasure at the work he had been a part of and the impact he hoped to have made. Ms. Weinstein introduced Louis Iglhaut as the Acting Assistant Vice President, Office of Facilities Development. She said she was thrilled to have him by her side and wished him the best. Committee members welcomed Mr. Iglhaut.

Ms. Weinstein explained that there had been two real estate agreements on the draft agenda but at the request of the Committee Chair, some additional negotiating would be attempted and those resolutions would hopefully be brought before the Committee at the December meeting instead. She made note that the resolutions were scheduled to be presented, as requested, ahead of expiration, and they would be coming back slightly closer to that expiration date.

Ms. Weinstein advised that the meeting agenda would include a license agreement with the Regional Health Information Organization (RHIO), for space at Elmhurst Hospital Center, as well as a resolution for a one year extension of six Construction Management contracts, to maintain continuity as an anticipated Project Labor Agreement (PLA) was being drafted. Both items would include power point presentations to provide supporting information.

Ms. Weinstein said that an update would be provided on the major modernization project at Gouverneur Healthcare Services, but noted that project budget amounts had been fluctuating, and she wanted to preliminarily note that while the project budget for DASNY has been reported as $247.1 million excluding “added dollars”, the Capital Committee should know that the total project budget was $251 million, including in-kind support, Certificate of Need (CON) fees, decontamination, and other outliers. The total cost was $251 million, as seen in the included budget page, which was first presented in January, 2014.

Ms. Weinstein assured that reporting would be more transparent or understandable when construction costs were discussed.

Ms. Youssouf thanked Ms. Weinstein and explained that previous reporting had not been all inclusive, as a construction project should be. She stated that she wanted every piece included, all project related items.

That concluded Ms. Weinstein’s report.

**Action Items:**

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”) to execute a revocable five-year license agreement with the Interboro Regional Health Information Organization (the “RHIO”) for its continued use and occupancy of approximately 575 square feet of space on the third and fifth floors of the Annex “G” Building at Elmhurst Hospital Center (the “Facility”) to provide technical and administrative services to the RHIO in which most of the Corporation’s hospitals are participants with the occupancy fee waived as an in-kind contribution to the RHIO.

Chris Constantino, Senior Vice President, Queens Health Network, read the resolution into the record. Mr. Constantino was joined by Al Marino, Executive Director, Interboro Regional Health Information Organization.

Mr. Marino narrated a power point presentation outlining what the RHIO does and its origins. He explained that the organization was born out of work and learning at Elmhurst Hospital Center and throughout HHC around implementing Electronic Medical
Records (EMR) and how that could help coordinate care across venues, and providers and how those tools could be used to drive improvements in healthcare quality and safety while reducing costs. He said that their mission was to take that learning and expand beyond the hospital walls.

Ms. Youssouf asked if this was in response to any mandates. Mr. Marino said that the program grew out of Healthcare Efficiency Accountability Law (HEAL) grant projects. There was a State regulation issued in September, 2014, that will eventually require all State regulated organizations to participate.

The goal of the organization is to improve health care quality and safety and reduce costs, develop a health information infrastructure which facilitates the exchange of patient health information among disparate clinicians, provides access to the information necessary to guide clinical decisions and care coordination, and, to promote a system that follows the health care consumer so they are the center of their care.

Antonio Martin, Executive Vice President, asked if pharmacies are tied into the system. Mr. Marino said not yet.

Josephine Bolus, RN, asked if interfacing with small private practice groups would be possible. Mr. Marino said that was possible and that a few were already members. He noted that as part of the State initiative more and more parties would be involved. Mrs. Bolus asked if the private practices would benefit in any way. Mr. Marino said that they would see benefits in care coordination and readily accessible information. She asked if HHC offset costs or if these small groups would have to spend money to participate. Mr. Constantino explained that grants covered certain costs and HHC had subsidized some of the smaller organizations. Mr. Marino added that there were State initiatives to provide funds for purchasing of systems, and if meaningful use was shown then there would be an increase in ability to solicit additional funds.

Mr. Marino advised that organizational members included most HHC acute care hospitals, over 300 small community practices (through heal grant) and others providers. Data is being collected from a number of sources.

Ms. Youssouf asked if the eventual goal was to have everyone on one Network. Mr. Constantino explained that the eventual goal is to place all the data from the various RHIOs into one place so that the information is available in one place. Mrs. Bolus asked how many RHIOs there were. Mr. Marino said there were 11, and at present, each of those was working on building up their data bank. It was anticipated that by mid-2015 the various RHIOs would link together.

Ms. Youssouf asked if every tri-state hospital was in a RHIO. Mr. Marino said the goal was to get everybody in but it wasn’t there yet. He said that the majority of New York City was covered but a few had not joined yet. Mrs. Bolus asked how many RHIOs were in the City. Mr. Marino said three in the Downstate area. The big piece will come this year when all the RHIOs were linked.

Mrs. Bolus asked if there would be difficulty interfacing with different systems. Mr. Marino said the organization was working on that and it was not anticipated to be an issue. It was still developing but there should be very standard ways of sharing data.

Ms. Youssouf noted that cost savings would be another great benefit of the program.

Mr. Marino outlined benefits; patient record look-up; real time access to patients’ clinical data, records from multiple sources, and providing more complete picture of a patient’s health. Benefits of the CCD Exchange would be the ability to query and retrieve documents from within a provider’s EMR. Benefits of event alerts; real time notification on: emergency department visits, inpatient admissions and discharges, and alerts to clinicians’ e-mail and secure clinical mail box.

He added that future plans for the RHIO include; integration of all HHC Acute and D&T Cs, expected support for DSRIP programs, cross RHIO exchange, cross RHIO event alerts, single sign-on, and care plan interface.

There being no further questions or comments, the Committee Chair offered the matter for a Committee vote.

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

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”) to execute one year extensions of existing agreements with six of the seven construction management services firms: Gilbane Building Company; HAKS; Hunter Roberts Construction Group; Jacobs Engineering; LiRo Program and Construction Management; and, TDX Construction Corporation (the “CMs”), to provide professional construction management services on an as-needed basis at various facilities throughout the Corporation at an additional aggregate not-to-exceed limit of $2.5 Million.

Louis Iglhaut, Acting Assistant Vice President, Office of Facilities Development, read the resolution into the record.

Ms. Youssouf asked for an explanation of the excel sheet in the package accompanying the resolution. Mr. Iglhaut explained that the document outlined the to-date usage of the firms for whom contract extension was being requested.
Ms. Youssouf asked why the threshold was set at $2.5 million. Mr. Iglhaut explained that the original contract, for a three year term, was for $6 million dollars, but being that the extension request was only for one year, the contract amount was adjusted accordingly.

Ms. Youssouf asked why extension was only being sought for six of the seven firms. Mr. Iglhaut advised that the seventh firm was never utilized and therefore the need for their services was not anticipated.

Ms. Youssouf asked why the term was being extended by a year. Mr. Iglhaut explained that a Project Labor Agreement (PLA) was being drafted and that would negate the need to issue a Request for Proposals (RFP) for new contracts. Mr. Iglhaut noted that Jeremy Berman, Deputy General Counsel, would be showing a power point presentation outlining Project Labor Agreements (PLAs) and how they are expected to benefit HHC.

Mr. Berman explained that Wick's Law, part of the NY State General Municipal Law dating from 1912, applied to public construction projects of more than $3 Million, and required that four separate contracts be bid and let for each job: plumbing, electrical, HVAC and construction. This prevented the use of a general contractor from contracting for the entire job and subcontracting with the four trades, which makes coordinating construction jobs difficult. Fixed price jobs and jobs with fixed deadlines are impossible. These regulations make CM-at-Risk projects unlawful, which makes it difficult to coordinate construction jobs.

Additionally, Mr. Berman noted, all public jobs are also subject to prevailing wage requirements. Under NYS State Law, all public projects must pay construction workers “Prevailing Wages.” Prevailing Wages substantially amount to Union Wages. All HHC construction contracts require that Prevailing Wages are paid. HHC is responsible for ensuring that Prevailing Wages are paid, resulting in much policing and enforcement. That was an immense amount of additional work on the Office of Facilities Development, and a cost to projects that is rarely seen because it is a back office function.

Mr. Berman explained that recent changes to the Wicks Law exempt projects subject to a PLA. PLAs are made with the construction unions and subject the projects to be covered by union work rules. Non-union companies can work on the covered project but must follow the union work rules.

Some factors will remain neutral; 1) Wages under PLA jobs should not be higher than on Non-PLA jobs because Prevailing Wages must be paid regardless, and 2) HHC’s bigger jobs tend to be Union jobs anyway, so there will be no stricter work rules under a PLA.

One slight negative effect is that work rules on Union jobs may add cost. Ms. Youssouf asked for an example. Mr. Berman explained that the length of a work day is dependent on how the union views the hours, and how overtime is decided, as well as how any disciplinary activities are monitored or handled.

Mrs. Bolus asked how Minority and Women Owned Business Enterprise (MWBE) thresholds would be maintained. Mr. Berman said that negotiations for the PLAs should address that concern. He explained that PLAs had been drafted for other City agencies, so some common concerns have been hashed out by others ahead of HHC and therefore are known issues. It is a concern that PLAs minimize competition but these agreements are being drafted to address these concerns.

Some pros; 1) being able to give a single contract to a general contractor or a CM that will be responsible for the entire project may save between 20 - 30% due to greater efficiency and accountability; 2) most contractors will be Union shops who do the Prevailing Wage administration saving HHC cost and ensuring compliance with the law; 3) some contractors without the resources to do HHC work at Prevailing Wage will not bid; and 4) with a single contract, HHC can negotiate for fixed prices and fixed construction schedules. Contractor disputes, wage issues, financing issues, etc., should not affect the course of HHC projects as these issues will be dealt with by the Construction Manager and/or Unions directly.

Mr. Berman explained that HHC was negotiating with the Building & Construction Trades Council on the terms of the PLA, and that negotiation was being coordinated with the City. The scope covered will include virtually all of HHC construction work, including Sandy Mitigation work. It was anticipated that the agreement would be complete by spring of 2015. All parties were on board. Mr. Berman noted that HHC was lucky that others had gone down this road before us and we could learn from what others had already been through. So as other organizations prepare to renew agreements, HHC would get a solid start.

Ms. Youssouf expressed her excitement at the implementation of the PLA and how it would benefit the Corporation, and commended the team for working on it. Mrs. Bolus agreed, reiterating that maintenance of MWBE requirements be addressed.

There being no questions or comments, the Committee Chair offered the matter for a Committee vote.

On motion by the Chair, the Committee approved the resolution for the full Board's consideration.
Information Item:

Gouverneur Healthcare Service Major Modernization Status Report

Martha Sullivan, Executive Director, Gouverneur Healthcare Services, Matthew McDevitt, Gouverneur Healthcare Services, John Pasicznyk, Managing Director, Downstate Operations, Dormitory Authority of the State of New York, and Steve Curro, Managing Director, Construction, Dormitory Authority of the State of New York, collectively provided the status report.

Mr. Curro advised that the project was 96% complete, as measured by construction in place as of 9/30/14. The new Ambulatory Care facility was occupied. In the existing facility: floors 2, 3, 4, 5, 6, 7, 8, 9, 12 and 13 had been completed and were occupied. Floors 10 and 11 received a New York City Department of Buildings (NYC DOB) Temporary Certificate of Occupancy (TCO) on October 17, 2014, the Department of Health (DOH) inspection was completed and floors were ready to be occupied. Floor 1 received a NYC DOB TCO on April 9, 2014, Multipurpose Room Public Assembly approval received on October 24, 2014, and the facility was working on obtaining approved FSP/EAP from FDNY.

Mr. Curro listed work completed after the 1st floor TCO; Multi-purpose room completed in May 2014; Exterior vertical granite and parking lot paving, in May 2014; Henry Street sidewalk replacement, in September 2014; Courtyard, in October 2014; and, the Low Roof in October 2014.

He stated that in Progress work included; Linde Gas, anticipated for completion in March 2015; Upgrade of Existing Five Elevators, July 2015 (1st elevator complete); and, Basement code compliance work design had been completed and documents forward to Contractors for pricing, with responses expected by mid-November.

Mr. Curro noted that there had been a total of $235,469,000 billed to date for the project, and there were $10,043,000 remaining: $6,966,000 for construction, and $3,077,000 for soft costs and Furniture, Fixtures, and Equipment (FF&E).

Ms. Youssouf asked that when the project was complete the Committee be invited to visit the space.

Ms. Youssouf advised that delay reports would not be provided verbally but that documentation was included in the Capital Committee package.

Finance Committee – November 12, 2014
As reported by Mr. Bernard Rosen

Senior Vice President’s Report

Ms. Marlene Zurack informed the Committee that included on the agenda was a presentation by Danielle Holahan who was unable to attend but was being represented by Sara Rothstein, who would be presenting the status of the NYS health exchanges. The presentation is of importance in that open enrollment as part of the ACA begins on November 15, 2014 and that HHC through the Exchanges will continue benefit in its efforts to convert uninsured individuals into exchange members or qualified health plans (QHP) in addition to assisting MetroPlus, HHC’s health plan in its enrollment efforts. Last week there was a hearing conducted by Councilman Corey Johnson, Chair of the Council’s Committee on Health, on collaborations with key representatives of various City agencies, City DOH, HRA and HHC focusing on preparation for the Exchanges and the next enrollment period. Representing HHC in the hearing, Ms. Zurack stated that the overall outcome was very successful in terms of the issues that were raised at that time. There have been subsequent discussions and meetings about the group’s efforts in working with community based organizations (CBOs) in addressing some of the concerns relative to the enrollment process. During the first year of the enrollment, there were presentations to this Committee on HHC’s preparation for the exchange relative to the training of HHC’s staff, of which 570 employees were trained as certified application counselors (CAC). MetroPlus’ successfully enrolled 40,000 individuals into a QHP and the transitioning to a new Medicaid process. Each year there is a new enrollment period and HHC’s goal is to improve in the process. The purpose of the background information was to provide the Committee with a context for the presentation by Ms. Rothstein. In addition to the payor mix report that would be presented later on the agenda by Ms. Olson.

FEMA Funding Update

Last week a press conference was held at Coney Island Hospital whereby Mayor De Blasio, Senator Schumer announced the outcome of the FEMA application for public assistance that resulted in an award for repairs and mitigation totaling $1.6 billion for HHC, $900 million for Coney Island, $376 million to Bellevue, $120 million, Metropolitan and $181 million to Coler SNF. There is a lot of work and process to be undertaken as well as the completion of those projects. In response to Mr. Page’s question on whether the $1.6 billion would cover the actual cost, Ms. Zurack stated that it would depend on a number of factors that could cause the cost to increase. However, the funding award for HHC was a major achievement in many ways for Senator Schumer, in
that he authored the 428 program which is new, whereby the total funding is capped at a certain level by FEMA for mitigation projects. In exchange for that cap, relief is given in the process requirements. In calculating the cap which is the $1.6 billion, HHC with the assistance of its contracted engineering firm reviewed multiple alternatives for mitigation for each facility. The alternative that drove the cap is more expensive than the one HHC is likely to do which is allowed. Consequently the cap is in excess of HHC’s calculation of which the project costs are likely to be. In that regard it is achievable. However, on the other side it will depend on whether there is a change in the scope or a delay in the completion of those projects which poses some risk. Therefore, HHC must be vigilant in its project management given that HHC is subject to the cap which was an option that HHC decided to take. If not the cap, there may have been some restrictions on doing some of the things HHC had proposed to do and ultimately delayed the funding award for perhaps a couple of years.

Mrs. Bolus asked whether HHC would be affected by the recent actions taken by FEMA whereby some homeowners affect by the storm and got FEMA funding have been asked to return that funding after a review of their applications. Is HHC at risk of having that happen after the completion of those projects?

Ms. Zurack deferred to Mr. Russo, Senior Vice President / General Counsel adding that HHC is in the process of getting a letter of undertaking that would provide some protection of HHC’s interest in the process. There a project worksheets that document the detailed requirements for each project. At the press conference there was some concern regarding a congressional back-track which Senator Schumer indicated would not be likely given that appropriations were passed at the time; therefore there would not be a need to go back to Congress to request funding.

Mr. Russo added that there is no guarantee given the political shifts that could occur in the future but as reasonable as possible HHC is protected in that event under the current set of circumstances.

Ms. Youssouf asked if HHC has addressed the possibility that there will be changes given the background of capital projects that are labor intensive and the detailed planning phases are yet to be determined.

Ms. Zurack stated that there is an enormous amount of detailed information housed in binders on those projects that were incorporated into the actual application with the assistance of a reputable architectural and engineering firm, Arcadis. There was a lot of pre-work done relative to the FEMA requirements; therefore, the pre-work for the actual projects must be done. In terms of the scoping, the FEMA requirements were far more rigorous than the requirements for the pre-work for a regular capital project. However, just to reiterate, if there are changes or deviations in the scope there is likely to be an impact on the budget.

Mr. Rosen asked if the $1.6 billion was for new work or for work that already has been completed.

Ms. Zurack stated that there is a small amount included in that allocation for work that has been done particularly at Coney Island and Bellevue hospitals whereby some of the permanent repair work was done. However, there is another amount pending for work that was done that will probably balance out. In other words, there is another grant for emergency preparedness and restoration that the claims process is yet to be completed. In doing the restorations there was some permanent work done. Therefore, some of the funding for that permanent work will be reimbursed through the $1.6 billion with the expectation of getting more claims processed through the pending grant process relative to cash relief for another $200 million in addition to the $1.6 billion that could increase to $1.8 billion which is yet to be finalized by FEMA.

Cash Flow

Ms. Zurack reported that HHC was successful in getting CMS to approve the down payment on the UPL payments in which $287 million was received on November 5, 2014 with an additional $65.7 million expected by November 21, 2014. The cash on hand (COH) was at 24 days which was higher than reported in the prior months. However, it is important to note that HHC is very much dependent on additional supplemental Medicaid payments that are reflected in its cash flow and are scheduled for receipt in December 2014 and January 2015. There is a $731 million in DSH payments that is needed by early January 2015 and with receipt of those funds, HHC’s cash flow will be in good standing through the end of the current FY 2015. There being no further discussions, the reporting was concluded.

Dr. Raju extended thanks to Ms. Zurack, staff, and FEMA staff for the enormous amount of work that was done in addition to reaching an agreement with CMS on the methodology for the UPL payments and for the City’s assistance in getting it done.

Key Indicators/Cash Receipts & Disbursements Reports

Ms. Zurack informed the Committee that as part the monthly reporting, the Key Indicators/Cash Receipts and Disbursements reports were included in the package and in the essence of time those reports would be entered into the record.

Payor Mix Reports, Inpatient, Adult and Pediatrics

Ms. Zurack stated that last year as HHC prepared for the exchange as part of the Affordable Care Act (ACA) and how it would affect HHC, there wasn’t sufficient data to measure HHC’s performance; however, some data has been made available from NYS
on how HHC has performed and with the second open enrollment period starting, November 15th it is important to keep track of how HHC is doing. The payor mix data reflects the uninsured as well as Medicaid data that will provide some insight relative to the impact of the ACA.

Ms. Krista Olson stated that the first quarter for the current FY 15 is the first report to show the impact of the ACA compared to last year’s first quarter which was prior to the implementation date for the open enrollment period. The first quarter particularly for inpatient was susceptible to changes in timing given the lag in processing Medicaid applications which can take several months. Overall the percentage of Medicaid has increased from 59.4% to 60.9%. The process for applying for Medicaid has changed significantly and by facility those changes have had a very different impact in that some have improved and some have worsen. However, overall the share of Medicaid has increased and the uninsured has decreased from 9.2% to 7.9%. Some of the change may be due to an increase in the processing of the Medicaid applications faster. Over time, HHC will be able to determine how much of that decrease is attributable to a change in enrollment.

Ms. Youssouf asked where there has been decreases at the facilities was there a trend.

Ms. Zurack stated that there have been some problems relative to retroactive processing; therefore, it is anticipated that a positive trend will result as those issues are resolved. There are some cases in the pipeline. It is not expected to deteriorate. On the inpatient side the lag and processing issues are more prevalent.

Ms. Olson stated that the adult outpatient payor mix report showed a greater improvement in the share of Medicaid from 42.9% to 45.4%, commercial from 7.4% to 8.5% uninsured down from 30% to 26.9%.

Ms. Zurack stated that the facilities are doing more outpatient applications and are being processed faster, in twenty minutes.

Ms. Olson stated that on the pediatrics side less dramatic changes have occurred. There was a slight improvement in Medicaid; commercial decreased slightly and uninsured remained flat. This may be due to fewer eligibility changes for the pediatrics population.

**NYS EXCHANGE UPDATE**

Ms. Zurack introduced Ms. Sara Rothstein of the NYS of Health who would be presenting to the Committee an update on the Exchanges.

Ms. Rothstein stated that the reporting would cover how NYS ended last year; open enrollment; and where NYS is headed this year. Open enrollment last year started October 1, 2014 through April 15, 2013 during that period NYS enrolled nearly 1 million NYers over half were enrolled in Medicaid; 38% in QHP; and 7% in CHP. There was an even split between men and women who enrolled; 63% of those who enrolled in the QHP were previously uninsured; 93% enrolled in Medicaid were insured and 87% enrolled in CHP were uninsured. These were all very positive indicators in terms of reaching some of the uninsured population. More than half of the enrollees came from NYC; 14% from Long Island and the balance from upstate. More than half of the consumers who enrolled did it in person and 41% enrolled on line with no assistors; 11% with customer service. Lower income individuals were more likely to use or required an in-person or assistor than people who had higher income or did not need or qualify for financial assistance.

Mrs. Bolus asked if there were any issues relative to language barriers.

Ms. Rothstein stated that if there were it was not an issue. If there is a need for language other than English there are ways individuals can get that assistance. The navigators who are funded by the State provide assistance in 48 different languages. A lot of that language capacity is in NYC and people tend to speak the language of the communities that they serve. Assistance is available through customer service center for translation or interpretation.

Ms. Zurack stated that at the Council hearing there were questions raised regarding the availability of material in the various languages and when that material will be available to the consumers.

Ms. Rothstein state that the first priority last year was to get the website up and working and that Spanish was important and the website for that language is launching and other language will be added; however it is too soon to know when it will all be completed and available. There is a commitment to get things done as soon as possible. There are some complicated issues relative to IT in the translation and the manual coding of each page to commit to a completion time frame. The marketing materials are being expanded in other language this year.

Ms. Youssouf asked if the languages were being tracked that would identify the most in demand.

Ms. Rothstein stated that the tracking is done at the customer service center. The breakdown of those languages although the actual data is not readily available is Spanish, Haitian Creole, Mandarin, Cantonese, Russian, Polish and English.
Ms. Zurack stated that given that the process is evolving it is important that all of HHC staff and the CBO’s work together.

Ms. Youssouf added that it is important to keep track of those languages given the constant changes.

Ms. Rothstein stated that the language request through the customer service center is tracked and getting the website up and running in the various languages is a very complex process that requires extensive lead time. Any demand for a new language cannot be accomplished immediately; however, the customer service center is available to meet that demand.

Ms. Rothstein stated that the age of the enrollees, 3% under 18 will go into CHP plans; one third between the ages of 18-34; 18% between 35 – 44; and 45 – 48 or older three fourths qualified for a QHP financial assistance. There were sixteen insurers in the marketplace and a good distribution of enrollment across those insurers. The enrollment included in the various plans included more than half in silver plans including cost saving reductions; 13% in platinum; 10% gold and 19% bronze; and 2% catastrophic plans.

Mr. Rosen asked if the silver was the most popular. Ms. Rothstein stated that it was the choice for those individuals who chose cost sharing reductions. The in-person assistance and the assistors at HHC enrolled more than 26,000 individuals. Reports were distributed on statewide data in June 2014 for each county of the state that included uninsured data, enrollment, gender, age, self-reported ethnicity, language, plan etc. The data has been expanded to include zip codes level up to 10 zip codes in the search data. NYS is preparing for 2015 and on Saturday November 15, 2014 the open enrollment period starts. NYS has two goals for this year. First to keep the enrollees who signed up last year; and the second is to enroll more people. An automatic renewal process is currently being undertaken for the first time that NY in any of its program has done an automatic renewal process. The goal is to have as many people as possible to automatically renew their eligibility to provide their plan enrollment so that they do not need to do anything to stay ensured. If the consumer want to change their plan, the goal is to reduce the burden on the consumer as much as possible. For consumers in household for some of the QHP and for commercial insurances, renewal letters have been sent out over the past few weeks and by Friday, November 14, 2014 notification will be sent out on whether they are automatically renewed in their health plan or whether there would be a need for them to come and update their application in order to have coverage for next year. For consumers that only have public coverage in their household, only Medicaid or CHP that is happening on a roll-in basis and none will lose coverage before their renewal unless there is a change in the application.

Mr. Rosen asked if there is no change the individuals can stay in their current plan. Ms. Rothstein stated that is the goal and if that is the case a letter will be sent stating that the coverage has been successfully renewed. On the website there is video detailing information on how to renew coverage. There is a lot of material that is being review to make it consumer friendly. There has been a revamping of the marketing efforts through a variety of different ways. There are a number of consumer tools; a video on how to choose a health plan in an effort to address some of the issues raised by the consumers. A more robust comparison plan tool has been added that will allow consumers the ability to understand the difference between plans and contrasts the difference. The premium calculations will be available. There are theme campaigns, presentations, and tear off cards available for use by the consumers as part of the improvements to the website and for the users. Key date open enrollment sign-up by February 15, 2015 and applications are processed faster.

Ms. Youssouf asked what the expectations for enrollment this year are.

Ms. Rothstein stated that when the marketplace was established the expectation of the enrollment based on the full implementation over the three year period included an estimate that 615,000 would sign-up for QHPs. In the first year 370,000 signed up; however, it is yet to be determine whether there will be a repeat of that number this year or of the 615,000 the majority signup in the first year and a much lower rate in the second year would be expected. There are arguments that could be made both ways. The estimate is that by the end of the three years, 615,000 will be signed up.

Ms. Zurack stated that there is some concern about Medicaid relative to the renewal process and how it will work for Medicaid.

Ms. Rothstein stated that it will work the same. An effort will be made to automatically renew eligibility determination and health plan enrollment. Whether it is automatic or not will depend on a number of factors such as the information originally submitted in the application against the federal data. There could be a greater share of people in Medicaid than in QHPs. However, every effort is being made to make the process automatic.

Ms. Zurack asked if individuals will be notified before April 15, 2015. Ms. Rothstein stated that it will depend on when the individual files their taxes next year. The forms are sent to the consumer by January 31st. Ms. Zurack added that might be an important milestone and the assistors might be challenged and may require some training in that area.
Ms. Rothstein stated that NYS is creating that level of expertise. Federal funds were received for consumer assistance to assist with the tax credit reconciliation and the completion of the tax form. Tax preparers were included in the distribution of that information. The message is that NYS is trying to keep people covered.

Committee member HRA Commissioner Steve Banks asked if there is a capacity concern if the 615,000 expected enrollees increase.

Ms. Rothstein stated that from a system’s perspective if the volume should increase it can be accommodated; however, from a provider perspective she was not in a position to comment.

Dr. Raju asked whether the discussions with the consumers regarding the increase is done with and without the subsidy given that it could help in choosing the right plan given that the plans could increase but the subsidy could increase as well.

Ms. Rothstein stated that the exact wording for the renewal letter would need to be reviewed in terms of how that particular language would be incorporated given that the amount of the tax credit could vary and change.

Ms. Zurack stated that last year MetroPlus was the lowest plan and being able to compare plans and to decide whether to stay with the current plan or switch to another plan is an important factor for consumers. In light of that, what can HHC do at the local level with the CBOs to prepare in the event the numbers do increase.

Ms. Rothstein stated that the best effort would be to reach out to the community and have the assistors be the face of the community to provide a personal message in helping to sign up, to enroll and to understand how insurances work and what works in the communities.

Ms. Zurack stated that HHC will continue to work closely with the State to ensure that the goals for the enrollment are successful.

Medical & Professional Affairs / Information Technology Committee
November 6, 2014 - 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

HHC ACO Inc. held a meeting of its Board of Directors on Nov 3 to discuss changes in Board membership and the distribution of savings that were achieved in the MSSP (Medicare Shared Savings Program). The ACO achieved high quality scores (74th percentile nationally) and ~7% reduction in cost to Medicare. This resulted in 50% of ~$7m being distributed from CMS to the ACO, and 50% of that 50% being distributed to the “participants”. CMS envisages that this is used as a financial incentive to the primary care physicians who provide care to the beneficiaries attributed to our ACO. The resolutions from the Board meeting relating to Board membership will be brought forward to the HHC Board of Directors meeting.

The ACO is beginning its preparations for the next annual quality reporting process, which will include IT exports from the data warehouse, manual chart review supported by the Quality Management teams, and a patient satisfaction survey administered by Press Ganey. This is reporting for the second performance year and the final year of our current three year agreement with CMS.

Ebola Preparedness

HHC continues to maintain preparedness for assessing and screening any patient at risk for Ebola at our 11 Emergency Departments and at our ambulatory clinics. This is being done with continued systematic training in the use of PPE (Personal Protective Equipment), as well as development and sharing of standard protocols and procedures for many aspects of the necessary care. NYS DOH will be soon commencing surveys on the Commissioner’s order for many of these elements.

In addition, the staff at Bellevue continues to provide care for the first Ebola patient in NYC. He continues to make good progress, with strong nursing, physician, lab and waste management leadership contributing to this progress. Hospital staff directly involved in the patient’s care will be actively monitored by the DOHMH for 21 days after their last involvement.

DSRIP

Continued activity at an extremely rapid pace is occurring in preparation for the HHC DSRIP application due in December. Guidance for the NYS DOH continues to be modified as all parties get more familiar with this highly complex undertaking. There is an information item later in this meeting where Board members questions can be answered.
RESEARCH

Human Subject Research Protections Program Policies and Procedures

HHC’s Human Subject Research Program Operating Procedure is discussed as an action item later in this meeting, and provides comprehensive information and guidance about the organization and focus of the Human Subject Research Protection Program at HHC.

This Program will facilitate excellence in human research at HHC while protecting research participants’ rights and safety, and ensuring a regulatory and legally compliant environment for the conduct of ethical research. The following is an outline of the significant issues (authority, role and procedures) covered by the Operating Procedure:

Commencement of Research at HHC

The Policies and Procedures set forth the requirements that a researcher must address prior to the commencement of research. The requirements include the criteria for eligibility, research involving vulnerable populations; protections for human subjects and researchers, such as valid informed consent and certificates of confidentiality; the process to determine the adequacy and feasibility of resources to support the research; and protecting HHC’s interests in any publications or inventions resulting from research conducted at HHC.

Investigational Drugs, Devices and Biological Materials

The Policies and Procedures addresses various issues with respect to investigational drugs, devices and biological materials used in research. It sets forth requirements under law and HHC policy for the use of an investigational drug or device in research, including the storage, handling and dispensing of investigational drugs and biologics, as well as contractual requirements for the transfer of such materials into and out of HHC, the use of anatomical gifts, and the disclosure of genetic information obtained through genetic testing.

Misconduct, Unanticipated Events and Noncompliance

The Policies and Procedures outlines processes to address conduct that departs from a research protocol or unexpected events during a research project.

Research Records, Reimbursement, Costs and Reporting

The Policies and Procedures set forth the requirements under law, regulation and HHC policy with respect to various recordkeeping and financial aspects of research, emergency medical treatment and financial support provided to human research subjects who sustain research related injuries as a direct result of research participation; the process by which approval is obtained for costs incurred by HHC in connection with research involving an affiliate grantee and the means by which HHC can obtain reimbursement for those costs; billing and reconciliation processes for clinical research services provided to patients enrolled in studies.

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 October 1, 2014 was 467,823. Breakdown of plan enrollment by line of business is as follows:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>389,919</td>
</tr>
<tr>
<td>Child Health Plus</td>
<td>12,047</td>
</tr>
<tr>
<td>Family Health Plus</td>
<td>9,419</td>
</tr>
<tr>
<td>MetroPlus Gold</td>
<td>3,349</td>
</tr>
<tr>
<td>Partnership in Care (HIV/SNP)</td>
<td>5,034</td>
</tr>
<tr>
<td>Medicare</td>
<td>8,395</td>
</tr>
<tr>
<td>MLTC</td>
<td>720</td>
</tr>
<tr>
<td>QHP</td>
<td>38,241</td>
</tr>
<tr>
<td>SHOP</td>
<td>699</td>
</tr>
</tbody>
</table>

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. As FHP membership is rolling into Medicaid, we will continue to see increases in the latter. However, the Medicaid membership increase experienced in the month of October was greater than the
transfer (rollover) from FHP. We have also seen a loss of Exchange membership due to non-payment from members who have passed their one- or three-month grace period (based on their financial status).

The first item of importance that I would like to bring to this Committee's attention is Sovaldi; namely the cost associated with this Hep C medication. In the first six months of 2014, we have spent $30M on Sovaldi for only 10% of the member population with a Hep C diagnosis code. We anticipate our spending on this drug to reach approximately $70M for this calendar year. This presents a significant financial impact not only on MetroPlus, but also on the HHC risk balance. Since NYS has unsuccessfully attempted to firm up the clinical guidelines for coverage of Sovaldi, MetroPlus is therefore abiding by the guidelines CVS CareMark (our Pharmacy vendor) has put in place.

In our effort to increase membership (by enrolling new members as well as maximizing existing member retention) we are implementing several marketing and communication campaigns, via both internal and external activities, that will help us reach our goals. In addition, based on feedback we received throughout the year from our members, being able to offer an interactive web portal that will allow our members to access their accounts online, print their IDs, view their claims, etc is of critical importance in achieving member satisfaction. MIS is actively working on finalizing this portal so it can go live by November 1, 2014.

MetroPlus is developing aggressive marketing strategies to promote FIDA. This line of business is scheduled to go live on January 1, 2015. We are waiting for the State to provide us with the necessary materials for its implementation (ID card and Member Handbook templates). The Compliance Department and Regulatory Affairs are reviewing this line of business and will be conducting targeting reviews of key risk areas related to this product.

MetroPlus hosted an audit by the Federal Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) on October 9, 2014. MetroPlus was one of four Managed Care Plans selected for review which was focused on New York's Medicaid program integrity procedures and processes. The focus of this CMS review was centered on three particular Medicaid program areas – federal Affordable Care Act provisions related to provider enrollment and screening, state managed care oversight, and managed care entities (MCEs). The Bureau of Quality Assurance (BQA), within the OMIG, was responsible for coordinating all responses to CMS.

In preparation for this audit MetroPlus' Compliance Department coordinated the corporate response and gathered all the data necessary for the CMS audit team. Areas affected and under review were the Special Investigations Unit (SIU), Provider Credentialing & Provider Contracting units. The review was composed of an offsite desk audit as well as a one day review onsite. The timeframe of the review was the last 4 fiscal years. Overall, the audit went well and there were no issues raised during the process by the CMS auditors. There will be additional information requested by CMS and this will be communicated to MetroPlus by the local Office of Medicaid Inspector General. We anticipate this information request to come to MetroPlus within the next two weeks.

We have also been working closely with our providers, educating them on our new Pay-for-Performance (P4P) program. This program is a payment model that rewards providers and facilities for meeting targeted performance measures for the delivery of quality and efficient health services. The goal of this program is to improve the health of our members. Providers with a panel size of more than 200 MetroPlus members are eligible for the P4P program. Currently, P4P eligibility is limited to our Medicaid, CHP, FHP, and HIV SNP participating providers.

I would like to conclude my report by thanking and congratulating the MetroPlus Communications team for their innovative work that led to MetroPlus' award-winning performance in the 2014 American Health and Wellness Design Awards. The awards program honors the importance of design in communication the value of health and wellness, and the organizations, people, products, and services that foster better health. From roughly 1,000 entries to the annual competition, just a handful of designs were selected as winners - including the MetroPlus "How Do I Enroll?" and the MetroPlus Marketplace Individual and Small Business Tax Credit projects. Other winning organizations whose designs were recognized include the American Heart Association, Columbia University Medical Center, N SLJ, and Kaiser Permanente.

Chief Information Officer Report
Bert Robles, Senior Vice President, Information Systems provided the Committee with the following updates:

Bert Robles (2) new important initiatives that will be launched this year: e-Prescribing and Meaningful Use (MU) for Eligible Professionals Stage 1. These projects are interrelated as e-prescribing is a core MU requirement this year. According to data received from the Credentialing Office, it was determined that HHC has ~7000 prescribers made up of physicians and allied health professionals (i.e., Physician Assistants, Nurse Practitioners and Certified Mid-Wives) and 3800 eligible professionals (Source: Unity Physician Master List).
e-Prescribing:

Every prescriber in the twenty-one (21) HHC facilities must e-prescribe by March 2015. New York State passed legislation designed to more effectively curtail forged and counterfeit prescriptions, track patterns of potential prescription misuse and improve patient safety. The Internet System for Tracking Over-Prescribing (I-STOP) law mandates that effective March 27, 2015, all prescriptions issued in New York State are done electronically. The e-prescription (eRx) function will be performed through QuadraMed. QuadraMed has partnered with DrFirst which will provide HHC’s e-prescribing solution. DrFirst is an industry recognized eRx solution that currently integrates with over 290 EMR/EHR vendors in the US. The configuration is underway enterprise-wide with Kings County Hospital as the pilot site. Additionally, an e-Rx Steering Committee was established to ensure timely delivery of the project plan. This committee, chaired by Dr. Machelle Allen, is responsible for making recommendations regarding electronic prescription, policies, workflow, implementation and communication plans. This process will be developed to support QCP as well as to ensure alignment with EPIC/ICIS future operational management. Various work groups were also formed for coordinating or executing all activities regarding the e-prescribing solution. Names of subject matter experts of these work groups were provided by the Medical Directors. There is also active collaboration with Medical Staff Credentialing and GME offices in identifying and validating all prescribers enterprise-wide as identity proofing is crucial for controlled substances. Due to time constraints, the implementation will be fast tracked with facilities going live simultaneously. Training will include classroom didactic, demos, webinars, grand rounds, computerized based training (CBT) with onsite support by super users. In order to achieve this deadline throughout the Corporation, we will need the commitment from the facilities that their physicians and allied health professionals will attend this training. A major disruption to hospital operations will result if participation is not mandated.

Meaningful Use (MU) for Eligible Professionals (EP):

With regards to MU, Eligible Hospitals Stage 2 began its second year on October 1st. In 2015, the Eligible Professionals (EP) Stage 1 program will be introduced for the first time to outpatient providers.

Who Can Participate:
The following are considered “eligible professionals” who can participate in the MU Incentive Program:
Physicians (primarily doctors of medicine and doctors of osteopathy), Nurse Practitioners, Certified Nurse-Midwives, Dentists and Physician Assistants (who provide services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant.)

Guidelines for Participation:
To qualify for participation in the MU Incentive Program, an EP must meet a minimum 30% Medicaid patient volume. For pediatricians to be eligible to attest, they must meet a minimum 20% Medicaid patient volume. Physician Assistants practicing in an FQHC or RHC must have a minimum 30% patient volume to be eligible to attest.

Please note - EPs who work in a hospital in-patient or emergency room setting cannot participate in the program.

For the first year under the MU guidelines, HHC can receive a portion of MU dollars under the adopting, implementing or upgrading (AIU) parameters. For the first payment in 2015, each Medicaid EP who meets the 19 objectives qualifies to receive $21,250. If they continue to meet these 19 objectives for each of next five (5) years, an additional payment of $8,500/year will be given for a total of $63,750 per EP. Based on preliminary assessment, we have identified 3800 providers of whom 2400 are already enrolled with Medicaid. For the remaining 1400 providers, the next step would be to enroll them in Medicaid. We plan to complete and submit the requirements for AIU submission by February 2015.

We also plan to demonstrate MU Stage 1 in 2015 since QuadraMed is scheduled to deliver its certified version (v6.1) by mid-January. Both initiatives are large scale with high impact to HHC stakeholders.

Action Item:

Authorizing the President of the New York City Health and Hospitals Corporation to implement the attached Operating Procedure 180-9 entitled “HHC’s Human Subject Research Program Policies and Procedures.”

The resolution was approved by the Committee for consideration by the full Board.

Information Items:

Lauren Johnston, Senior Assistant Vice President of Patient Centered Care presented on Patient Satisfaction.

The topics were Patient Experience Data Review, Inpatient HCAHPS and Outpatient Medical Practice. 2015 Innovations: Real-Time Feedback with Point of Care Surveying, Patient Experience Consulting w/ Press Ganey, Queens Hospital Center Cultural & Communication Training and Compassionate Connected Care.
Christina Jenkins, MD Senior Assistant Vice President of Quality Performance and Innovation presented on DSRIP. Covered the following items: HHC DSRIP Overview, PPS Update: Configuration, Projects, and Partners Governance and Funds Flow.

**Strategic Planning Committee - November 12, 2014**

As reported by Josephine Bolus, RN

**Senior Vice President Remarks**

**FEDERAL UPDATE**

Ms. Brown began her report by stating that, in Washington D.C., the Republicans had gained a majority in the U.S. Senate with several seats still undecided. Senator Mitch McConnell (R-KY) is so far unopposed to be Majority Leader in January. She added that the lame duck session, which was scheduled to begin today (November 12, 2014), must resolve several issues including funding federal agencies and programs into next year, as well as the appropriation of the Administration's $6 billion request for supplemental funding to address the international and domestic Ebola crisis.

**Ebola Preparedness**

Ms. Brown reported that, to support domestic Ebola preparedness efforts by state and local governments and hospitals, the Administration had proposed several initiatives including:

1. Using the Public Health Emergency Preparedness Program, the Centers for Disease Control (CDC) would get $1.8 billion, of which $7.13 million would come to New York to support accelerated planning and operational readiness for Ebola Virus Disease (EVD) preparedness and response within state and local public health systems including post arrival monitoring. The CDC proposes to fund the current 62 Public Health Emergency Preparedness (PHEP) awardees in the U.S through formula funding, including, but not limited to, funding distributed through the PHEP grant for:
   - Preparedness planning for state and local EVD response
   - Conducting exercises and improvement plans
   - Assuring state/local compliance with active monitoring and direct active monitoring activities
   - Development of training courses, materials, videos
   - Assuring compliance with CDC infection control guidance
   - Assuring responder safety and health
   - Development of risk communication messages and public information
   - Coordination with the Ebola Treatment Centers

2. The U.S. Department of Health and Human Services (HHS), excluding the CDC, would also receive $318 million of which, $2.5 million would be distributed to New York State, for direct support to no less than one Ebola treatment center in the state. An additional $4.89 million would be distributed to Hospital Preparedness Program (HPP) awardees in New York State.

3. Nationally, Ebola Treatment Centers would be established with no less than 55 well-equipped, highly-trained hospitals where patients can be transferred from Ebola screening centers in order to obtain definitive care.

4. A contingency fund of $1.5 billion would be created "to ensure that there are resources available to meet the evolving nature of the epidemic." This fund would be split equally between HHS, which includes CDC, and USAID.

Ms. Brown reported that the current thinking was that the lame duck session would adjourn on December 12, 2014; one day after the current Continuing Resolution to fund the federal government is set to expire.

Ms. Brown stated that, if the President were to issue an Executive Order regarding Immigration policy, it would be done during the window between Congressional adjournment and the New Year. She added that, when the new Congress is convened in January, it would face the March 31st deadline for fixing the perennial Medicare physician reimbursement cut under the Sustainable Growth Rate formula as well as potential breach of the debt ceiling around the same time. There is the ever-present danger of GME, IME and other hospital programs being cut to pay for other spending. There is also a danger of a Republican Congress undertaking "entitlement reform" also known as block granting Medicaid or funding Medicaid on a per capita basis, or privatizing Medicare through a voucher system so that beneficiaries must buy their health insurance in the market place.

Ms. Brown reported that there were some promises being made by the new Republican leadership about making changes in some of the aspects of Obama Care. She commented however, that it was to be seen how successful that would be.
STATE UPDATE

Governor Cuomo Outlines Vision for Second Term

Ms. Brown reported that, on October 23, 2014, Governor Cuomo released, “Moving the New New York Forward,” which is a 259-page document that highlighted the accomplishments of his first term that laid out an agenda for his second term.

Ms. Brown noted that Governor Cuomo devoted four pages to outline his successes in the area of healthcare, which included the approval of the Medicaid Redesign Team (MRT) Waiver, the implementation of the new Health Insurance Exchange, increasing recoveries for services inappropriately billed to Medicaid, legalizing Medical Marijuana, implementing initiatives to combat opioid abuse, increasing investments in Supportive Housing, the establishment of a Statewide Health Information Network (SHIN-NY), and the development of a plan to end the AIDS epidemic.

The document included only one new initiative, which was the State Health Innovation Plan (SHIP). The Plan, which the Governor describes as a “five-year strategic blueprint,” is designed to “align the entire health care system, including private insurance, to further improve quality, keep costs low, and improve the health of all New Yorkers.” Specifically, the Plan would focus on the following:

- Improving coordination and integration of care
- Improving transparency to allow patients and providers access to information they need to make informed healthcare decisions
- Transforming healthcare payment systems from models that are based on volume to models that pay based on value (defined as efficiently provided care with the best possible outcomes)
- Developing a healthcare continuum that links physicians and community-based resources

Ms. Brown reported that the State recently applied for a $100 million federal State Innovation Model (SIM) grant to implement that plan. In the grant application, the state indicates that the plan is expected to generate $4.4 billion in savings, of which $2.2 billion would be reinvested in the healthcare system. Ms. Brown added that, under their payment reform vehicle, the viewpoint of state Medicaid, the Health Department and Mental Health was that all the efforts including DSRIP and managed behavioral health would all come together under SHIP.

Republicans Take Back Majority in New York State Senate

Ms. Brown reported that, in a turn of events few had expected, voters elected a clear majority of Republicans in the New York State Senate. She informed the Committee that for the past two years, the Senate had been controlled by a coalition of Republicans and the Independent Democratic Conference (IDC), a group of five Democrats led by Bronx Senator Jeff Klein. Going into Election Day, there was a great deal of speculation about which party the IDC would align. However, the Republicans held onto all 29 seats that they had previously occupied and picked up an additional three seats Upstate. This gives them a 32-vote majority in the 62 member Senate. In addition, Democrat Simcha Felder of Brooklyn is expected to continue to caucus with the Republicans.

CITY UPDATE

City Council Considers Ways to Boost Enrollment under ACA

Ms. Brown reported that last month, the City Council Health Committee heard testimony from City agencies and scores of community-based organizations on ways to increase enrollment during the second year of open enrollment under the Affordable Care Act. She informed the Committee that for the past two years, the City had been controlled by a coalition of Republicans and the Independent Democratic Conference (IDC), a group of five Democrats led by Bronx Senator Jeff Klein. Going into Election Day, there was a great deal of speculation about which party the IDC would align. However, the Republicans held onto all 29 seats that they had previously occupied and picked up an additional three seats Upstate. This gives them a 32-vote majority in the 62 member Senate. In addition, Democrat Simcha Felder of Brooklyn is expected to continue to caucus with the Republicans.

Information Item:

DSRIP Community Needs Assessment Review and Preliminary Findings
Dona Green, Senior Assistant Vice President, Corporate Planning/HIV Services

Ms. Green began her presentation by providing an outline of her presentation, which is described below:
Purpose of Community Needs Assessment (CNA)
Methodology and Data Sources
DSRIP Guidelines and Valuation
Key Findings in Select Queens Neighborhoods

Ms. Green described the purpose of the DSRIP CNA as the following:
- The DSRIP CNA builds on the recently completed health assessments tied to the New York State Prevention Agenda
- In order to choose the most effective projects, the Performing Provider Systems (PPSs) must understand the broad health status and health care system in the geographic region in which they are functioning
- The CNA forms the basis and justification for system transformation, clinical improvement and population health improvement

Ms. Green stated that the CNA provided information on:
- Whom aren’t we reaching?
- What is the scale of concern with special populations?
- What are the big problems we have missed in the past?
- What aren’t we doing that patients want/need?
- Where are the service gaps?
- Where are we over-resourced?

Ms. Green explained that the CNA is a compilation of primary and secondary research. The primary research in the form of interviews, focus groups and surveys and using specific statistical methods and tools to collect analyze and interpret this information. The secondary research also entailed the collection, analysis, manipulation and interpretation of existing data sets, published articles and studies. All of this research is used to fill in some knowledge gaps. For instance, providers usually know who they are services, but through primary and secondary research, providers can begin to apply some discipline to identifying these gaps in knowledge – all for the purpose of assisting the PPS in its project selection by identifying population health concerns and gaps. Ms. Green added that, our job and that of our consultant collaborators was to apply some disciplined concentration to the problem of finding/acquiring the knowledge that was heretofore untapped about the population, the majority of whom will be potential patients in a PPS targeted ecosystem – whether they be direct patients of the PPS or of a clinical partner that will share resources with the PPS to improve the health in a targeted health care ecosystem.

Ms. Green reported that the HHC PPS would prioritize its efforts in neighborhoods that had high Medicaid and/or uninsured populations, and where the PPS would have a sufficient range of services and resources to improve population health. HHC PPS' service areas include:
- Queens: All neighborhoods excluding the Rockaways and Eastern Queens, and including East New York in Brooklyn
- Manhattan: North of 90th St, extending into the South Bronx (due to the fluidity of patients between the two boroughs); and south of W est 58th Street and East 40th Street
- Bronx: All neighborhoods
- Brooklyn: All neighborhoods

Ms. Green reported that the CNAs were conducted in collaboration with other PPSs. The CNA partners are the following:
- For Brooklyn
  - AW Medical, Lutheran HealthCare, Maimonides Medical Center, SUNY Downstate Medical Center
- For Queens
  - Medisys Health Network
- For the Bronx
  - AW Medical, SBH Health System/Bronx Partners for Healthy Communities

Ms. Green stated that support to conduct the CNAs was provided by the New York Academy of Medicine (NYAM) and Tripp Umbach. These organizations provided support in the following manner:
- The New York Academy of Medicine (NYAM)
  - In the boroughs of the Bronx and Brooklyn, NYAM collected and analyzed all primary and secondary data and produced first draft of the reports
  - In the borough of Queens, NYAM collected and analyzed primary data
- Tripp Umbach
  - In Manhattan, Tripp Umbach conducted focus groups and performed analysis of primary data

Ms. Green described the CNA’s primary data collection process. She stated that, to collect primary data, NYAM and Tripp Umbach partnered with community-based and local organizations. Primary data collection included focus groups, key informant interviews, and a resident survey. Specific activities included the following:
Ms. Green shared with the Committee the list of community-based organizations that participated in the CAN process. She noted that some had conducted both focus groups and resident surveys, while others had only conducted resident surveys. Ms. Green also shared with the Committee a list of institutions/organizations that provided key informant interviews.

Mr. Steven Fass, Senior Director, Corporate Planning Services, described the CNAs’ secondary data collection process, which included the following:

- Demographics and Population Health Status
  - Examples of data sources:
    - US Census American Community Survey
    - NYC DOHMH Community Health Survey and EPIQUERY
    - Behavioral Risk Factor Surveillance Survey
    - NYS Prevention Agenda 2013-2017 Tracking Indicators
    - NYC/NYS Vital Statistics
    - NYS Perinatal Database
    - NYU Furman Center Data on Housing

Ms. Fass added that, in addition to the datasets that have been used in the past, in support of DSRIP, the State had made available a great deal of summarized information regarding the utilization of Medicaid beneficiaries, and the providers that bill Medicaid. Some of the healthcare and community resources data were gathered from sources including:

- NYC Department of City Planning
- Greater New York Hospital Association (GNYHA) Health Information Tool for Empowerment (HITE SITE)
- NYS Department of Health
- NYS Office of Mental Health
- NYS Department of Education
- NYS Department of Corrections (via Justiceatlas.com and Gothamist)
- Center for Health Workforce Studies
- National Alliance on Mental Illness (NAMI)

Mr. Fass described the DSRIP CNA scoring process. He stated that the DSRIP PPS Organizational Application included the following criteria, with each criterion being assigned a score and all criteria collectively summing to 100%. These criteria included:

- Completion of CNA (i.e., quality, citations, etc.)
- Health provider infrastructure (e.g., number and types of providers, assessment of capacity, service area)
- Community resources supporting the PPS (e.g., number and types of resources)
- Community demographics (e.g., age, income, disability education)
- Community population health and identified health challenges (e.g., health risk factors such as smoking, causes of hospitalization, and disease prevalence)
- Healthcare provider and community resources identified gaps (e.g., description of the PPS’ capacity compared to community needs)
- Stakeholder and community engagement (e.g., description of public engagement strategies, focus groups, and consumer interviews)
- Summary of CNA findings (requires completing a chart provided by the State to summarize the community needs identified that the PPS will address in its DSRIP programs and projects)

Mr. Fass described the DSRIP CNA guidelines and requirements. He informed the Committee that the State was very precise in what it expected to see. With the knowledge that the CNA would be scored, HHC and its partners followed the guidelines very carefully and interpreted every suggestion as a requirement. He stated that there were five main sections to the report, which included:

1. Exhaustive inventory of health resources and community programs available to Medicaid beneficiaries and uninsured individuals
2. Community demographics, especially as it may affect effective delivery of care
3. Current health status of the community using official criteria
4. Identification of additional health challenges, such as behavioral and environmental risk factors
5. Comparison of existing community resources and health related needs, factoring in additional health service challenges
Mr. Fass informed the Committee that, due to its size, it would not be possible to present findings from the entire report because the full CNA report covered all of NYC except for Staten Island, all DSRIP disease priority areas, all DSRIP provider priority areas, and in great detail. To keep the presentation manageable in size, Mr. Fass stated that he would be presenting the highlights of the findings for three neighborhoods in Queens including Jamaica, Southwest Queens, and West Queens. He added that his presentation would focus on just two DSRIP priority areas, which are Behavioral Health/Mental Health and Asthma.

Mr. Fass first explained how the data were organized on the presentation slide focused on demographics (presentation slide #18). He stated that the columns of his presentation slides from left to right provided data for NYC, the Borough of Queens, Jamaica, Southwest Queens, and West Queens. Going down the rows in almost every category, it showed that West Queens stood out compared to the other areas with:

- 51% Medicaid beneficiaries
- 27% uninsured residents
- 61% foreign born residents
- 30% of adults having less than a high school education

He added that these were some of the factors that providers needed to take into consideration in order to determine how to improve population health, how best to deliver health care, and which community services are needed.

He reported that the following three presentation slides/charts described the health of the population, which included:

- All Medicaid beneficiaries
- Medicaid beneficiaries with a behavioral health diagnosis
- Medicaid beneficiaries with an Asthma diagnosis

He stated that these slides were organized in a similar manner as the demographic slide with the exception that a column was added to include all of New York State as a comparison. He added that the rows showed three health indicators that will be analyzed throughout the duration of DSRIP, because not only do they describe population health, these indicators will be reported to the state on a quarterly basis. The trend of these indicators show the state whether the HHC DSRIP projects are being successful, which will determine future payments, which are based on the success of the selected projects. Mr. Fass explained that were other indicators that the State would use, but these are especially important.

The three indicators all reflect inappropriate care that would result when there is insufficient access to primary care, and patient management. They include:

- Potentially avoidable ED visits
- Potentially avoidable admissions
- Potentially avoidable re-admissions

Mr. Fass reported that all three Queens neighborhoods were performing well compared to the City and the State; and that going forward, it was expected that there improvements in the current performance of these neighborhoods would continue.

Mr. Fass reported on the findings of the population health with a behavioral diagnosis. He explained that the percent of Medicaid beneficiaries diagnosed with mental illness on the top row of the presentation slide (slide #20) was one indicator of how much need there is for Mental Health services in these Queens neighborhoods. The percent of Medicaid beneficiaries with a mental illness diagnosis is 17% statewide, nearly 20% citywide, compared to 11.5% in West Queens. The state will use other indicators to evaluate success of Behavioral Health related projects. These indicators will include:

- Percent of adults with major depression and treated with medication who remained on medication for greater than 12 weeks
- Percent of adults with schizophrenia and diabetes who diabetes was tested
- Percent (%) age 6+ with mental health disorder hospitalization who had outpatient visit within 30 days of discharge

Mr. Fass reported that, the three Queens neighborhoods were performing well compared to the city and the state for the most part with regard to these indicators.

Mr. Fass reported on the health of the population with regard to Asthma. He stated that the prevalence of Asthma was higher statewide than in Queens, and was more than one third greater than in West Queens. He added that, for the state designated indicators of population health, which focused on potentially inappropriate ED and inpatient care, the three Queens neighborhoods outperformed the statewide average.
Mr. Fass reported on some of the health service challenges for these neighborhoods. He added that these factors were identified by residents and experts in interviews and focus groups as affecting population health and that successful population health projects would need to take these challenges into account. These health services challenges for the target Queens neighborhoods include the following:

- Difficulties meeting basic needs (e.g., housing, food) which leads to extended work hours and emotional stresses
- Work, children and education tend to be prioritized over health
- Lack of sufficient information on health and health services
- Minimal knowledge, interest, and engagement in prevention services
- Stigmatization of behavioral health treatment among foreign born/new immigrants
- Fear of medical bills, medical debt, and deportation

Mr. Fass reported on other health services challenges that were associated with health risk behaviors for NYC, Queens, Jamaica, Southwest Queens and West Queens. He stated that these additional challenges included risky patient behavior. For example, an indicator is the percent of the female population over age 40 that had a mammogram test within the past 2 years. For this indicator, the state and city are both at 74%, but in West Queens, it is less, at 60% of the population.

Mr. Fass reported on the findings from the primary data that was collected concerning Behavioral Health. He reported that:

- 23% of survey respondents reported that mental health issues were a main concern in their community
- 17% of survey respondents report personally facing depression or anxiety
- Depression was cited as relatively common in older adults, with implications for physical health and disease self-management
- CBO key informant reported that:
  "...And also one of the issues on the physical side that is connected with isolation is poor nutrition. A person oftentimes when they're alone has no incentive to cook or to eat. And we find that many of the [older adult] clients that [we see] are nutritionally compromised."
- Emergency department staff reported that caring for patients with alcohol issues was difficult and put a strain on ED resources
- Feedback from focus group:
  "We see a pretty large group of patients with alcohol related issues. And so those patients are very regular here and very difficult, despite trying to get interventions for them, whether it is psychiatric interventions or substance abuse interventions. It's extremely difficult to get them connected and to get them to stay in any kind of program. Once we admit a patient with intoxication, we treat and release, they go back and drink."

Mr. Fass reported on the environmental health risks for NYC, Queens, Jamaica, Southwest Queens and West Queens. The environmental factors include the incidence of homes with cockroaches, adults reporting second-hand smoke at home, homes with leaks and households rating neighborhood structures as good or excellent. These are factors that affect those with Asthma. The three Queens neighborhoods have lower asthma rates than the NYC average. Mr. Fass explained that there seems to be a relationship with some of these risk factors, specifically:

- Homes with cockroaches are less in Queens
- Mold in the home is less are less in Queens
- Homes with leaks is less are less in Queens
- Households are in better condition in Queens

Mr. Fass commented that, while these factors were less of a concern in Queens, they are of higher concern in other boroughs.

Mr. Fass stated that, having outlined the Medicaid communities’ health care and related needs, the analysis is followed by a comparison of current resources. This type of analysis is important to DSRIP project designers to identify questions for follow up regarding possible gaps in coverage. He highlighted presentation slide #26, which showed the number of Medicaid beneficiaries and uninsured in relation to the number of Safety Net physicians, which are those physician who serve a significant percent of Medicaid patients. He stated that the table on the left showed the relationship by neighborhood, and the Queens map showed the ratio by zip code. The CNA report includes similar looking tables and maps for each of the types of facilities and programs that provide care to all populations identified by the DSRIP Guide in all 4 boroughs. The chart shows that NYC as a whole has more physicians per 100,000 population than Queens, 331 vs. 168. It is known from other sources including government reports that all boroughs in NYC have many neighborhoods with physician shortages. Does this mean Queens is even more under-resourced than NYC? The answer is maybe, but not necessarily. From the surveys, it was discovered that mental health services is a greater concern than medical health services. Queens residents are healthier on average, have few risk behaviors such as smoking, and fewer cockroaches.

Mr. Fass stated that presentation slide #27 showed the number of Medicaid beneficiaries with a mental health disorder in relation to the number of psychiatrists. The finding is that NYC as a whole has more psychiatrists per 100,000 Mental Illness diagnosed beneficiaries than in Queens.
Mr. Fass explained that presentation slide #28 showed the number of primary care providers in relation to the number of Medicaid beneficiaries. The finding is that there is a greater number of physicians citywide than in Queens.

Mr. Fass reported on the number of Medicaid beneficiaries diagnosed with Asthma and High Medicaid Primary Care Physicians. The distribution of High Medicaid PCPs (excl. OBGYN) per 100,000 Asthma diagnoses is the following:

- **NYC**: 2,412
- **Queens**: 2,047
- **Jamaica**: 1,830
- **Southwest Queens**: 1,623
- **West Queens**: 2,398

Ms. Green informed the Committee that the CNA findings were to:

- Inform project selection by identifying population health concerns
- Identify neighborhoods and zip codes citywide with greatest healthcare needs
- Identify potential PPS Partners by showing gaps between existing provider and community resources and community need
- Shape project design by describing target populations and align with state health priorities

Ms. Green concluded her presentation by stating that the CNA supported HHC’s PPS project selections. Selected HHC PPS Projects include:

**System Transformation (Domain 2) Projects**

- 2.a.i Integrated delivery system
- 2.a.iii Health Home at-risk intervention program
- 2.b.iii ED care triage for at-risk populations
- 2.b.iv Care transition intervention models to reduce 30 day readmissions
- 2.d.1 Project 11: Engage uninsured and Medicaid low- and non-users of care

The CNA findings that support the selected System Transformation projects include:

- Potentially avoidable admission rates and ER visits are high in all boroughs, but particularly in neighborhoods and zip codes with high Medicaid and uninsured populations
- Potentially avoidable admission rates for chronic diseases are 3% higher citywide than statewide
- Inadequate health services in the community contributes to inappropriate ER use (CNA interviews)
- The rate of mental health readmissions among Medicaid beneficiaries in 23.3% in NYC compared to 20.9% statewide

**Clinical Improvement and Population-wide Projects (Domain 3 and 4)**

- 3.a.i Integration of primary care and behavioral health
- 3.b.i Evidence-based strategies for Cardiovascular Disease Care management
- 3.d.ii Expansion of Asthma home-based self-management program
- 3.g.i Integrate Palliative care into PCMH model
- 4.a.iii Strengthen Mental health and substance abuse infrastructure
- 4.c.ii Increase early access to and retention in HIV care

Medisys projects that do not overlap with HHC

- 3.c.i Evidence-based strategies for Diabetes Care management
- 4.b.i Promote tobacco use cessation

The CNA findings that support these clinical improvement and population-wide projects include:

- Asthma prevalence is higher than statewide in most boroughs and parts of Queens
- Cardiovascular prevalence is 14% higher in NYC than Statewide, and the gap is much greater in hot-spot neighborhoods
- 65% of all NYC Medicaid Beneficiaries with substance use diagnosis had an admission over a one year period, a 9% greater rate than statewide
- Vast health disparities in HIV rates across the City. New HIV infection among the Black/African American population is four times higher than the white population. Many of the same populations that are struggling with HIV are now challenged by the increasing incidence and prevalence of Hepatitis C.

**Improving Access to Care for LGBT Patients**

Mark Winiarski, PhD, Assistant Director of Planning, Corporate Planning Services
Stephen Davis, Director of Nursing Excellence and Utilization Management, Metropolitan Hospital Center
Dr. Nadia Duvilaire, Medical Director, Comprehensive LGBT Health Center, Metropolitan Hospital Center
Dr. Winiarski began his presentation by providing some background information on HHC’s efforts to improve access to care for LGBT patients. He stated that a 2008 Public Advocate report recommended that local hospitals should do more to improve access for this population. Dr. Winiarski described HHC’s response as the following:

In-house discussions
- Explored whether La Clinica del Barrio can host an LGBT clinic
- Co-wrote grant applications with Transgender Legal Defense and Education Fund
- Mandatory training for all staff members
  - Contract with National LGBT Cancer Network to:
    - Produce a video
    - Develop curriculum
    - Conduct train-the-trainer sessions
- PeopleSoft training module available to staff
- Facilities conducted trainings and embarked on projects

Dr. Winiarski reported that an LGBT Advisory Committee was formed in 2014. This committee is comprised of 25 individuals who are interested in LGBT-related issues and quality care for all. Issues of concern were:
- Electronic Health Record
  - Questions regarding gender identity and sexual orientation
  - Neutral fields, e.g., “parents” instead of “mother” and “father”
- Wording in state-promulgated Patient Bill of Rights
- Translation of policies into many languages

Dr. Winiarski reported on HHC’s effort to gain the Human Rights Campaign designation of “Leader in LGBT Health Care Equality.” To gain this designation, a facility must meet the “Core Four” criteria, which include:
1. Managers and leaders must be trained
   - Two training sessions by Shane Snowdon, director of HRC’s Health & Aging Program
   - Attended by approximately 400 staff members
2. “Patients’ Bill of Rights” must include the terms “sexual orientation” and “gender identity”
   - Communicated to patients and employees
3. Visitation policy explicitly grants equal visitation to LGBT patients and visitors
   - Communicated to patients and visitors
4. Employment policy includes the terms “sexual orientation” and “gender identity”
   - HHC’s corporate policy (0P 20-32) states:
   “The Corporation’s unequivocal policy is to provide equal opportunity to all...without regard to...gender (including ‘gender identity’)...sexual orientation.”

Dr. Winiarski reported that in 2014, a total of 10 HHC facilities had earned the designation as “Leader In LGBT Health Care Equality.” These facilities include:
- HHC’s acute care facilities
  - Bellevue Hospital Center
  - Metropolitan Hospital Center
  - Harlem Hospital Center
  - Woodhull Medical & Mental Health Center
  - Jacobi Medical Center
  - North Central Bronx Hospital
  - Coney Island Hospital
  - Lincoln Medical Center
  - Elmhurst Hospital Center

- HHC’s Diagnostic & Treatment Center:
  - Cumberland D&T

Dr. Winiarski highlighted four key LGBT projects at select HHC facilities including Metropolitan Hospital Center, Bellevue Hospital Center and at Harlem Hospital Center.
Mr. Stephen Davis, Director of Nursing Excellence and Utilization Management at Metropolitan Hospital Center, stated that, in addition to his role at Metropolitan Hospital, he was also a doctoral student at Yale University. He has focused his translational research on executive leadership and succession planning. Related to how healthcare executives effectively lead and manage organizations, the program requires candidates to perform an ethical analysis. Given the increasing focus on LGBT health, he chose to evaluate the ethical issues surrounding access and resource utilization for the LGBT population in the context of the safety net. Metropolitan's executive leadership team approved his use of the hospital's work on LGBT health as a case study for this project and his paper was submitted in December 2013. In March, Dr. Nancy Berlinger, an adjunct faculty member at Yale and research scholar at the Hastings Center, contacted Mr. Davis to adapt his work for publication in the Hastings Center Special Report on LGBT Bioethics. In addition to showcasing Metropolitan Hospital as a leader in caring for the LGBT population from a safety net perspective, the article highlights the moral imperative public institutions have to allocate resources aimed at reducing LGBT health disparities. Additionally, significant attention is given to the resource challenges public institutions may face in comparison to private hospitals. Building on the recent release of this article and the others published in the special report, The Hastings Center and Montefiore are holding a symposium on LGBT health and Dr. Raju will be participating on the expert panel.

Mr. Davis stated that he was thrilled that Metropolitan Hospital and HHC are part of this critical dialogue to address healthcare for an extremely vulnerable population that needs the safety net to provide inclusive and comprehensive care.

Dr. Nadia Duvalaire, Medical Director, Comprehensive LGBT Health Center LGBT at Metropolitan Hospital provided the Committee with information about the groundbreaking LGBT Clinic at Metropolitan Hospital. She stated that a total of 25 sessions have been held so far and that they were looking forward to having more sessions. She added that they were proud to have achieved the 2014 HEI Leader in LGBT Healthcare Equality status and that the staff was committed to earning this status year after year by expanding LGBT services by:

- Renovating clinic space and holding clinic sessions Monday through Friday in addition to Saturdays
- Increasing visibility and patient base through formation of strategic partnerships with community-based organizations and other healthcare organizations
- Developing specialty transgender health care to address higher rates of health disparities experienced by transgender community
- Ensuring quality patient experience at the LGBT clinic and throughout Metropolitan Hospital by undertaking staff trainings in LGBT competency
- Embarking on the long-term goal of hosting researchers focusing on LGBT health

Bellevue Hospital Center

Ms. Evelyn Borges, Associate Director, Office of Patient Experience and Founder of the LGBT Patient and Family Advisory Council at Bellevue Hospital Center provided information to the Committee regarding Bellevue's LGBT Parent and Family Advisory Council. She stated that the Lesbian, Gay, Bisexual, & Transgender- Patient and Family Advisory Council (LGBT-PFAC) was comprised of patients, their families and staff. It is a multi-disciplinary and expansive advisory resource that strives to support the mission, vision, and goals of Bellevue Hospital Center. The LGBT-PFAC delivers the highest standard of comprehensive and compassionate health care. The PFAC aims to accomplish this goal by partnering with patients and families in identifying opportunities to effect changes for improving service and care to the LGBT community. The LGBT-PFAC is primarily concerned with ensuring dignity and respect for patients and their families by:

- Providing complete, unbiased information to LGBT patients and their families
- Sharing the decision-making process and responsibility with patients at the level they choose.
- Collaborating with patients and their families in creating the policies and programs for their well-being

Ms. Borges stated that, in addition to achieving the HEI designation, the Human Rights Campaign had also requested the Bellevue LGBT-PFAC brochure be used as a model for future Patient and Family Advisory Councils. Additionally, through the internal informational/educational awareness events, the Bellevue LGBT-PFAC has been able to establish relationships with various community groups including the LGBT Community Center and the Asian Pride Project. Ms. Borges described their next steps as including:

- The design and develop of a directory of providers who specialize in LGBT care
- Increasing the LGBT-PFAC membership
- Increasing community outreach

Harlem Hospital Center

Ms. Austin, Public Health Educator, Family Planning Program at Harlem Hospital Center and creator of the program she calls SAFE informed the Committee that Harlem Hospital was committed to attaining the Human Rights Campaign’s “Leader in LGBT Healthcare Equality” designation and to demonstrate competency and improve the quality of its clinical care and customer services. She stated that a meeting was convened with the Harlem Hospital leadership of Nursing, Patient finance, Admitting,
Ms. Austin reported that 10 Harlem Hospital staff participated in a cultural competency/empathy master training program. She stated that, over a period of eight weeks, they were able to train 148 staff from various departments. While completing this training, it was discovered that they needed to create a marketing “tag line” to promote LGBT patient-centered care. The tag line is Harlem Hospital Center is SAFE! (“SAFE” stands for Services and Advocacy that Foster Empowerment).

Ms. Austin explained that this tag line communicated Harlem Hospital’s commitment to providing equity in LGBT healthcare. SAFE will be a symbol to LGBT Patients that HHC is a “safe” place where one can come and get the services they need. SAFE means when an LGBT person comes to an HHC facility, that individual will have advocates and allies to help them get what they need without trauma. She stated that to be empowered with equitable health care an individual needs a “safe” space and, HHC is SAFE!

Ms. Austin described Harlem Hospital’s vision for the future as including the use of social media. She explained that Harlem Hospital can remove the barriers of information with platforms such as Google, Facebook, and Twitter. A successful marketing plan promoting LGBT patient-centered care including traditional brochures, posters, radio ads and print ads, adopted across the corporation is what is needed.

Ms. Austin concluded her presentation by stating, “How wonderful would it be to see HHC is SAFE on MTA Public Transportation!”

SUBSIDIARY BOARD REPORT

HHC ACO (Accountable Care Organization), Inc.
November 3, 2014 – As reported by Dr. Ramanathan Raju

New Business
The first item on the agenda was consideration of a resolution to elect certain directors as officers of the ACO. A motion was made and duly seconded to adopt the resolution identified as number one on the agenda:

RESOLUTION authorizing that the following persons be elected to serve in the offices of the ACO as set forth below, subject to such person’s earlier death, resignation or removal, in accordance with the laws of the State of New York until such person’s successor is duly elected and qualified:

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ramanathan Raju, M.D.</td>
<td>Chairman</td>
</tr>
<tr>
<td>Ross M. Wilson, M.D.</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Marlene Zurack</td>
<td>Treasurer</td>
</tr>
<tr>
<td>Salvatore J. Russo</td>
<td>Secretary</td>
</tr>
</tbody>
</table>

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

The next item was consideration of a resolution to expand the ACO’s Board to include a director to be named by New York University School of Medicine (“NYU”). A motion was made and duly seconded to adopt the resolution identified as number two on the agenda:

RESOLUTION authorizing that the number of Directors of the ACO’s Board of Directors be fixed at ten (10), subject to approval by the Centers for Medicare and Medicaid Services (“CMS”) of a Director to be named by New York University School of Medicine (“NYU”); AND

Authorizing, upon such CMS approval, that a person to be named by NYU, as specified in a writing by NYU that is delivered to the Chairman of the ACO, is hereby elected to serve as an additional Director of the ACO’s Board of Directors, subject to such person’s earlier death, resignation or removal, in accordance with the laws of the State of New York until such person’s successor is duly elected and qualified, subject to ratification by the ACO’s sole Member, the New York City Health and Hospitals Corporation (“HHC”).

Dr. Wilson explained that under the Medicare Shared Savings Program (“MSSP”) regulations, ACO participants must bill Medicare for Part B physician services. CMS did not contemplate the situation of affiliates that provide services in Elected Teaching Amendment arrangements, such as NYU employed physicians working at Bellevue and Woodhull. Although NYU cannot technically be an ACO participant, they have agreed to comply with the MSSP requirements and they serve a significant number of ACO attributed patients. The proposed resolution provides NYU with a voice in ACO governance and decision making.

There was no further discussion of the motion. The motion was unanimously approved.
The next agenda item was a report from Dr. Wilson, Chief Executive Officer of the ACO. Dr. Wilson presented data on the ACO attributed patient population and discussed how HHC’s ACO differs from others throughout the country, particularly with respect to the high rates of dual eligible and disabled patients, as well as patients living with End Stage Renal Disease, psychiatric diagnoses, HIV, and other chronic conditions. The ACO has about 12,000 patients currently attributed, with quarterly churn in the population.

The HHC ACO’s MSSP participation agreement with CMS began on January 1, 2013, and will conclude at the end of 2015, at which point there will be a determination of whether to continue. For the first year-and-a-half, the ACO has focused on building the right platform for management/governance, data collection and reporting, and so forth. This work takes time, and the architects of the Delivery System Reform Incentive Payment (“DSRIP”) should pay attention to the learning curves of the ACO.

The ACO is now focused on enhancing the population health management strategies in HHC’s primary care clinics. The ACO population is segmented into three categories: high risk, at risk, and low risk. The ACO prospectively identifies high risk and at risk patients using predictive modeling techniques, then moves these patients into care management programs. The ACO is working with Professor John Billings on a more sophisticated model for risk stratification. ACO data is shared with clinical and administrative leadership via a Population Management Dashboard, which Dr. Wilson briefly previewed.

Dr. Wilson reported that of the 243 ACOs participating in the MSSP for 2013, only 25% earned shared savings by meeting the program’s cost and quality goals. The HHC ACO scored in the 74th percentile nationally on clinical quality indicators and realized a 7% reduction in Medicare expenditures, which qualified the ACO for a performance payment. Dr. Wilson acknowledged Dr. Nicholas Stine and Megan Cunningham for supporting the ACO’s activities.

Dr. Wilson explained that the ACO seeks to allocate the earned performance payment of $3,639,766 according to a methodology set forth in legal agreements between the ACO, HHC, and physician groups. The shared savings are first retained by HHC as an offset to “reasonable and customary costs,” as indicated in the ACO’s audited financial statements for Fiscal Year 2014. The remainder is split equally between HHC and the physician groups (with the exception of the Mount Sinai Elmhurst Faculty Practice Group, which did not join the ACO until 2014), with the intention that the physician groups further distribute their funds to primary care physicians. The Shared Savings Allocation Report included with the Board meeting materials provides additional detail about the underlying calculations. Dr. Wilson recommended that representatives from each physician group meet with the ACO team to establish a distribution plan that complies with MSSP regulations and ACO agreements, as well as internal rules for physician incentive payments.

Dr. Wilson emphasized that the earned performance payment is cause for celebration, and that the ACO’s success was driven by corporate-wide policies and initiatives centered on improving the quality and capacity of primary care. Dr. Stine added that physician engagement was and will continue to be a critical aspect of the ACO’s performance, which underscores the importance of incentive payments to physicians.

Dr. Moshirpur asked whether the distribution should go to all employed physicians or just primary care providers. Dr. Wilson explained that the MSSP attribution model and quality measures are predicated upon primary care, so the intent is for primary care physicians to receive the incentive payments. Dr. Marcos requested more information about how the affiliate share was calculated. Dr. Wilson referenced the ACO agreements and the Shared Savings Allocation Report, and reminded the Board that HHC’s share is intended to compensate for the infrastructure needed to support physicians, including IT systems, care managers, and nursing staff. Dr. Kanna and Dr. Kalkut questioned whether the ACO would identify primary care providers who should receive distributions, and how many patients were attributed to each physician/facility. Dr. Wilson stated that the ACO team would share this data in their meetings with the individual physician groups.

Dr. Kalkut asked whether the ACO conducted an analysis to determine how the $7 million in savings was achieved. Dr. Stine replied that the biggest trends were in reduced hospitalizations, and increasing utilization of end of life/hospice care by approximately 40% in this performance year; however, hospice utilization remains below benchmarks, so there is additional opportunity in this area. Dr. Wilson emphasized the role of the Patient Centered Medical Home (PCMH) practice transformation efforts.

Additionally, Dr. Wilson stated that the ACO serves as a model for the entire HHC organization, and that HHC expects to scale ACO systems and processes to other populations including Medicaid, perhaps forming a Medicaid ACO under new State regulations, as part of a broader, long-term strategy for transformation to support the Triple Aim.

Dr. Wilson read a resolution authorizing the ACO to distribute shared savings. A motion was made and duly seconded to adopt the resolution identified as number four on the agenda:
RESOLUTION authorizing the ACO to distribute the 2013 Performance Payment as described in the Shared Savings Allocation Report (Exhibit B), with the intent that such payments be used to further the ACO’s goals of improving quality and reducing overall cost of care, and for distribution to the physicians providing direct primary care to the ACO patient population.

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

The Acknowledgement of Fiduciary Duties and Responsibilities was distributed for signature by each Board member. Dr. Wilson offered additional education/training to be coordinated by the ACO team upon request. Dr. Morshipur asked if the ACO could provide periodic updates and progress data, so that Board members are kept informed between meetings. Dr. Wilson explained that reports are regularly shared with the designated ACO Lead at each facility, and the ACO would consider how to share information with other local clinical and administrative leaders as well.

Dr. Marcos commented that hospital emergency rooms and in-patient services may lose revenue if ACOs are successful in keeping patients healthy in the community. Dr. Wilson explained that healthcare payment reform initiatives such as DSRIP are incentivizing reductions in preventable hospitalization, and acknowledged that HHC has to harmonize various payment models. Dr. Moshirpur asked whether different staffing arrangements are needed to support evolving priorities in healthcare. Dr. Wilson replied that HHC will ensure that its workforce meets the demands of the new care delivery models.

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

**A MESSAGE ABOUT DOCTORS COUNCIL AND OUR PHYSICIANS**

I want to inform you that labor negotiations, led by the New York City Office of Labor Relations, currently are ongoing between the Doctors Council, HHC, and our three affiliate physician groups. We are actively engaged in these talks and optimistic that a fair and timely resolution soon will be forthcoming. I know the Board joins in my view that HHC physicians every day earn our respect and admiration for the compassionate, high quality, mission-driven care that they render to patients across our Corporation.

Also, you should know that we are working with Doctors Council, along with City Hall and community groups, to create a team to implement (within the boundaries of governance and regulatory constraints) the recommendations of the Doctors Council "whitepaper" that seeks increased collaboration with physician staff on issues of patient quality and related matters.

**LEASING OF HHC SPACE**

In recent months, the Board and its Capital Committee inquired as to HHC policy concerning the leasing of space to City agencies, and to non-profit organizations.

My staff has reported in detail on these matters to the Capital Committee and has consulted individually with the Committee Chair, Committee members, and the Board’s Acting Chair. As a result of these discussions, I wish to report that going forward management is implementing a policy whereby HHC generally will not charge any city agency to occupy leased space unless, in specific cases, economic considerations such as reimbursement of lease fees through a grant are cause to override the general policy. Lease of space to non-profit organizations that further the mission of HHC will be viewed similarly.

Of course, the Board retains its discretion on all such transactions.

**EBOLA PATIENT TREATED AND DISCHARGED**

On November 11th, I proudly joined Dr. Craig Spencer, Mayor de Blasio, DOH Commissioner Bassett, HHC’s Dr. Laura Evans, and Sophie Delaunay of “Doctors Without Borders” on the occasion of Dr. Spencer's discharge from Bellevue Hospital.

Dr. Spencer, New York City's first and only patient treated for Ebola Virus Disease, was going home healthy and disease free after the dedicated, compassionate, and skillful care provided him by the Bellevue team and its collaborators.

I believe Dr. Spencer is a true hero who put himself in harm’s way to care for others at the source of this epidemic in West Africa. We are especially proud to have cared for him and brought him back to good health.

As Dr. Spencer and we approached the grand Bellevue atrium for the press conference, dozens and dozens of staff lined the hallway cheering. Many of his nurses stood proudly behind him at the podium as Dr Spencer spoke movingly of the need for all of us to focus – not upon him – but upon the continuing disease burden in West Africa. As I witnessed Dr. Spencer’s remarks, those of Dr
Evans, and the nurses standing behind, it was clear that a quite special bond had developed between our patient and his dedicated care team.

The world watched as New York City Health and Hospitals Corporation and Bellevue joined the very limited ranks of hospitals in the US that have successfully treated an Ebola patient. And we once again demonstrated the value of public hospital systems in this country, why we need to support them, and why the compassionate and selfless professionals who staff them deserve our gratitude and respect.

I want to extend my heartfelt thanks to the Bellevue team and to every one of our hospitals and their teams who stand ready to serve -- I could not be more proud.

**EBOLA COSTS**

When New York City had the urgent need to prepare for Ebola it was HHC that stepped forward first and did the job right, without concern over costs. Our focus from the beginning of the Ebola crisis has rightly been on providing only the best care to our patients and ensuring our staff has the resources they need to work safely. But, clearly, this has been an expensive undertaking at a time that our public health care system faces tough fiscal challenges.

We estimate that New York City's preparation and continued response to the Ebola epidemic, which has been a multiagency effort, has cost the City more than $20 million to date. Thankfully, we have the support of Senator Schumer, who last Sunday made a very public stand by calling for the federal government to cover the city's Ebola expenses. The Senator said federal reimbursement for most of the costs is justified because the efforts are helping to prevent the deadly disease from getting a foothold in the United States. As a major port of entry to this country, New York City receives the largest amount of travelers from the affected West African countries. And with the ongoing Ebola outbreak in West Africa, the city's costs are expected to rise.

**FEMA COMMITMENT TO HHC**

After many months of negotiations, I was once again joined by Mayor de Blasio, along with Senator Schumer, at Coney Island Hospital, to announce and celebrate a milestone. The Federal Emergency Management Agency (FEMA) approved a commitment of at least $1.6 billion that will permit the restoration and fortification of four Health and Hospitals Corporation facilities that suffered damage during Hurricane Sandy two years ago now.

When Coney Island Hospital was temporarily closed after Hurricane Sandy, it reminded us all that hospitals are not just about healthcare delivery but are part of the social fabric of the community and of the local economy. When public hospitals close as did Coney Island and Bellevue after Sandy, the community loss and suffering is even greater because of the especially vulnerable persons who rely on them.

The federal funding will assure over the long term that never again will we face the circumstances of a storm like Sandy without structures designed to withstand extraordinary climate forces like those of Superstorm Sandy.

We would not have reached this agreement without the persistent, professional, caring efforts of many. From the bottom of my heart I wish to express my personal gratitude and the gratitude of all of the HHC family to all those who worked to bring us this agreement. I specifically want to thank: Tony Martin, Marlene Zurack, Fred Covino, Arthur Wagner, Steve Alexander, Jeremy Berman and John Levy of Base Tactical who has advised us throughout.

**DSRIP UPDATE**
HHC is moving forward in developing a Performance Provider System (PPS) to participate in the State Medicaid Waiver program, the Delivery System Reform Incentive Payment (DSRIP) program that will provide funding for public and safety net providers who meet outcome milestones and achieve statewide metrics. The goal of this $6.42 billion allocation to the Medicaid program is to reduce healthcare costs and avoidable hospital use by 25 percent over five years.

Late last month we secured agreements with four other emergent PPS's to work together to implement health care projects that will improve quality, expand access, lower costs and transform the healthcare delivery system in New York City. By working under a common set of projects and metrics, HHC and the PPS's lead by SBH Health System in the Bronx, Maimonides in Brooklyn, Lutheran in Brooklyn and Medisys Health Network in Queens, will be able to avoid duplication, create a more complete continuum of care for patients and make it easier for community-based partners in each PPS to participate in the program.

DSRIP requires that each PPS select a number of projects from a list of 44 based on the results of Community Needs Assessments. Although the DSRIP program does not require emerging provider systems to work on the same projects, we felt strongly that the needs of our communities and patients will be best met with a consistent and coordinated approach to improving the models of care throughout the city. Our collaboration with the other healthcare systems and their PPS's is a common sense strategy to bring more value to the healthcare improvement projects we need to develop for the community we collectively serve.

HHC remains on target to meet the State's December 16th deadline to apply as a PPS.

The HHC-led Performing Provider System (PPS) held its first formal Advisory Committee meeting on November 18th at Bellevue Hospital. We are honored to have engaged over 130 community and city-wide partners, community-based organizations, labor and affiliate partners, and HHC Community Advisory Board members in discussion of the community needs assessment (CNA) process and results, review of our selected projects, and creation of guiding principles for successful partnership over the five-year program period and beyond. HHC looks forward to holding two educational e-townhalls in the next two weeks, so that our community partners from across the city can log in and learn more about the requirements of each project and more specific opportunities for involvement.

**FLU IMMUNIZATION CAMPAIGN**

The last few months of public concern about Ebola have given us an opportunity to talk about the flu virus – which results in similar symptoms, but is a much more serious risk to the health of our communities. Both Mayor de Blasio and Health Commissioner Bassett were very forceful in their advocacy in urging New Yorkers to get a flu shot.

Influenza kills more than 1,800 New Yorkers and HHC is committed to doing all we can to make the vaccine available for our patients and our staff.

It is particularly urgent for health care providers to get a flu shot to protect their own health and the health of our patients. All our health care facilities are actively offering free flu shots to our employees before the state Health Commissioner designates the beginning of the flu season. We will be subject to the same regulation that was adopted last year by the NYS Department of Health, which requires that all healthcare workers are either vaccinated or use a mask for the duration of the flu season. HHC strongly supports that regulation and we are committed to exceeding our employee vaccination rate from last year.

**A GREENER, STORM RESILIENT CONEY ISLAND HOSPITAL**

HHC has just completed a $21 million project to make Coney Island Hospital more energy efficient and more resilient for future storms like Sandy. Thanks to a grant from the New York Power
Authority and National Grid, we have a brand new boiler plant, more than 2,000 new windows and 500 air conditioning units that will save HHC over $1.2 million per year in energy costs and will reduce greenhouse gas emissions from the hospital by over 7,000 tons per year. The hospital will run on clean natural gas for the first time in 100 years. The new heating system, which was completely destroyed by Sandy, includes new emergency generators and was built on new concrete floor slabs. Other critical equipment was elevated above the FEMA 100-year flood line to ensure this does not happen again.

I'd like to thank Governor Cuomo and the Power Authority for their support and we look forward to completing other energy efficiency projects at other HHC facilities, including Elmhurst, Metropolitan, Woodhull, Harlem, Kings and Lincoln.

**SUPPORTIVE HOUSING COLLABORATION BETWEEN KINGS COUNTY HOSPITAL AND CAMBA**

HHC has a unique role in New York City's healthcare system. Sometimes we make headlines with cutting edge medicine, such as leading the City's response to the Ebola crisis. But more often we are known as the healthcare provider for the City's neediest and most vulnerable residents. That is really our core mission, and it's one that we excel at. We serve all New Yorkers, without exception, and our aim is always to keep the City's most vulnerable populations at their healthiest.

That's the driving force behind our great partnership with CAMBA Housing Ventures, Inc. On Monday, we celebrated the CAMBA Gardens Phase I ribbon cutting and CAMBA Gardens Phase II groundbreaking, which together provide 502 units of sustainable, supportive and affordable rental housing in Wingate, Brooklyn, representing over $165 million in public and private investment. The CAMBA Gardens model re-uses underutilized public hospital property to create much-needed affordable housing for local residents, connects formerly homeless families and individuals to stable housing and critical social services, and provides tenants with access to healthcare. Both Phase I and II, in partnership with HPD and HHC provide preferences within the HPD housing lottery for local community board residents and Kings County Hospital Center employees, among other preferences.

As HHC leads the transformation of healthcare in Brooklyn, which is being incentivized by the State's Medicaid waiver, projects such as these help us manage population health. By harnessing the resources of a great institution such as Kings County Hospital Center, and partnering with innovative and compassionate groups such as CAMBA, we not only create over 500 units of sustainable, supportive and affordable rental housing, but we do so in a way that maximizes the well-being of the residents, helps them stay healthy and avoid unnecessary hospitalizations, and best of all, enhances their dignity and their quality of life.

I'm very proud of what has been achieved here. I'm very glad HHC has helped produce this remarkable and supportive new environment for Brooklyn. And I hope that in the future we can be involved with more projects such as these, and work with other groups similar to CAMBA, to bring more people closer to better healthcare, and to help them live better lives.

**BELLEVUE, LINCOLN AND NCB PRAISED BY THE JOINT COMMISSION**

Three of our hospitals were acknowledged this month by The Joint Commission, the national organization that accredits our hospitals and nursing homes, as Top Performers in their Key Quality Measures program. Bellevue, Lincoln and North Central Bronx hospitals were in good company, including Johns Hopkins, Cleveland Clinic and the Mayo Clinic, in showing that evidence-based interventions are delivered in the right way and at the right time. Bellevue and Lincoln are recognized for improvement in heart attack, heart failure, pneumonia and surgical care, NCB for heart failure, pneumonia and surgical care. The Joint Commission published the acknowledgment in its annual report America's Hospitals: Improving Quality and Safety. Congratulations to Steve Alexander, Milton Nuñez and Bill Walsh, and their staffs for this outstanding honor. Let me direct
your attention to the framed certificate of this recognition from The Joint Commission that is now on display in the light box located near the entrance of HHC's Board Room.

**NURSING CHAMPION AWARD**

As I mentioned in my report to the Board last month, we held our annual Nursing Excellence Awards to acknowledge the impressive talents, skill and dedication of our nurses, and to celebrate the accomplishments of six of our nurses. I’d like to bring your attention to the plaque for the Nursing Champion Award that will be hung in this room as a permanent reminder of their excellence and commitment to our patients. That award yearly will recognize one individual whose work supports and elevates the voices of nurses. This year the recognition went to Carolyn Jones, Director of The American Nurse, an award winning documentary that follows the work of five nurses, inspiring a newfound appreciation for nurses and the challenges they face.

Last year, the first time we presented the nurse champion category, the award went to our own, HHC Board Member Josephine Bolus, for her tireless work in the field leading up to and following her retirement in 1997. Josephine served as a Staff Nurse in the Pediatric Emergency Room at Kings County Hospital. She pioneered the establishment of the certification guidelines for the nurse practitioner in New York State, and served as Preceptor for Pediatric Nurse Practitioner students at Columbia University and for Registered Nurse students at Kingsboro Community College. As a Board member, Josephine is a true advocate and voice for patients and nurses, and we are very fortunate to have her serving in this role.

We'll keep the award in this room to be reminded of the efforts put forth by our Nursing Champions, and the indispensable role of nurses on the front lines of today's healthcare delivery.

**GUNS DOWN, LIFE UP ASSEMBLY**

Just as an announcement, I wish to let you know that The Fund for HHC tomorrow will host the inaugural Guns Down, Life Up Assembly at Pier 60 / Chelsea Piers to bring together violence-reduction activists, experts, and leaders. Guns Down, Life Up (GDLU) is the banner under which HHC's gun violence prevention work is organized. My gratitude and best wishes for the success of this event and these programs go to the organizers at the Fund for HHC.

**FEDERAL UPDATE**

In Washington, the Republicans gained a majority in the US Senate with several seats still undecided.

The current session must resolve several issues: funding Federal agencies and programs into next year and the Administration’s $6 billion request for supplemental funding to address the international and domestic Ebola crisis.

For domestic preparedness through State and Local Governments and Hospitals the Administration proposes the following:

- Using the Public Health Emergency Preparedness Program, the Centers for Disease Control (CDC) would get $1.8 billion, of which $7.13 million would come to New York to support accelerated planning and operational readiness for Ebola Virus Disease (EVD) preparedness and response within state and local public health systems including post arrival monitoring.

- The U.S. Department of Health and Human Services (HHS), excluding the CDC, would also receive $318 million of which $2.5 million would be distributed to New York, for direct support to no less than one Ebola treatment center in the State and an additional $4.89 million would come to Hospital Preparedness Program (HPP) awardees in New York State.
• The Hospital Preparedness Program (HPP) awardees would support overall health system preparedness and response for Ebola. Funding will be allocated to awardees by formula. All U.S. health care facilities must be prepared to screen patients for Ebola.

• A contingency fund of $1.5 billion would be created "to ensure that there are resources available to meet the evolving nature of the epidemic." This fund would be split equally between HHS, which includes CDC, and USAID.

In addition to the funding listed above, the Administration is requesting funds to conduct further research to advance drug development.

Nearly $2 billion of the request would be directed toward the U.S. Agency for International Development, $127 million for State Department multilateral assistance and $112 million for the Pentagon and its Defense Advanced Research Projects Agency efforts to address the virus.

Of the $6.2 billion, more than $4.5 billion would be designated as emergency spending, not needing to be offset with corresponding cuts elsewhere in the budget.

Current thinking is that the current session will adjourn December 12, one day after the current Continuing Resolution to fund the federal government expires.

If the President issues an Executive Order regarding Immigration policy, it is expected to be during the window between Congressional adjournment and the new year.

When the new Congress begins in January, they will face the March 31 deadline for fixing the Medicare physician reimbursement cut under the Sustainable Growth Rate formula as well as potential breach of the debt ceiling around the same time. There is the ever-present concern of GME, IME and other hospital programs being cut to pay for other spending. A Republican Congress might also undertake "entitlement reform" also known as block granting Medicaid or funding Medicaid on a per capita basis. There is also a concern that Medicare might be privatized through a voucher to participants to buy their health insurance on the market.

**STATE UPDATE**

In a turn of events few expected, voters elected a clear majority of Republicans in the New York State Senate. Republicans held onto all of the 29 seats they had previously occupied and picked up an additional three seats Upstate. This gives them a 32-vote majority in the 62 member Senate.

The governor must submit the proposed Executive Budget for Fiscal Year 2015-16 no later than February 1st. Although the State expects to end the year with a projected $4.8 billion surplus, the state Dept. of Budget (DOB) asked agencies to submit requests reflecting flat funding. Governor Cuomo is seeking to continue to limit overall growth in State spending to two percent annually, except for education funding and Medicaid.

As you may recall, since 2010 the State Budget has included a Global Cap on Medicaid Spending and corresponding authority for the State Health Commissioner to make cuts to keep spending beneath the Cap.

On October 23rd, Governor Cuomo released "Moving the New New York Forward," a 259-page document that highlights the accomplishments of his first term and lays out an agenda for his second term.

Cuomo devoted four pages to outline his successes in the area of healthcare: the approval of the Medicaid Redesign Team (MRT) Waiver; the implementation of the new Health Insurance Exchange; increasing recoveries for services inappropriately billed to Medicaid; legalizing Medical Marijuana;
implementing initiatives to combat Opioid abuse; increasing investments in Supportive Housing and the Statewide Health Information Network (SHIN-NY); and developing a plan to end the AIDS epidemic.

The document included one new initiative: the State Health Innovation Plan (SHIP). The Plan, which he describes as a "five-year strategic blueprint," is designed to "align the entire health care system, including private insurance, to further improve quality, keep costs low, and improve the health of all New Yorkers." Specifically, the Plan focuses on the following:

- Improving coordination and integration of care;
- Improving transparency to allow patients and providers access to information they need to make informed healthcare decisions;
- Transforming healthcare payment systems from models that are based on volume to models that pay based on efficiently provided care with the best possible outcomes; and
- Developing a healthcare continuum that links physicians and community-based resources.

The State recently applied for a $100 million federal State Innovation Model (SIM) grant to implement the Plan. In the grant application, the State indicates that the Plan is expected to generate $4.4 billion in savings, of which $2.2 billion will be reinvested in the healthcare system.

**FEATURED PROGRAM:**

**WOODHULL HOSPITAL'S CHRONIC PUBLIC INEBRIATE (CPI) PROGRAM**

Most of you in this room know that alcoholism can be both a cause and a result of homelessness. Individually, each of those conditions impacts health outcomes of many in our city. Experienced together, the complications are enormous for the men and women who are living through both. It also creates a unique set of challenges for the health, social service and public safety agencies that, historically, have tried to solve each of these problems in isolation.

I believe both issues need to be addressed simultaneously, and through true collaborations between health care providers and community based organizations. An innovative new program at HHC Woodhull Hospital is aiming to do just that.

The partnership between the Woodhull Hospital Emergency Department, the NYC Department of Homeless Services and a nonprofit housing agency, Common Ground, is helping persons who have chronic alcohol intoxication and have also been homeless for a good part of the last two years. The goal of the program is to place individuals into long-term housing as an initial step to reduce the high utilization of ED services in this population.

Like many urban emergency rooms, Woodhull sees a significant number of homeless individuals who suffer from substance abuse. This population represents many of the high utilizers of ED services. In fact, when Woodhull conducted a snapshot look at ED visits during a three week span in January, they identified more than 30 individuals who came to the ED once daily -- on average -- due to alcohol intoxication, and a majority of them were homeless.

Now, with the help of the Department of Homeless Services and Common Ground, the staff at Woodhull can begin to direct some of these patients to safe, secure housing, with essential on-site support services to help them address the psychosocial, mental, and physical health problems that are obstacles to independent living.

Though the program is still under development, they already have been able to place a few high utilizers of ED services at Woodhull in steady housing. Because this is a voluntary program, not everyone accepts the offer and some remain on the street. And two of the patients on the original list recently died, underscoring the vulnerability of this population and the great need for effective collaborations and interventions like this one.
This partnership is a model for how we need to be doing population health management, particularly among the most vulnerable in our community. It is the way of the future of health care, and an example of how HHC will lead in the transformation of health care delivery in our city.

I want to thank the staff and partners in this effort: Dr. Robert Chin, Chief of Emergency Medicine at Woodhull; Chris Tabellario, Brooklyn Community Director of Common Ground; Danielle Minelli Pagnotta, Assistant Commissioner and Cindy Voorspuy, Program Analyst, Department of Homeless Services.

Patients who have chronic alcoholism and are also considered chronically homeless represent a revolving door in our EDs. It is a cycle that needs to be broken.

**HHC FEATURED INDIVIDUAL:**

**DONA GREEN, SENIOR ASSISTANT VICE PRESIDENT, CORPORATE PLANNING**

I want to recognize an HHC employee who is extraordinary by many measures and highly respected by her colleagues at HHC. Time and again, she's stepped forward to take on some of the biggest, most complex and most challenging projects, always finding ways to keep patients first, support the needs of the communities we serve, value team work, and help HHC become more efficient.

I'm speaking of Dona Green, HHC's Senior Assistant Vice President for Corporate Planning Services. Dona has been with HHC 27 years. And the number and variety of tasks that she and her team have taken on over the years is truly impressive.

Dona's personal beginnings were as diverse as the HHC projects she has led. She is the seventh daughter of a seventh daughter – and has always relished her family placement. Her father is from Baltimore, her mother from the Caribbean. Her extended family also has East Indian and Puerto Rican roots. She received a Bachelor's degree from Antioch College, known for its communitarian commitment to social action, and followed it up with an MBA in Finance from NYU and an MA in Aging Services from the University of Maryland.

That training proved incredibly relevant from her first planning project here at HHC -- at the Brooklyn Long Term Care Facility, to the planning around Gotham Health, our future Federally Qualified Health Center look-alike, to the planning of the relocation of Goldwater patients who no longer required skilled nursing care but needed support to live on their own.

The Goldwater project was certainly complex and vital to the well-being of many of our residents and to the financial health of HHC. Dona worked with city and state agencies and community-based organizations to find proper housing for over 200 people, and found solutions for another 150 people who could live in the community with some assistance. That was an amazing achievement.

Her latest contribution to HHC also promises to be a high impact operation that's creating a critical base for HHC's work to transform health care delivery in New York City. Dona has been leading the team responsible for the CNA's – the Community Needs Assessments -- that will determine and define HHC projects under the $6.42 billion Medicaid program – the DSRIP program.

I don't know if many people know this, but Dona has yet another talent: she does more than practice yoga – she is a certified yoga instructor and is seeking certification from the Arthritis Foundation in Yoga for Arthritis. It's part of her passion to find alternatives for people whose lives are challenged by disabilities.

Dona Green has shown time and again that she has the passion and energy to lead HHC in the months and years ahead. We're lucky to have her as part of our leadership at HHC. Please join me in thanking Dona Green for her many contributions to our patients and our Corporation.
HHC IN THE NEWS HIGHLIGHTS

Broadcast

City Officials Confirm Patient at Bellevue Hospital Tests Positive for Ebola, NY1, 10/24/14

HHC President Dr. Ram Raju, CNN "New Day," 10/28/14

Coalition for Asian American Children and Families Awards Gala, Myfoxny.com, 10/30/14

Four City Hospitals Damaged by Sandy Get $1.6 Billion for Upgrades, NY1, 11/7/14

Dr. Craig Spencer Leaves New York Hospital Ebola-Free, ABC News, 11/12/14

Should cities be reimbursed for Ebola costs? One U.S. senator says yes, CNN, 11/17/14

Completed Project Makes Coney Island Hospital More Energy Efficient, NY1, 11/14/14

Print

Ebola Puts Spotlight on Bellevue, Key NYC Trauma Center, Dr. Ram Raju, HHC, The Wall Street Journal, 10/23/14

ICU Team Takes on Ebola, Dr. Ram Raju, Dr. Laura Evans, Bellevue, The Wall Street Journal, 10/26/14

NYC's famed Bellevue Hospital put to the test with Ebola patient, Dr. Lewis Goldfrank, New York Daily News, 11/2/14

Bellevue Hospital ICU patients head to NYU Langone to free up staff for Ebola cases: sources, HHC, Bellevue, New York Daily News, 10/27/14

Bellevue Employees Face Ebola at Work, and Stigma of It Everywhere, Mayra Martinez, Dr. Nate Link, Ana Marengo, The New York Times, 10/30/14

Plenty of Hugs as Craig Spencer, Recovered New York Ebola Patient, Goes Home, Dr. Laura Evans, Dr. Ram Raju, Bellevue, The New York Times, 11/11/14

Dr. Craig Spencer, NY Ebola Patient, is Released, The Wall Street Journal, 11/12/14

Four New York City Hospitals to Receive $1.6 Billion for Storm Improvements, Bellevue, Metropolitan, Coler, New York Times, 11/6/14

Coney Island Hospital gets $21 million for storm enhancements, Coney Island, NY Daily News, 11/13/14

Report: HHC's financial picture is "troubled", Dr. Ram Raju, Crain's New York Business, 11/6/14

Fiscal Challenges for NYC's Health and Hospitals Corporation, HHC, Huff Post New York, 11/11/14

New York's Heroes: Dr. Spencer and Bellevue RNs, Bellevue, NYSNA.org, 11/13/14

HHC chief: system needs help caring for uninsured, Dr. Ram Raju, HHC, 11/18/14
Wealthy hospitals warned they need to care better for city's uninsured patients, Dr. Ram Raju, HHC, New York Daily News, 11/18/14

New Labor & Delivery Unit a NCBH delivers first baby, NCBH, Bronx Times, 11/3/14

Baby step! First infant born at North Central Bronx Hospital's new maternity ward, NCBH, New York Daily News, 10/28/14

Bronx Networks Collaborate, HHC, Crain's Health Pulse, 11/10/14

East Harlem Seniors May Soon Call former Dormitory Home, HHC, NY1, 10/23/14

500 Affordable apartments Underway at Kings County Hospital Complex, DNAInfo New York, 11/17/14

Ebola case puts spotlight on Staten Islander, Dr. Ramanathan Raju of HHC, Dr. Ram Raju, HHC, 11/5/14

Indian American Doctor Ramanathan Raju Leads Ebola Response Team, Dr. Ram Raju, 10/27/14

"Walk with a Doc" steps off on a crisp fall morning: "Let's make Staten Island the healthiest borough," Dr. Ram Raju, Staten Island Advance, 11/9/14

Six nurses at New York City Health and Hospital Corporation facilities are honored for going above and beyond the call of duty, Dr. Ram Raju; Lauren Johnston, Senior Assistant Vice President, HHC CNO, Marian McNamara, RN, Sea View; Grace Ann Rodicol, BSN, Elmhurst; Lovely Simon, RNC, Coney Island; Michael Impollonia, RN, Woodhull; Terry Hunte, RN, Kings County; Jeanmarie Fitch, BSN, Health & Home Care, New York Daily News, 10/29/14

Harlem Hospital Leads Way in Effort to Increase Cord Blood Donations, Dr. Edgar Mandeville, NY1 News, 11/3/14

Elmhurst Hospital to Prescribe Fruit & Veggies, Dr. Ram Raju, HHC, Elmhurst, Bellevue, Tribune Online, 10/23/14

East Harlem nurses welcome patients to new LGBT clinic, Metropolitan, Lillian Diaz, Nurse.com, 11/12/14


Lincoln Hospital Auxiliary celebrates hospital's 175 years, Lincoln, Harlem, Carl Kirton, Evelyn Montecer, Elaine Stewart-Hyton, Denise Soares, Milton Nunex, Amsterdam News, 10/30/14

ACS Partners with Bellevue for Juvenile Justice MH Services, Dr. Ram Raju, Dr. Jennifer Havens, New York Nonprofit Press, 11/2/14
RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation to implement the attached Operating Procedure 180-9 entitled "HHC's Human Subject Research Program Policies and Procedures."

WHEREAS, the existing research operating procedure of the New York City Health And Hospitals Corporation (HHC), adopted by the Board in 1991, reflected the then current regulations and restrictions related to human subject research; and

WHEREAS, since 1991, there have been substantial changes in both federal and state regulations and the national institute of health guidelines for the protection of human research subjects; and

WHEREAS, the implementation of this operating procedure will provide guidance to HHC and affiliate research personnel in an effort to protect human research participants’ rights and safety and ensure regulatory and legal compliance.

NOW, THEREFORE BE IT RESOLVED that the HHC Board of Directors authorizes the President of the New York City Health and Hospitals Corporation to execute the attached operating procedure entitled "HHC Human Subject Research Protections Program Policies and Procedures"; and

BE IT FURTHER RESOLVED that the operating procedure adopted by the New York City Health and Hospitals Corporation Board of Directors in 1991 is to be repealed; and that the President of the New York City Health and Hospitals Corporation is authorized to execute any and all revisions to said operating procedure as it is customarily exercised for all HHC operating procedures.
2. Advisory role

a. Disseminate information
b. Information and education

2. Training and education

2. Advisory role

a. Disseminate information
b. Information and education
The Exceptional Person: Hebrew Director of Programs, 3rd Edition

I. Introduction

1. The Exceptional Person: Hebrew Director of Programs, 3rd Edition

2. Exceptional People have a special responsibility to

3. Exceptional People are called to

II. The Exceptional Person: Hebrew Director of Programs, 3rd Edition

1. The Exceptional Person: Hebrew Director of Programs, 3rd Edition

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III. The Exceptional Person: Hebrew Director of Programs, 3rd Edition

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V. The Exceptional Person: Hebrew Director of Programs, 3rd Edition

1. The Exceptional Person: Hebrew Director of Programs, 3rd Edition

2. Exceptional People have a special responsibility to

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EXHIBIT 2
The rights and powers of the Commission, including any power described in Rule 2-1094, are exercised by the Commission or by a member designated by the Commission. The Commission may authorize any person or entity to exercise any power or duty of the Commission.

I. INTERPRETATION AND COMPLIANCE

A. Interpretation

The terms of this Exhibit shall be interpreted in accordance with the following principles:

1. The words "including" and "such as" shall be considered to mean an example or illustration and shall be construed to include anything of the kind or nature of the subject mentioned.

2. The words "shall" and "may" shall be considered to mean a mandatory or discretionary duty, respectively.

3. The words "may" or "may be" shall be considered to mean the exercise of discretion in the performance of a duty or the making of a determination.

4. The words "or" shall be considered to mean an alternative of the kind or nature of the subject mentioned.

5. The words "and" shall be considered to mean the conjunctive of the kind or nature of the subject mentioned.

6. The words "or" shall be considered to mean the disjunctive of the kind or nature of the subject mentioned.

7. The words "and" shall be considered to mean the disjunctive of the kind or nature of the subject mentioned.

8. The words "or" shall be considered to mean the conjunctive of the kind or nature of the subject mentioned.

B. Compliance

The Commission shall be deemed to be in compliance with this Exhibit if it is shown that the Commission has complied with the following requirements:

1. The Commission has complied with the provisions of this Exhibit and the rules and regulations promulgated thereunder.

2. The Commission has taken all reasonable steps to ensure that the actions taken by the Commission comply with the provisions of this Exhibit and the rules and regulations promulgated thereunder.

3. The Commission has taken all reasonable steps to ensure that the actions taken by the Commission comply with the provisions of this Exhibit and the rules and regulations promulgated thereunder.

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SECTION 3. HIC RESEARCH APPROVAL PROCESS

The research approval process is managed by the research office, which is responsible for receiving and reviewing all research projects that fall within the jurisdiction of the HIC. The review process involves the following steps:

1. Proposal Submission: The investigator submits a research proposal to the HIC.
2. Initial Review: The proposal is reviewed by the HIC's Research Committee for preliminary evaluation.
3. Full Committee Review: The proposal is reviewed by the full HIC Committee for final approval.
4. Approval: Upon approval, the research project is conducted under the oversight of the HIC.

SECTION 2. TRAINING OF RESEARCH TEAM MEMBERS AND OTHERS

The research team is trained in the following areas:

1. Research Ethics: Training in ethical considerations and principles.
2. Data Management: Training in data collection and analysis.

The training is conducted through workshops and seminars, and ongoing feedback is provided to ensure compliance with ethical standards.
SECTION 4. INFORMED CONSENT

4.1. Authorized Person.

A person approved by the facility is the only person who may make the determination that the PPI meets the requirements of the informed consent process. The authorized person must be a licensed health care professional who is knowledgeable about the PPI and has been approved by the facility to perform the informed consent process.

4.2. Approval of HIC.

The HIC must review and approve the informed consent before the PPI can be performed. The approved informed consent must be maintained in the patient's medical record.

4.3. Acknowledgment of Approval.

The patient or their legally authorized representative must sign and date the approved informed consent. The signed and dated informed consent must be maintained in the patient's medical record.

4.4. Communication to the RA Office.

The RA Office must be notified of the approved informed consent. The notification should include the date of approval and the name of the authorized person who approved the informed consent.


SECTION 2 - USE OF INFORMATIONAL PROOF OR DECEIT

The Applicant uses informational proof or deceit to establish the existence of a certain fact or claim. The Applicant falsely represents information or data to support their argument or position.

The Applicant's use of informational proof or deceit is not only unethical but also illegal in many jurisdictions. It is essential to adhere to ethical standards and provide accurate and verifiable information in all communications and presentations.

Additionally, the Applicant's use of deceitful practices may have serious consequences, including legal liabilities and damage to their reputation.

In conclusion, the use of informational proof or deceit is unacceptable and should be avoided at all costs. Ethical and transparent communication is crucial in maintaining credibility and trust in any professional or legal context.

[End of Document]
This page contains a series of numbered items. Each item is preceded by a number and followed by a brief statement or a series of statements. The text seems to be a list or an enumeration of points, possibly related to a set of guidelines, instructions, or regulations. The content is dense and appears to be directed at an audience familiar with the context in which these points are relevant. Without more context, it's challenging to provide a detailed summary of the text.
OTHER SPECIFIC CLASSES

SECTION 7.

RESERVATION CONCERNED ON VULNERABLE POPULATIONS AND

EXCEPTIONS CONNECTED TO THEM.

These exceptions are intended to accommodate the needs of

Section 7.4.

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Disclose all pertinent financial interests.

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possible conflict of interest and work with the PHS Awarding Component to expeditiously resolve the conflict of interest concerns.

(c) Review of SFIs Disclosed After Commencement of Research.

(i) New Disclosures for Ongoing Research Projects. Where a Covered Individual submits an initial SFI Disclosure Form related to any ongoing Research Project (i.e., a Research Project transferred from another institution, or the Covered Individual is new to a Research Project), the COIR Official shall, within sixty (60) days of the disclosure determine whether a Financial Conflict of Interest exists; and, if so, implement, on at least an interim basis, a management plan, as set forth in Section 9.3.4(d).

(ii) Review of SFIs not Timely Disclosed. Whenever HHC identifies a Significant Financial Interest that was not disclosed in a timely manner by a Covered Individual or, for whatever reason, was not previously reviewed by the COIR Official during an ongoing PHS-funded Research Project (e.g., was not timely reviewed or reported by a Subrecipient), the COIR Official shall,

(1) within sixty (60) days of discovery of the SFI, determine whether a Financial Conflict of Interest exists; and, if so:

(2) implement, on at least an interim basis, a management plan as set forth in Section PART 19.3.4(d); and

(3) conduct a retrospective review, as described below in Section 9.3.4(c)(ii).

(iii) Retrospective Review.

(1) A retrospective review to determine whether a FCOI resulted in bias in the design, conduct or reporting of the Research Project during the time of noncompliance must be conducted by the COIR Committee within 120 days of discovery of any of the following circumstances:

a. a failure by the Covered Individual to disclose a Significant Financial Interest that is determined by HHC to constitute a Financial Conflict of Interest;

b. failure by HHC to review or manage such a Financial Conflict of Interest;

c. failure by the Covered Individual to comply with a Financial Conflict of Interest management plan; or

d. any other failure to comply with these procedures.

(2) HHC will document the retrospective review in a retrospective review report that shall include all elements and information required by law and regulation.

(3) Based on the results of the retrospective review, if appropriate, HHC shall update any other reports submitted to any PHS Awarding Component specifying the actions that will be taken to manage the Financial Conflict of Interest going forward. If a retrospective review reveals bias, HHC will notify the PHS Awarding Component promptly and submit a Mitigation Report to the PHS Awarding Component, as described in Section 9.3.5(b).

(d) Management Plan for the Conflicts of Interest.

(i) If it is determined through the above review procedures that an SFI is a FCOI, the COIR Committee, in consultation with the PI, must create a management plan to manage, reduce, or eliminate any FCOI. Specific management methods in handling individual FCOIs include, but are not limited to:

(1) Full disclosure to any Human Subjects of the Covered Individual’s FCOI.

(2) Disclosure of the Covered individual’s FCOIs in all written and oral presentations, publications, and abstracts.

(3) Modification of the Research Project Protocol, including changing the site(s) of the Research Project.

(4) Monitoring of Research by independent reviewers.

(5) Diversification of Significant Financial Interests.

(6) Severance of relationships that create actual or potential conflicts.

(7) Disqualification of the Covered Individual from part or all of the Research Project.

(ii) Once a management plan is in place, it will be reviewed on an ongoing basis until the completion of the PHS-funded Research Project. The Covered Individual must inform the COIR Committee of any changes in the SFI.
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An application for loan is to be submitted by the applicant according to the following procedure:

1. A copy of the approved budget proposal.
2. A description of the project.
3. A detailed budget proposal.
4. A description of all relevant financial documents and reports.
5. A plan for the project's implementation.
6. A description of any additional information required by the lending institution.

The application must be submitted along with all necessary supporting documents and information.

1.6. Procedures

The procedures for loan applications are as follows:

1. Application submission
2. Review of the application
3. Approval or rejection of the application
4. Signing of the loan agreement
5. Disbursement of the loan
6. Monitoring and evaluation of the project

All loan procedures are governed by the lending institution's policies and regulations.
For purposes of this Section 12 the following definitions shall apply:

**Definition:**

SECTION 12 USE OF TRANSFERRED HOUSING MATERIALS

12.1. **Use of the VHFA**

Use of the VHFA means the use of the VHFA to build, construct, or reconstruct any structure, facility, or property for the purpose of providing housing for human inhabitants.

12.2. **Approval**

Approval means the written consent of the authorizing official to the use of the VHFA.

12.3. **Approval Letter**

Approval Letter means the written consent of the authorizing official to the use of the VHFA.

12.4. **Transfer Agreement**

Transfer Agreement means the written agreement by which the VHFA is transferred from the VHFA to another party.

12.5. **Repayment**

Repayment means the return of the VHFA to the VHFA.

12.6. **Recapture**

Recapture means the recovery of the VHFA from another party.

SECTION 12 MATERIAL TRANSFER AGREEMENTS

12.1. **Material Transfer Agreement**

Material Transfer Agreement means the written agreement by which the VHFA is transferred from the VHFA to another party.

12.2. **Approval**

Approval means the written consent of the authorizing official to the use of the VHFA.

12.3. **Approval Letter**

Approval Letter means the written consent of the authorizing official to the use of the VHFA.

12.4. **Transfer Agreement**

Transfer Agreement means the written agreement by which the VHFA is transferred from the VHFA to another party.

12.5. **Repayment**

Repayment means the return of the VHFA to the VHFA.

12.6. **Recapture**

Recapture means the recovery of the VHFA from another party.
SECTION 24. GUIDELINES FOR USE OF ANATOMICAL GRAFTS

24.1 AAH Guidelines for Use of Autologous and Allogenic Grafts

24.1.1 General Guidelines

24.1.2 Specific Guidelines for Autologous Grafts

24.1.3 Specific Guidelines for Allogenic Grafts

24.2 AAH Guidelines for Use of Tissue-Engineered Grafts

24.2.1 General Guidelines

24.2.2 Specific Guidelines for Tissue-Engineered Grafts
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Section 2: Authorization and Priorities

Authorization is granted and prior to the initiation of any action or event, the

Responsibility for the movement of the security information from the

Classified environment to the Non-Cleared environment shall be the

responsibility of the security officer who oversees the

Classified environment.

The security officer shall be responsible for ensuring that all

security information is properly handled and that all security

requirements are met.

The security officer shall also be responsible for ensuring that all

security information is properly stored and that all security

requirements are met.

The security officer shall be responsible for ensuring that all

security information is properly retrieved and that all security

requirements are met.

The security officer shall be responsible for ensuring that all

security information is properly disposed of and that all security

requirements are met.

The security officer shall be responsible for ensuring that all

security information is properly transmitted and that all security

requirements are met.

The security officer shall be responsible for ensuring that all

security information is properly maintained and that all security

requirements are met.

The security officer shall be responsible for ensuring that all

security information is properly archived and that all security

requirements are met.

The security officer shall be responsible for ensuring that all

security information is properly secured and that all security

requirements are met.

The security officer shall be responsible for ensuring that all

security information is properly evaluated and that all security

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22.2.1 Procedures

22.2.2 Definitions

22.2.3 Reporting of Unanticipated Problems

22.2.4 Changes to the Section 22.2 Definitions
SECTION 6. REPORTING NON-COMPLIANCE

24.1 Requirements

Non-compliance means that the requirements of the Regional Authorities are not met. Non-compliance must be reported by the WHC and the Regional Authorities, and non-compliance must be reported by the WHC and the Regional Authorities within 24 hours of the detection of non-compliance.

24.2 Penalties

The penalties for non-compliance with the requirements of the Regional Authorities are as follows:

- A fine of up to $10,000
- Revocation of the license or permit
- Criminal charges

24.3 Procedure

The procedure for reporting and investigating non-compliance is as follows:

- The Regional Authorities must investigate the non-compliance within 24 hours of notification.
- The investigation must be conducted by an independent investigator.
- The results of the investigation must be reported to the Regional Authorities within 48 hours.

24.4 Reporting

The reporting of non-compliance must be done in writing and must include the following information:

- Date of occurrence
- Location of occurrence
- Nature of non-compliance
- Name and contact information of the person reporting the non-compliance

24.5 Review

The Regional Authorities must review all reports of non-compliance and take action as necessary to ensure compliance with the requirements of the Regional Authorities.

24.6 Appeal

Any party aggrieved by the decision of the Regional Authorities may appeal to the Regional Authorities within 14 days of the decision.
charges will be removed from the Human Subject’s bill by the Facility’s finance department. Any required refunds or adjustments will be made for charges already paid for by the Human Subject or his or her insurance plan.

SECTION 29. RESEARCH COSTS

29.1. Definitions

For purposes of this Section 29, the following definitions shall apply.

"Research Project Costs" means the amount due to HHC from an Affiliate when such Affiliate is the Grantee with respect to a specific Research Project and the Research is conducted at an HHC Facility, such amount being calculated under an agreement between HHC and the Affiliate that includes terms for reimbursement of such costs.

29.2. Policy

HHC will work with researchers and Affiliates to encourage research throughout the HHC system. Where research for which an Affiliate is the Grantee is conducted at an HHC Facility, however, HHC cannot financially absorb all of the costs for the use of its Facilities to carry out such Affiliate research. Therefore, Facility resources will not be committed and Research will not be approved by HHC (through the approval process outlined in Section 3 and Section 12 of these Policies and Procedures) to be conducted at a Facility by a PI or any person unless HHC and the Facility have reviewed and approved all costs that may be incurred by the accomplishment of such Research, and the Affiliate and HHC have agreed in writing as to how such costs will be reimbursed to HHC.

29.3. Procedures

29.3.1. Preparation of Budget for Research Project. Where there is an application for external funding for research to be conducted at a Facility, the finance department of the Facility will assist the PI in the preparation of a budget for the Research Project that sets forth those activities that are standard of care and those that are strictly research related. The Facility will provide relevant budget information to the Principal Investigator in a timely manner. A copy of relevant financial sections shall be provided to the Facility and to HHC as part of the Research approval process described in Section 3 of these Policies and Procedures. The Facility will obtain all salary and related personnel services information from the Affiliate.

29.3.2. Items To Be Included In Proposed Budget.

The procedure for preparing a proposed budget should be considered with any affiliation agreement and/or research agreement in place between an Affiliate and HHC.

(a) If a research agreement exists between an Affiliate and HHC, the proposed budget must give sufficient financial information to allow the parties to comply with the compensation requirements of such agreement. Such proposed budget must include a breakdown by billable and funded services, providing enough information to support to supply a complete picture of the actual cost and benefit of the project.

(b) If a research agreement does not exist between the Affiliate and HHC, and the applicable affiliation agreement does not contain conflicting provisions, the following will apply:

(i) Direct Costs. Regardless of funding source, the proposed budget must list anticipated total direct costs, including, but not limited to, any applicable research fees, any facility resource usage fees (e.g., salary, fringe and other than personal services "OTPS") and all indirect costs.

(ii) Indirect Costs. With respect to indirect costs, if HHC is the Grantee, then, for all Federal grants, the proposed budget must utilize the indirect cost rate previously negotiated with the federal government. If the source of funding is other than the federal government, the proposed budget must utilize the indirect cost rate negotiated with the funding source and approved by the Office of Legal Affairs. If an Affiliate is a subcontractor to HHC then the proposed budget should state the amounts to be paid to the Affiliate pursuant to the agreement negotiated with the Affiliate and approved by the Office of Legal Affairs.

(c) Affiliate Payments. Where an Affiliate is the Grantee, the proposed budget must include the amounts, including the indirect overhead rate, negotiated with the Affiliate and payable to HHC as subcontractor.

(d) HHC Direct Costs. It is the expectation of HHC that HHC employees, HHC agents, or HHC subcontractors, as designated by HHC, contribute directly to the science of Research Projects conducted at a Facility and be recognized as principal investigators or sub-investigators through the awarding subcontracts and that HHC employees, agents, or subcontractors will be utilized to participate in such studies.

29.3.3. HHC Costs.

(a) Where the Affiliate is the Grantee with respect to a Research Project, the Facility will invoice such Affiliate for the Research Project costs in accordance with the terms of the applicable agreement HHC has with such Affiliate according to the terms established in such agreement.

(b) On a case by case basis, where permitted by law, the Facility’s Executive Director may waive all or a portion of the Research Project Costs where such Executive Director deems it appropriate. Before such a waiver may be given, however, all Research related costs must be identified and documented by the Facility and given to the Executive Director.
23.2. Procedure

The procedures for the establishment of the project will be

23.2.1. Pre-bid Meeting

23.2.2. Bid Opening

23.2.3. Contract Award

23.2.4. Contract Administration

23.2.5. Project Close-out

23.2.6. Final Report

23.3. Contractual Obligations and Requirements

23.4. Contract Administration

23.5. Final Report

23.6. Final Payment

23.7. Project Close-out
Federal Register

Protection of Human Subjects: Notice of Intent to Make an Announcement

Office of the Secretary

Department of Health and Human Services

Part 15

EXHIBIT 1
EXHIBIT 2

POLICIES AND PROCEDURES

HHC HUMAN SUBJECTS PROTECTION PROGRAM

NYC Bureau of Health and Research

Facility Name

Signature of Medical Director

Date

Signature of Executive Director

Date
PART I

DISCLOSURE OF SIGNIFICANT FINANCIAL INTERESTS AND OBLIGATIONS

EXHIBIT 7
Date

Signature

Knowledge

I certify the answers to the questions are accurate and truthful to the best of my

knowledge, with the assistance of the documents and references provided.

Conclusión of Course

I have read and understood the HHC Chinese Insurance Practice Module in

Investment Certification

Note the answers to the above questions and answer to the question below:

A) No B) Yes

Complete the following questions:

1. The information provided in questions 1 through 4 above is accurate and truthful.

2. The information provided in questions 5 through 10 above is accurate and truthful.

3. Any of the above is incorrect.

4. If you answered "Yes" to ANY of questions 1 through 4 above, please complete the special instructions below.

Specific instructions: Please check in the appropriate column for each question. Once verified, sign the document. If you do not have an answer, please leave the space blank.

If you answered "Yes" to ANY of questions 1 through 4 above, please provide the following information:
PART II

Have you a member of any independent executive board from which the value of the shares exceeds $10,000?

☐ N ☑ Y

The members who exceeded $10,000

☐ N ☑ Y

The members whose shares exceeded $10,000 in the organization have a financial interest in the organization which may affect the organization's ability to perform its obligations?

☐ Y ☑ N

There you hold in the entity (☐ member or ☑ officer, director, trustee, etc.)

☐ Y ☑ N

Spouse or dependent children (will exceed $10,000)

☐ Y ☑ N

The amount of compensation and benefits received is how much?

☐ Y ☑ N

Yes, you exceed in the entity (☐ member or ☑ officer, director, trustee, etc.)

☐ Y ☑ N

The amount of compensation and benefits received is how much?

☐ Y ☑ N

Name of the person involved: ☐ other than you member:

☐ Y ☑ N

Investigator Name:

☐ Y ☑ N

If you please explain:

☐ Y ☑ N
<table>
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<tbody>
<tr>
<td>Date</td>
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<td>Patent Number</td>
<td>Date</td>
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<td>Assigned to</td>
<td>Designation</td>
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**For a complete description please include an attachment with the following:**

- Title of Invention
- Brief Description of Invention
- Summary of the Invention
- A complete and detailed description of the invention

**Any third party software used in the invention**

<table>
<thead>
<tr>
<th>Name of Sponsor</th>
<th>Other</th>
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<td>OR</td>
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**Invention Disclosure Form**

**Exhibit 8**

**Disclosure Statement**

- [ ] Full Description of Invention
- [ ] Summary of the Invention
- [ ] Claimed Inventions
- [ ] References
- [ ] Claims
- [ ] Structure
- [ ] Function
- [ ] Performance
- [ ] Material or composition of matter
- [ ] Process
- [ ] Machine
- [ ] Manufacture

**Corrected form should be submitted:**

- **Exhibit 5**
- **Exhibit 6**
- **Exhibit 7**

**Invention Description Form**
<table>
<thead>
<tr>
<th>Name of Invention Owner for IPC Classification</th>
<th>IPC Classification</th>
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<tbody>
<tr>
<td>John Doe</td>
<td>A01D G00/00</td>
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A01D G00/00

John Doe

Invention Description is Complete and Accurate (see sections of this form to ensure that the information is complete and accurate).
EXHIBIT 10

INVESTIGATIONAL DRUGS AND SUPPLIES
LETTER OF UNDERSTANDING (LOU)

Medical Facility Name: ________________________________
Protocol or Study Name: ______________________________

This letter reflects the understanding between __________________________ (hereinafter referred to as 
"Health and Hospitals Corporation (HHC) Affiliate") and the HHC Medical facility at __________ regarding the circumstances under which the HHC Affiliate agrees to provide study drug/device to the HHC Medical Facility for the protocol or study referenced above (hereinafter referred to as 
"Protocol" or "Study"). A copy of the Protocol, dated __/__/____, is attached and incorporated herein by reference.

The HHC Medical facility Pharmacy Service at __________ serves as a liaison between the HHC Affiliate and the HHC investigator and acts as the central control and distribution center for

[Insert drug name and strength] and matching placebo (hereinafter referred to as "Study Drug") for the Study in accordance with the following provisions.

The HHC Medical facility at __________ and the HHC Affiliate have agreed upon the following operating procedures in connection with the Study and this Letter of Understanding:

1. **Conduct of the Study.** The HHC Medical Facility at __________ will conduct the Study in accordance with the terms of Protocol and within HHC guidelines with the participation of the HHC Affiliate.

2. **Drug Supply, Distribution, and Accountability.** The HHC Affiliate will supply Study Drug for the duration of the Study, free of charge, and will include in planning allowances for wastage that may unavoidably occur during dispensing. The HHC Affiliate will provide shipment of Study Drug directly to the Pharmacy Service in accordance with the schedule agreed to by both parties. The Pharmacy Service will label and dispense Study Drug and keep all records of drug disposition. The Pharmacy Service warrants that in its process the Study Drug shall not be adulterated or misbranded, in accordance with the Food, Drug and Cosmetic Act. Pharmacy Service agrees to use the Study Drug supplied by HHC Affiliate only for the investigational purposes authorized under the Protocol. No other use of the drug will be permitted by Pharmacy Service. In the event that the Pharmacy Service has unused Study Drug at the time the Study is completed or terminated, the Pharmacy Service will dispose of Study Drug in accordance with operating procedures outlined by the HHC Affiliate.

3. **Safety Information Reporting.** The Principal Investigator is responsible for reporting adverse events with respect to Study Drug to the HHC Affiliate and/or Food and Drug Administration in conformance with all applicable laws, rules, and regulations in effect.

(a) The Principal Investigator must provide to the HHC Affiliate any information on any serious adverse event, side effect, injury, toxicity, sensitivity reaction or any unexpected incidence and the severity thereof related to the Study Drug that is associated with its "clinical" use in accordance with the Protocol. "Serious Adverse Events," as used in this context, have the meaning ascribed thereto in the Protocol.

(b) It is understood and agreed that these adverse events reporting requirement provisions are based upon the HHC Affiliate's respective policies and procedures and regulatory reporting requirements. Accordingly, in the event of changes to HHC Affiliate's policies and procedures for adverse events reporting, the principal investigator agrees to comply with such revised notification requirements as reasonably requested in writing by the HHC Affiliate. This is provided that the scope and extent of activity and undertakings are not materially increased. The HHC Affiliate agrees to pay all costs associated with this request.

4. **Early Study Termination.** The Study may be terminated at any time by the Institutional Review Board for safety or efficacy reasons if it is thought to be in the best interest of the patient. Either HHC or the HHC Affiliate may withdraw support from the Study with 90 days written notice only if this agreement has been violated.

5. **Patient Confidentiality.** Patient confidentiality must be maintained at all times in accordance with applicable law and HHC policy. Reports issued for public distribution or to the HHC Affiliate will contain only aggregate data with all patient identifiers removed.

6. **Selection of Participants.** The HHC Medical Facility at __________ is responsible for all decisions concerning the selection and/or discontinuation of participants in the Study.

7. **Record Retention.** The HHC Medical Facility at __________ must retain all records related to the Study (according to HHC policy and procedure) for a minimum period of 3 years from the date of the last patient follow-up. At that point the Study records will be evaluated for archiving.

8. **Term of Agreement.** This agreement shall be effective as of the date last signed below and shall expire upon completion of all activities related to the Study as defined by the submission of the final Study report to the HHC Affiliate and the primary publication of the Study results.

9. **Modification to Agreement.** This agreement may be amended or superseded only by a written agreement of the parties.

10. **Approval.** The following signatures indicate approval of the terms of this letter of understanding.

(Remainder of page intentionally left blank.)
The parties agree to the following terms and conditions:

1. The Materials Transferred Agreement (MTA) is hereby granted to the recipient for the purposes specified in this Agreement.

2. The Materials Transferred Agreement (MTA) is non-exclusive and non-transferable. Neither party shall assign, sublicense, or otherwise transfer any rights under this Agreement without the prior written consent of the other party.

3. The Materials Transferred Agreement (MTA) is effective upon execution by both parties and shall remain in effect until terminated by either party upon written notice.

4. The Materials Transferred Agreement (MTA) is binding upon the parties and their respective successors and assigns.

5. The Materials Transferred Agreement (MTA) is governed by the laws of the State of [State Name]. Any disputes arising under this Agreement shall be resolved in accordance with the laws of the State of [State Name].
The rental agreement contains the following clauses:

1. The tenant must pay rent on time every month.
2. The property must be kept in a clean and safe condition.
3. The tenant is responsible for all utilities, including electricity and water.
4. The landlord reserves the right to enter the property for maintenance purposes.
5. The tenant is prohibited from subletting the property without the landlord's consent.

The lease agreement is subject to the following conditions:

- The tenant must provide proof of insurance.
- The property must be inspected before and after the lease.
- The tenant is responsible for any damage to the property.

The lease agreement also includes the following provisions:

- The tenant must pay a security deposit equal to one month's rent.
- The tenant is required to vacate the property upon expiration of the lease.
- The landlord can terminate the lease if the tenant violates any of the terms.

Both the tenant and the landlord have agreed to the terms of the lease agreement.
RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute one year extensions of existing agreements with six of the seven construction management services firms: Gilbane Building Company; HAKS; Hunter Roberts Construction Group; Jacobs Engineering; LiRo Program and Construction Management; and, TDX Construction Corporation (the "CMs"), to provide professional construction management services on an as-needed basis at various facilities throughout the Corporation at an additional aggregate not-to-exceed limit of $2.5 Million.

WHEREAS, the Corporation entered into contracts with the CMs for as-needed construction management services on November 30, 2011 for a not-to-exceed aggregate limit of $6 Million following a competitive request for proposals process and pursuant to authorization of the Corporation’s Board of Directors; and

WHEREAS, to date all but approximately $77,000 of the funding for these contracts has been expended; and

WHEREAS, the Corporation is currently in negotiations with the City of New York and the Central Labor Council for the execution of a "Project Labor Agreement" that will impose new work rules on virtually all of the Corporation’s construction projects and will free the Corporation from the requirements of the Wicks Law; and

WHEREAS, normally, at this point the Corporation would make a new solicitation for construction managers but any such solicitation should, ideally, include the requirements of the proposed Project Labor Agreement but that agreement will likely not be finalized for another three to six months; and

WHEREAS, under the circumstances it makes most sense to merely extend six (6) of the seven (7) current contracts for a short period until the Project Labor Agreement is finalized and at that point do a completely new solicitation. A1 Works in Progress Associates’ services were not utilized and therefore will not be renewed.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute one year extensions of existing agreements with six of the seven construction management services firms: Gilbane Building Company; HAKS; Hunter Roberts Construction Group; Jacobs Engineering; LiRo Program and Construction Management; and, TDX Construction Corporation to provide professional construction management services on an as-needed basis at various facilities throughout the Corporation at an additional aggregate not-to-exceed limit of $2.5 Million.
RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a revocable five-year license agreement with the Interboro Regional Health Information Organization (the "RHIO") for its continued use and occupancy of approximately 575 square feet of space on the third and fifth floors of the Annex "G" Building at Elmhurst Hospital Center (the "Facility") to provide technical and administrative services to the RHIO in which most of the Corporation's hospitals are participants with the occupancy fee waived as an in-kind contribution to the RHIO.

WHEREAS, in February 2010, the Board of Directors authorized the President to enter into a revocable license agreement with the RHIO, a not-for-profit corporation serving the City of New York, and established to facilitate the sharing of patient information among authorized health care providers at the point of care; and

WHEREAS, the RHIO is a continuation of a project initiated at the Facility through a grant via the "Healthcare Efficiency and Affordability Law for New Yorkers" (HEAL NY) and has expanded to include most of the Corporation's facilities; and

WHEREAS, the RHIO links community physicians to other participants including most of the Corporation's facilities, to facilitate the exchange of health information to improve health care quality, safety, and reduce costs; and

WHEREAS, the RHIO's efforts are aligned with and support the Corporation's goals of improving patient safety and health care quality and reducing costs; and

WHEREAS, the Facility continues to have space available to accommodate the RHIO's program needs.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a revocable five year license agreement with the Interboro Regional Health Information Organization (the "RHIO") for its continued use and occupancy of approximately 575 square feet of space on the third and fifth floors of the Annex "G" Building at Elmhurst Hospital Center to provide technical services to the RHIO in which most of the Corporation's facilities are participants with the occupancy fee waived as an in-kind contribution to the RHIO.
RESOLUTION

DSRIP APPLCIATION

Authorizing the New York City Health and Hospitals Corporation (the “Corporation”) to (i) submit an application to the New York State Department of Health (“DOH”) to participate in the Delivery System Reform Incentive Payment program (“DSRIP”) pursuant to which the Corporation will establish a single Performing Provider System (a “PPS”) in collaboration with various health care providers (the “Participants”); and

CONTRACTS WITH PPS PARTNERS

Authorizing the Corporation to (ii) enter into agreements within the PPS structure with those Participants listed on the attached Schedule of Participants designated as “City Wide” and those Participants designated as “Hub-Based” in the attached Schedule of Participants subject to the addition of additional Hub-Based Participants or the removal of some Hub-Based Participants at the discretion of the Corporation President as he determines to be necessary or appropriate to respond to evolving DOH requirements, guidance and regulations, and the Corporation’s assessment of the ability of the Hub-Based Participants to perform as required for the DSRIP program; (iii) enter into such other and further ancillary contracts as are necessary or appropriate to carry out the purposes of the DSRIP program and to ensure the Corporation’s successful execution of its DSRIP projects using the structure diagramed in the attached Table of Organization; and

HHC ASSISTANCE CORP TO FUNCTION AS CENTRALIZED SERVICE ORGANIZATION

Authorizing the Corporation to (iv) cause the HHC Assistance Corporation (the “CSO”) to provide technical assistance to the PPS in the capacity of a centralized service organization; (v) nominate from among the officers and senior managers of the Corporation the directors of the CSO provided that the Corporation President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of the Corporation provided further that such outside directors never exceed 25% of the total of CSO directors;

PROCUREMENT, COMPLIANCE AND REPORTING

Directing the Corporation to (vi) subject the activities of the CSO under the DSRIP program to the Corporation’s compliance and internal audit programs; (vii) requiring that all procurement contracts of the CSO be subject to the procurement rules applicable to the Corporation; and (viii) make regular, periodic reports to the Corporation’s Board of the progress of the DSRIP application and the implementation of the DSRIP projects including an overview of all contracts made by either CSO or the Corporation to carry out the DSRIP program.
WHEREAS, pursuant to a waiver issued by the Centers for Medicaid and Medicare Services, DOH designed the DSRIP program to reduce preventable hospital admissions by 25% over a five-year period by implementing various health care reform projects; and

WHEREAS, DSRIP requires healthcare providers, mostly led by public hospitals and safety-net hospitals, to form PPS’s to collaborate in providing coordinated health care within geographic areas; and

WHEREAS, the DSRIP program requires that each PPS choose from among 26 projects or initiatives to implement to achieve the desired health care reform goals with certain projects and a certain required over-all scale of projects being required; and

WHEREAS, the DSRIP program provides for substantial funds to flow: through the PPS's to the PPS Participants based upon their performance of the projects launched measured against various statistical benchmarks; to the PPS’s to compensate for certain administrative expenses incurred in their operation, the implementation of the projects and the preparation of the required reports to DOH; and to the PPS’s for acute care hospital Participants to offset the loss of revenue attendant to the reduction of hospital admissions to the extent achieved as a result of the DSRIP program; and

WHEREAS, in June 2014, the Corporation filed with DOH a DSRIP Grant Funding Application that outlined in preliminary terms the DSRIP projects the Corporation intends to pursue, the criteria for selection of Participants and the general structure envisioned for the PPS all to form the foundation for the DSRIP Application that was due in December 2014; and

WHEREAS, DOH accepted the Corporation’s Grant Funding Application and awarded the Corporation a DSRIP planning grant that the Corporation used to prepare its DSRIP Application; and

WHEREAS, on or about December 19, 2014 the Corporation filed its DSRIP application; and

WHEREAS, the Corporation’s DSRIP application indicates that the Corporation will pursue eleven projects under the umbrella of a single PPS but administered by four Hubs each operating within a defined geographic area (each, a “Hub”); and

WHEREAS, to achieve the goals of the projects, it is necessary to create a management and governance structure for the PPS and a structure to provide essential technical services to the PPS; and

NOW, THEREFORE, be it

RESOLVED, that the New York City Health and Hospitals Corporation (the “Corporation”) be, and it hereby is, authorized to submit an application to the New York State Department of Health (“DOH”) to participate in the DOH Delivery System Reform Incentive Payment program (“DSRIP”) pursuant to which the Corporation will establish a single Performing Provider System (the “PPS”) in collaboration with various health care providers (the “Participants”); and it is further
RESOLVED, that the Corporation be, and it hereby is, authorized to enter into agreements within the PPS structure with those Participants listed on the attached Schedule of Participants designated as “City Wide” and those Participants designated as “Hub-Based” in the attached Schedule of Participants subject to the addition of additional Hub-Based Participants or the removal of some Hub-Based Participants at the discretion of the Corporation President as he determines to be necessary or appropriate to respond to evolving DOH requirements, guidance and regulations, and the Corporation’s assessment of the ability of the Hub-Based Participants to perform as required for the DSRIP program; and it is further,

RESOLVED, that the Corporation be, and it hereby is, authorized to enter into such other and further ancillary contracts as are necessary or appropriate to carry out the purposes of the DSRIP program and to ensure the Corporation’s successful execution of its DSRIP projects using the structure diagramed in the attached Table of Organization; and it is further,

RESOLVED, that the Corporation be, and it hereby is, authorized to cause the HHC Assistance Corporation (the “CSO”) to provide technical assistance to the PPS in the capacity of a centralized service organization; and it is further,

RESOLVED, that the Corporation be, and it hereby is, authorized to nominate from among the officers and senior executives of the Corporation the directors of the CSO, provided that the Corporation President shall have the authority to nominate one or more directors of the CSO who are not officers or employees of the Corporation provided further that such outside directors never exceed 25% of the total of CSO directors.

The Corporation, the CSO and the Participants shall enter into a Master Hub and Services Agreement under which the CSO shall furnish technical services to the PPS including information technology, training, accounting, tracking, reporting, data analysis and health care management consulting services and for the CSO to be compensated for such services performed. Furthermore, the Master Hub and Services Agreement will establish the formulae to distribute: to the Participants DSRIP funds received based on the achievement of the DSRIP reform objectives and to the acute care hospital Participants to offset the loss of revenue attendant to the loss of hospital admissions to the extent achieved as a result of the DSRIP program.

The PPS will be managed by an Executive Committee with the support of a Care Models Sub-Committee, a Business/IT Sub-Committee, a Stakeholder Sub-Committee and such other sub-committees as may be established by the Executive Committee. Each of the Hubs will be governed by a Hub Committee consisting of representatives of Participants in that Hub. The PPS will have a Nominating Committee that is responsible for recommending members of the Executive Committee, the Sub-Committees, and the Hub Committees. The PPS will also establish a PPS Advisory Committee (the “PAC”), as required by DSRIP. The PAC will be comprised of all partners and providers from each borough-based hub, as well as representatives from unions, affiliate representatives, City agencies, Community Advisory Board representatives, and other key stakeholders.

The Corporation will be responsible for entering into a DSRIP project contract with DOH under which it will be the fiduciary. As fiduciary, HHC will be responsible for collecting DSRIP
funding from DOH, and for distributing such funding to CSO and the Participants. And it is further,

**RESOLVED**, that the President of the Corporation be, and it hereby is, authorized to perform all other acts and to do all other things and to execute and/or attest all such documents for and on behalf of the Corporation as he, in his sole and absolute discretion, from time to time determines to be necessary, desirable, advisable or appropriate and in the best interests of the Corporation to carry out the purposes of these Resolutions; and it is further,

**RESOLVED**, that any and all actions taken or contracts entered into heretofore by any officer of the Corporation, on behalf of the Corporation in connection with the DSRIP program be and the same are hereby ratified, approved and confirmed, and all such actions and contracts are hereby adopted by the Corporation, as applicable, as if each and every act had been done pursuant to the specific authorization of the Corporation, and it is further,

**RESOLVED**, that the Corporation be, and it hereby is, directed to subject the activities of the CSO under the DSRIP program to the Corporation’s compliance and internal audit programs; and it is further,

**RESOLVED**, that all procurement contracts of the CSO be subject to the procurement rules applicable to the Corporation; and it is further,

**RESOLVED**, that the Corporation be, and it hereby is, directed to make regular, periodic reports to the Corporation’s Board of the progress of the DSRIP application and the implementation of the DSRIP projects including an overview of all contracts made by either CSO or the Corporation to carry out the DSRIP program.

The provisions of these Resolutions shall be separable and if any section, phrase or provision of these Resolutions shall for any reason be declared invalid, such declaration shall not affect the validity of the remainder of the sections, phrases or provisions of these Resolutions.
<table>
<thead>
<tr>
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<td>Each organization name listed may include the organization's affiliates, sites, members, and operating divisions</td>
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<p>| Acacia Network, Inc. |
| AHRC New York City |
| American Dental Offices |
| ArchCare |
| CassenaCare |
| Coordinated Behavioral Care |
| CenterLight |
| Centers Health Care |
| Community Healthcare Network |
| FEGS Health &amp; Human Services |
| Metropolitan Jewish Health System |
| Office of Mental Health |
| PAGNY |
| Rockaway Care Center |
| Ryan Center |
| Sentosa Care |
| The Children's Collaborative |
| Village Care |
| Visiting Nurse Service of New York |
| The New York State Nurses Association (NYSNA) |
| Allen Healthcare Services (National Healthcare Corp) |
| Calvary Hospital |
| Compassionate Care Hospice of New York, LLC |
| Concern for Independent Living |
| Doctors on Call |
| MetroNY Home Health Care PLLC |
| Hospice of New York, LLC |
| Jewish Home Lifecare |
| National Black Leadership Commission on AIDS, Inc. (NBLCA) |
| People Care Inc. |
| Progressive Home Health Services, Inc. |
| St. Mary’s Center, Inc |
| Puerto Rican Family Institute |
| Bronx Mental Health Clinic |
| Brooklyn Mental Health Clinic |
| Manhattan Mental Health Clinic |
| Fortune Society |
| Health Leads |
| Callen-Lorde Community Health Center |
| TRI Center Inc. (The Recovery Institute) |
| St. Mary’s Community Care Professionals |
| Extraordinary Home Care (St. Mary’s Home Care) |
| St. Mary’s Hospital for Children |
| The Osborne Association |
| Able Health Care Service, Inc. |</p>
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<tr>
<td>All Metro Health Care</td>
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<tr>
<td>Gotham Per Diem, Inc.</td>
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<td>Unlimited Care, Inc.</td>
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<td>Xincon Home Health Care Services</td>
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<tr>
<td>CityMD</td>
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<td>Premier Healthcare, Inc.</td>
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<td>Medicaid Service Coordination NY</td>
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<td>Young Adult Institute Inc (YAI)</td>
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<tr>
<td>a.i.r. nyc</td>
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<tr>
<td>START Treatment &amp; Recovery Centers</td>
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<td>Americare (Certified Special Services, Inc.)</td>
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<td>BestCare, Inc.</td>
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<tr>
<td>Cornerstone Medical Arts Center Hospital</td>
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<tr>
<td>Cornerstone Treatment Facilities Network</td>
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<tr>
<td>EAC, Inc</td>
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<tr>
<td>God's Love We Deliver</td>
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<tr>
<td>Harlem United / Upper Room AIDS Ministry</td>
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<tr>
<td>HELP/PSI Inc.</td>
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<tr>
<td>Independence Care System</td>
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<tr>
<td>Iris House, Inc.</td>
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<tr>
<td>Isabella Geriatric Center</td>
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<tr>
<td>Kings Harbor Multicare Center</td>
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<tr>
<td>LegalHealth (NYLAG)</td>
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<tr>
<td>Lott Assisted Living Operating Corp. / Lott Community Home Health Care, Inc.</td>
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<tr>
<td>Mental Health Providers of Western Queens</td>
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<td>Northern Manhattan Rehabilitation and Nursing Center</td>
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<tr>
<td>Odyssey House</td>
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<tr>
<td>Pelham Parkway Nursing Care &amp; Rehab (IHS of New York, Inc.)</td>
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<td>SES Operating Corp. (Harlem East Life Plan)</td>
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<tr>
<td>Transitional Services for New York, Inc. (TSINY)</td>
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<td>YMCA</td>
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<td>NYC DOHMH (Department of Health and Mental Hygiene)</td>
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<td>1199SEIU Training and Employment Funds</td>
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<td>Department for the Aging</td>
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<td>MetroPlus Health Plan</td>
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<tr>
<td>Promoting Specialized Care &amp; Health (PSCH)</td>
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</table>

Page 2 of 8
Organization Name
Each organization listed may include the organization's affiliates, sites, members, and operating divisions

Shield of David, Inc. (The Shield Institute)
Upper Manhattan Mental Health Center, Inc.
Addicts Rehabilitation Center Fund, Inc.
AIDS Service Center of Lower Manhattan Inc., dba ASCNYC
Gay Men's Health Crisis (GMHC)
Little Sisters of the Assumption Family Health Service (LSA)
Queens Nassau Rehab & Nursing
Union Settlement Association
Lenox Hill Neighborhood House
Center for Comprehensive Health Practice
BOOM!Health
Providence Rest
Terrace Healthcare
Rebekah Certified Home Health Care
Rebekah Certified Home Health Agency
Rebekah Rehab & Extended Care Center
United Odd Fellow & Rebekah Home
Blythedale Children's Hospital
Bronx Park Rehab & Nursing Center
BronxWorks (formerly Citizen Advise Bureau)
Bronxwood Home for the Aged
Ocean Breeze Home Care (Community Surgical Supply)
Dominican Sisters Family Health Service
Family Home Health Care Inc.
Park Gardens Rehabilitation and Nursing Center
Allcare Medical
Grand Manor Nursing Center
Amato Pharmacy, Inc.
Avanti Health Care
Best AID Pharmacy
NORC-Naturally Occurring Retirement Community (Bronx Jewish Community Services)
Morris Park Nursing and Rehab Center
Neighborhood SHOPP
Falak Pharmacy
Fedcap Behavioral Health Services
Hostos Community College
Medical Center Pharmacy, Inc.
Planned Parenthood of New York City, PC (PPNYC)
RAIN, Inc.
Cucina Dolores
Riverdale Mental Health Association
Pilgrim Pharmacy
Specialty Care Pharmacy, Inc.
Total Care Pharmacy BX, Inc.
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<th>Total Care Pharmacy, Inc.</th>
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<td>Gold Crest Care Center</td>
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<td>Regeis Care Center</td>
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<td>Bronx Community College - CUNY</td>
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<tr>
<td>Grameen PrimaCare</td>
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<td>Asthma Coalition of Queens</td>
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<td>The PAC Program</td>
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<td>Chapin Home</td>
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<tr>
<td>The Child Center of New York, Inc</td>
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<tr>
<td>Hamilton Madison House</td>
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<tr>
<td>Hamilton Park Nursing &amp; Rehab</td>
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<tr>
<td>Cerebral Palsy Associations of New York State</td>
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<tr>
<td>Queens Sickle Cell Advocacy Network</td>
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<tr>
<td>Lakeville Ambulette Transportation, LLC</td>
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<tr>
<td>Queens Long Island Renal Institute</td>
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<td>The Abraham &amp; Henrietta Malamut Community Health Center - Adult Day Care Program of Parker Jewish Institute</td>
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<tr>
<td>Parker Jewish Institute for Health Care &amp; Rehabilitation (AgeWell New York, LLC)</td>
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<tr>
<td>Comprehensive Community Hospice of Parker Jewish Institute</td>
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<td>Sutphin Drugs (Pills on Wheels)</td>
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<tr>
<td>Queens Community House</td>
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<td>Sunnyside Home Care Project, Inc.</td>
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<td>Sunnyside Citywide Home Care Services</td>
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<td>Sunnyside Community Services, Inc.</td>
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<td>Queens Village Committee for Mental Health for J-CAP, Inc.</td>
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<td>CABS Home Attendants Service, Inc.</td>
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<td>CABS Nursing Home Co, Inc.</td>
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<td>Saints Joachim &amp; Anne Nursing Rehabilitation Center</td>
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<td>Arms Acres Inpatient</td>
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<td>Arms Acres Outpatient - Bronx</td>
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<td>Arms Acrs Outpatient - Queens</td>
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<tr>
<td>Conifer Park Inpatient</td>
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<td>Bensonhurst Center for Rehabilitation and Healthcare</td>
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<td>FOUR SEASONS PHARMACY</td>
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<td>SUNRISE ADULT DAY HEALTH CARE CENTER</td>
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<td>LAKESIDE ADULT DAY HEALTH CARE CENTER</td>
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<tr>
<td>FOUR SEASONS CERTIFIED HOME HEALTH AGENCY</td>
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<tr>
<td>FOUR SEASONS HOME CARE PROGRAM</td>
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<tr>
<td>GATEWAY DIALYSIS CENTER</td>
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<td>Parkshore Health Care LLC (Four Seasons Nursing &amp; Rehab)</td>
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<tr>
<td>First MedCare, Inc.</td>
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<td>CAMBA</td>
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<tr>
<td>Caring Hospice Services of New York</td>
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<tr>
<td>Conifer Park, Inc.</td>
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<tr>
<td>Crown Nursing and Rehabilitation Center</td>
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Damon House
Brooklyn Center for Psychotherapy/New Directions
Marg Pharmacy, Inc. (Katz Drugs)
Moffat Garden Assisted Living Program
NAE Edison LLS (Edison Home Health Care)
Family Services Network of NY
La Nueva Esperanza
Ridgewood Bushwick Senior Citizen Council (RBSCC)
Buena Vida
Pella Care
St. Jude's Pharmacy
Scharome Cares, Inc.
St. Christopher's Inn
Family Care Certified Services (Tri-Borough Certified Health Systems of NY)
PSC Community Services, Inc.
Fort Green Strategic Action Partnership (SNAP)
Bedford Stuyvesant Restoration Corporation
Caribbean Women’s Health Association, Inc.

Community Physicians

A T M Yousuf Physician, PC
Afzal Hossain Physician PC
AMB Medical Services, PC
AMERICA MEDICAL GROUP
Be Well Primary Health Care Center, LLC
Bridget Chime DBA Hillside Polymedic DTC
Broadway Internal Medicine, PC
Care For The Homeless
East Harlem Council for Human Services /Boriken Neighborhood Health Center
Henry Sardar, MD
Highland Medical Center
Hillside Pediatrics, PC
Jamaica Family Practice & Osteopathic Medicine
Joseph R. Andrade, MD PC
Karine Mednik, MD
Kathrine A. Gold, MD (AKA Debevoise Health, per HC)
MedCare LLC
MEDICAL CLINIC 721 FLUSHING AVE/ Pala Community Care LLC
New York Medical & Diagnostic Center
North Valley Medical, PC
Park Avenue Pediatrics PC
REST Medical Care, PC
Smart Medical Care, PC
The Joseph P. Addabbo FHC
Uptown Health Care Management Inc.
## ZWH Medical Care, P.C.

### CBOs
- Academy of Medical & Public Health Services
- African Services Committee
- APICHA Community Health Center
- Arab-American Family Support Center
- Arthur Ashe Institute for Urban Health
- Asian Americans for Equality
- Brooklyn Perinatal Network
- Caribbean Women's Health Association, Inc.
- Coalition for Asian American Children & Families
- Commission on the Public's Health System
- Community Service Society of New York (CSSNY)
- Council of Peoples Organization (COPO)
- Goddard Riverside Neighborhood Center
- Greenwich House
- Haitian Centers Council
- Health People, Inc.
- Hudson Guild
- Indochina Sino American Community Center
- Make the Road by Walking
- Medicaid Matters NY
- NADAP
- New York Lawyers for the Public Interest
- Northern Manhattan Perinatal Partnership
- Northwest Bronx Community and Clergy Coalition (NWBCCC)
- Project Hospitality
- Public Health Solutions
- Shorefront Y
- Single Stop
- South Asian Council for Social Services (SACSS)
- Southeast Bronx Neighborhood Center
- Stanley Isaacs Neighborhood Center
- The Bronx Health Link
- The LGBT Community Center
- The New York Immigration Coalition
- United Neighborhood Houses
- University Settlement Society of New York
- Women’s Housing and Economic Development Corporation (WHEDco)

### SUNY Affiliated Providers
- SUNY Downstate Medical Center
- Abdulla Alwani, M.D.
- Abraham Sleem, MD
- Advantage Care Physicians
Each organization listed may include the organization’s affiliates, sites, members, and operating divisions

Albert A. Anglade, M.D.
Brooklyn Cancer Care Medical, PC
Carl Casimir, D.O.
Clifford Urias Young, M.D.
Cobble Hill Health Center, Inc.
Comprehensive Geriatric Medicine PC; DBA Doctors on Call
Daniel Khodadadian, MD
David E. Biro, M.D.
David Schwartz, M.D.
Dexter A. McKenzie, M.D.
Diaspora Community Services
Dove Pediatric Service
Eastern Pediatrics, PC
EAW Medical Care, PLLC
Elbaz, Tamer
Ernest Afflu, M.D.
First MedCare
Gentle Touch Medical PC
Gerald Valme, M.D.
Gwen P. Gentile, M.D.
Harold Fritz Kerolle, M.D.
Hazel L. Goodwin, M.D.
Hyacinthe, Llewellyn
Interboro Pediatrics
Jerry Uduevbo, M.D.
Kantu, Kanhaiyalal
Kelly Chin
Kevin Bruce Norowitz, M.D.
Kevin T. Custis, M.D.
Leonid Reyfman, M.D.
Lippman, Sheldon
Maria Elena Fodera, M.D.
Marie F. Conde-Wright, M.D.
Mark H. Krotowski, M.D.
Mauro L. Ruffy, M.D.
McMillan, George
Melvin C. Mahoney, M.D.
Ngozi Oji, MD
Ogiste-McBain, Sharon
Oluyemi O. Badero, M.D.
Otis M. Jones, M.D.
Oyenike Kilanko, MD
Park Nursing home
Peiying Xiao, M.D.
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Renaissance Medical Imaging, PC
Sabu John, MD
Schreiber, David
Scott, Claude
Shelby Kevin Samuel, M.D.
Sherill L. Purcell, M.D.
Sudhakar Bhagavath, M.D.
Tomasine Fodera, M.D.
SUNY UHB / UPB
Wellman W. Cheung, M.D.
Yechiel Zagelbaum, D.O.
Yogendra K. Saxena, M.D.
Grace Wong
Organizational Structure: HHC Assistance Corporation

- HHC is lead, or fiduciary, of PPS
- Existing, wholly-owned subsidiary of HHC
- Reports to HHC
- Operations funded by DSRIP Program
- Provides services to PPS partners
- Complies with HHC policies, including audit and procurement
- CSO Board members named by HHC President
- Employees are shared + hired
Resolution to Participate in DSRIP Program, Enter Arrangements with DSRIP Partners, and Establish Centralized Services Organization (CSO)

Christina Jenkins, MD
Sr. AVP, Quality, Performance and Innovation
December 18, 2014
Summary of Today’s Board Resolution

The components of today’s Board Resolution:

• Authorize HHC’s participation in the NYS DOH DSRIP Program, which necessitates the establishment of an HHC-led Performing Provider System (PPS)

• Authorize HHC to execute agreements between the HHC-led Performing Provider System (PPS) and PPS Partners

• Authorize the repurposing of HHC’s existing wholly-owned subsidiary, HHC Assistance Corporation, for use as a Centralized Services Organization (CSO) to provide services to the HHC-led PPS

  • Direct the Centralized Services Organization (CSO) to follow HHCs audit, procurement, and compliance policies
HHC’s Performing Provider System (PPS) Configuration

Key Elements of HHC’s PPS

- HHC will serve as lead, or fiduciary, of a single PPS
- The PPS is organized into four (4) borough-based hubs, each of which has a local advisory group, or PAC
- Each hub is comprised of PPS partners, whose medical and social services in aggregate span the healthcare continuum
- The proposed CSO will report to HHC and work in service to the PPS
What is a DSRIP Performing Provider System (PPS) Partner?

• The DSRIP definition of “partner” includes any organization with whom the Performing Provider System (PPS) will work in order to meet DSRIP Program goals

• Partners may be Medicaid providers, or may be other organizations or agencies that are important to meeting our communities’ health and social needs. For example, partners may include:
  
  • Community primary care physician practices
  • Acute hospitals
  • Long-Term Care facilities
  • Behavioral Health providers
  • Community-based organizations (CBOs)
  • Government agencies
  • Affiliate and Labor Organizations

• The HHC-led PPS has multiple partner types, and in this resolution we classify them by their geographic span of services:
  
  • City-wide Partners – Medicaid providers and organizations serving 2+ boroughs (hubs)
  • Hub-based Partners – Medicaid providers and organizations serving a single borough (hub)
HHC-led PPS Partner Contracting

- Participation in DSRIP requires the PPS to enter into formal arrangements with partners over five (5) year DSRIP Program life

- HHC has decided to minimize risk and operational burden of legal entity formation and proposes to use the Collaborative Contracting Model, an approach endorsed by NYS DOH

- In today’s resolution, we seek authorization to enter these contracting arrangements, intended to occur during 1H, 2015
  - Each partner will contract with the HHC-led PPS via a Master Hub and Services Agreement (MHSA) and a schedule
  - HHC has performed initial, high-level assessment of partner values, staffing and capacity, IT capabilities, management capabilities and financial stability
HHC Assistance Corporation

- The HHC Assistance Corporation is an existing subsidiary formed in October, 2012
  - It is a not-for-profit membership corporation, where HHC is the sole member
  - It is entirely controlled by HHC
  - It is the not-for-profit equivalent of a wholly-owned subsidiary, similar to MetroPlus
  - It is now substantially inactive and able to be used for additional purpose
    - Was established for transactions as part of a New Market Tax Credit Financing by HHC as part of Harlem Hospital Major Modernization Project

- In today’s resolution, we seek Board approval to take the following actions related to the HHC Assistance Corporation:
  - To repurpose it for use as a Centralized Services Organization (CSO), which will serve the HHC-led Performing Provider System (PPS)
  - For Dr. Raju to name new Directors, including replacement of former HHC President with new President, and to add outside Directors as is strategic
Proposed Organizational Structure + Function: HHC Assistance Corporation

• HHC is lead, or fiduciary, of PPS
• Existing, wholly-owned subsidiary of HHC
• Reports to HHC
• Operations funded by DSRIP Program
• Provides services to PPS partners, including:
  • Information technology
  • Performance data tracking and analysis
  • Accounting
  • Training
  • Healthcare management consulting services
• Complies with HHC policies, including audit, compliance and procurement
• CSO Board members named by HHC President
• Employees are shared + hired
RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”) to execute a five year lease extension agreement with LSS Leasing Limited Liability Company (the “Landlord”) for 5,120 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Women’s Medical Center (the “Center”), operated by Elmhurst Hospital Center (the “Facility”) at an initial rent of $225,280 per year or approximately $44 per square foot to increase at a rate of 2.75% per year for a five year total of $1,190,079.

WHEREAS, the Center is a community-based health care center that has been providing primary care services to residents of the Corona section of Queens since 1998; and

WHEREAS, the Center offers a full range of primary care services for women and children including prenatal care and gynecological services; and

WHEREAS, half of the leased premises have been and will continue to be occupied by a subtenant, Pediatrics Specialties of Queens, P.C. which will continue its arrangement of paying one half of all occupancy costs associated with the Center; and

WHEREAS, the proposed sublease with Pediatrics Specialties of Queens, P.C. will be the subject of a separate resolution presented to the Corporation’s Capital Committee and Board for authorization; and

WHEREAS, there remains a need for primary care services in this section of Queens and extending the lease for this site will allow the Center to continue to serve the community.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a five year lease extension agreement with LSS Leasing Limited Liability Company for 5,120 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Women’s Medical Center, operated by Elmhurst Hospital Center at an initial rent of $225,280 per year or approximately $44 per square foot to increase at a rate of 2.75% per year for a five year total of $1,190,079.
EXECUTIVE SUMMARY
QUEENS HEALTHCARE NETWORK
WOMEN'S MEDICAL CENTER
59-17 JUNCTION BOULEVARD
BOROUGH OF THE QUEENS

OVERVIEW: The President seeks authorization from the Board of Directors of the Corporation to execute a lease extension agreement with LSS Leasing Limited Liability Company (the “Landlord”) for space at 59-17 Junction Boulevard, Borough of Queens to house the Women’s Medical Center (the “Center”) operated by Elmhurst Hospital Center (“Elmhurst”).

NEED/PROGRAM: The Center is a community-based health care center that has been providing primary care services to residents of the Corona section of Queens since 1998. The Center offers a full range of primary care services for women and children including prenatal care and gynecological services. There remains a need for primary care services in this section of Queens and extending the lease for this site will allow the Center to continue to serve the community. Under a sublease agreement, Pediatric Specialties of Queens occupies approximately half the entire area leased and is responsible under the agreement for payment of half of the occupancy costs. The Center is open Monday through Friday 8:00 a.m. to 4:30 p.m.

UTILIZATION: For the FY 2014, the Center provided approximately 5,733 visits.

PRIOR TERMS: The Center has occupied the subject location under a lease dated April 6, 1999 and that commenced after landlord completed a build out of the space on January 17, 2000. The lease was for ten years and the Corporation held a five year option to renew the lease at 95% of fair market value. Rent escalated during the original and renewal term at approximately 3% during the initial term and by 2.5% during the renewal term. The rent currently paid at the space (including the portion covered by the subtenant) is $194,595. The new base rent under the proposed lease described below will be approximately 16% over the prior base rent.

TERMS: The Tenant will continue to occupy approximately 5,120 square feet of ground floor space. The lease extension will include a five year term. The base rent will be $225,280 per year or $44 per square foot. The base rent will be escalated by 2.75% per year. The rent for this lease extension has been determined to be a fair market value rate. The rent will total $1,190,079 over the five year lease extension term.

The Landlord will be responsible for structural repairs and maintenance and the repair and maintenance of all common areas including sidewalks, curbs and parking lots. The Tenant will be responsible for interior non-structural repairs and maintenance. The Tenant will be responsible for payment of separately metered utilities.

The Tenant will be responsible for the payment of its proportionate share of real estate tax increases above the 2014/15 base year.
SUMMARY OF ECONOMIC TERMS

SITE: 59-17 Junction Boulevard
       Queens, New York 11368
       Block 1918, Lot 112

LANDLORD: LSS Leasing Limited Liability Company
          40 W. 57th St.
          NY, NY 10019

TERM: Five years

FLOOR AREA: Approximately 5,120 square feet

BASE RENT: $44 per square foot or $225,280 per year

ESCALATION: 2.75% per year

UTILITIES: Tenant is responsible for payment for electricity, gas, and water and sewer rents

REAL ESTATE TAXES: Tenant is responsible for payment of its proportionate share of real estate taxes increases above the 2014/15 base year.

REPAIRS/MAINTENANCE: The Landlord will be responsible for structural repairs and maintenance and the repair and maintenance of all common areas including sidewalks, curbs and parking lots. The Tenant will be responsible for interior non-structural repairs and maintenance.
October 22, 2014

Mr. Dion Wilson
Office of Facilities Development, Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, 10013

Re: Fair Market Value/Appraisal of Women’s Health Service Center, 59-17 Junction Blvd., Queens, New York, a clinic operated by the Queens Health Network on behalf of Elmhurst Hospital Center of the NYC Health & Hospitals Corporation

Dear Dion:

Pursuant to your request, the referenced property was inspected on September 26, 2014 in order to assess its fair market value, specifically regarding the renewal terms presented by the LandLord, LSS Leasing LLC. This assessment is inclusive of the value of the Tenant improvements, CAM charges, if any, and real estate taxes and assumes that other operating expenses are directly procured by the Tenant unless indicated otherwise. This evaluation is subject to the following:

- The unit is currently occupied and zoned for use as a medical office.
- The lease expires 1/16/2015.
- The LandLord, in accordance with the terms of the original lease, has proposed a second, five year renewal term with 3.0% escalations per annum.
- The unit is approximately 5,120RSF.
- This evaluation is for the purpose of a lease renewal.

Medical offices in this area are typically situated in stand-alone buildings, retail “tax payers” used for various commercial purposes, ground floor spaces in residential buildings, or offices in commercial office buildings. Rents for turn-key (ready to use), general medical spaces pricing ranges from approximately $30 - $60 per rentable square foot with a median price of $45/RSF. Older, retrofit and side street medical spaces garner the lower rents with the larger mall-type spaces and newly constructed spaces commanding higher rents. These latter properties typically offer more amenities, i.e., on-site property management, parking, security, etc. Most of the opportunities for medical office space in these markets are for unimproved offices in small commercial buildings or retail sites, which will require extensive capital improvements.

Current market conditions for these types of spaces provide for minimal LandLord concessions. Additionally retail transactions do not provide for LandLord concessions other than rent abatements, which are not usually applicable in a renewal, although always negotiable. Most of the opportunities for medical office space in these markets are for undeveloped offices in commercial buildings or strip retail “taxpayers” where the Tenant will be offered few concessions by the LandLord despite market conditions denoting more of a “Tenant’s market”.

Savitt Partners LLC 530 Seventh Avenue, New York, New York 10018
Concessions are minimal and LandLords have traditionally been inflexible; preferring to see current market conditions dictate their flexibility. Rents in the commercial and retail markets within the Corona/Rego Park area have been flat for the past few years but have shown steady improvement over the last 18 months and this trend is expected to continue.

This requires that the Tenant improvements be provided greater weight as an overall factor in the assessment of the FMV rental due to the cost associated with relocation; relocating, or rebuilding with new construction, would entail an up-front expense of no less than $70/RSF or approximately $360,000.00 for construction for this specific Tenant’s use. Despite possible lower rents opportunities in the same market area this expense cannot be appropriately amortized over the proposed renewal term of 10 years.

The referenced medical office is a retail Tenant user within the Junction Blvd./Queens Blvd. area AKA Lefrak City, in the Rego Park/Corona section of Queens comprising mostly of moderately priced one- and two-family houses and larger apartment buildings that are both rental and co-op units. The referenced medical office is a retail Tenant user occupying a store front on the southernmost portion of the building’s ground floor located in a larger office building which houses commercial Tenants including a large occupancy and other NYC agencies accessed through the main lobby of the elevatored building with a concierge/security desk. In addition to this retail space housing the women’s practice, there is a drug store, deli, coffee shop and entrance to the below mentioned parking garage. The office is less than a minute away from the entrance to the LIE, a six minute walk to the subway and numerous bus routes can be accessed directly in front of the space on Junction Blvd. National franchises dot the local and surrounding streets including many clothing and consumer “big box” retailers which are located on the south side of the LIE just under a 10-minute walk from this location. Situated on the LIE’s north side service road, there is street parking; however, street parking difficult since it competes with both the residential and commercial population, specifically during the typical work week. There is a major for fee three-story public parking facility at the building at posted rates, which at the time of our visit was heavily used.

The Tenant has signage on the main entrance door. Once entered, there are two Tenants occupying the space, each properly marked within a small glass vestibule directing the population to either the described Women’s Health Service Center to the left, or to the subtenanted space, sublet by Pediatric Specialites of Queens, directly in front as the vestibule is entered. The spaces are clearly marked for each Tenant. The practice operates during posted hours on a Monday through Friday basis, no weekends. The office, including the sublet portion, is comprised of approximately 5,120 RSF on grade. There is no second floor or basement space available. Perimeter heat is supplied by the building with a supplemental HVAC system to provide cooling. There is no heat coil in the unit. The entrance and interior areas are accessible and compliant with the Americans with Disabilities Act. The office consists of the following:
• Waiting area with 14 chairs
• Reception/business area for 2-3 persons but occupied by one person at the time of the visit. The office and sublet space share the reception and business office area but operate independently.
  o 6 exam rooms with plumbing
  o 10 chair interior waiting area
  o Staff bathroom
  o Patient bathroom
  o Staff lounge with lockers
  o Supply closet
  o Electric closet
  o Telecom room
  o Janitor’s closet
  o Medical records – large room with rolling file system shared with subtenant. Both practices have their own door into the space. Neither entrance is locked.
  o Sublet space – in addition to the shared business office area, the waiting area and the shared storage space, the rest of that unit was not viewed however it appeared to be maintained well.

The Tenant improvement (T.I., build out of the space) should remain in fair to good condition with continued proper maintenance through the five year renewal term. The space showed well and is kept well. The value of the original capital expenditure is estimated at $70 per RSF, over and above the original LandLord improvements.

There does not appear to be any additional work required by Tenant from LandLord. However, while visiting the space, which as previously stated is in good condition, there is some concern regarding internal security provided by and maintained by Tenant. Specifically, the electronic door/lock from the waiting room into the clinical portion of the space was not functioning properly and should be repaired. In addition, the shared file room, used by both Tenant and subtenant, should have automatic locking mechanisms installed so that the space remains secure internally.

The renewal terms presented by the LandLord are commercially fair and reasonable based on this assessment, the condition of the space, LandLord’s contribution & LandLord and Tenant’s ongoing maintenance obligations. It is our conclusion that the fair market value of this space with the referenced services and amenities is between $44 - $46 per RSF. This takes into consideration comparable commercial/retail rents within the immediate market areas (see Schedule A attached) and the subsequent Tenant improvements of the space, as well as current availability for similar opportunities.

While it is our professional observation that the terms are fair and reasonable given current conditions and immediate vacancies within the surrounding areas, we would recommend further negotiations regarding the rent as it relates specifically on resetting the “tax stop” (base year) to the current 2014/2015 tax year. This would be fair and reasonable given the LandLord’s rent proposal to market the space to current rental rates for “like kind space” which we consider
within market terms. Also, after a 15 year occupancy, it would be appropriate to request a small workletter to either repaint and/or repair certain areas that might enjoy an update. This could be traded for some free rent of approximately one month in lieu thereof.

In the event that I can be of any further assistance to you, please do not hesitate to call.

Thank You,

Michael E. Dubin
Partner
## Schedule A – Comparables

<table>
<thead>
<tr>
<th>Property</th>
<th>Unit</th>
<th>Size</th>
<th>Price PS</th>
<th>Price Per annum</th>
<th>Price Per Month</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-16 82nd Street</td>
<td>Retail</td>
<td>2,000</td>
<td>$72.00</td>
<td>$144,000.00</td>
<td>$12,000.00</td>
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<tr>
<td>89-25 Queens Blvd</td>
<td>Retail</td>
<td>3,750</td>
<td>$120.00</td>
<td>$450,000.00</td>
<td>$37,500.00</td>
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<tr>
<td>37-03 92nd Street</td>
<td>Retail</td>
<td>2,400</td>
<td>$40.00</td>
<td>$96,000.00</td>
<td>$8,000.00</td>
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<tr>
<td>78-14 Roosevelt Ave</td>
<td>Retail</td>
<td>3,000</td>
<td>$60.00</td>
<td>$180,000.00</td>
<td>$15,000.00</td>
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<tr>
<td>72-32 Broadway</td>
<td>Retail</td>
<td>1,500</td>
<td>$130.00</td>
<td>$195,000.00</td>
<td>$16,250.00</td>
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<td>81-01 Broadway</td>
<td>Retail</td>
<td>2,150</td>
<td>$60.00</td>
<td>$129,000.00</td>
<td>$10,750.00</td>
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<tr>
<td>100 Queens Blvd</td>
<td>Retail</td>
<td>3,000</td>
<td>?</td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>8502 Queens Blvd</td>
<td>Retail</td>
<td>2,200</td>
<td>$50.00</td>
<td>$110,000.00</td>
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<td>$50.00</td>
<td>$105,000.00</td>
<td>$8,750.00</td>
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<tr>
<td>79-11 41st Avenue Part 1st</td>
<td>Part 1st</td>
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<td>$48.00</td>
<td>$52,800.00</td>
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<tr>
<td>80-15 41st Avenue P Ground</td>
<td>3,500</td>
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<td>$192,500.00</td>
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<td>86 Broadway Pt. 1st</td>
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<td>$13,333.33</td>
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<td>75-21 Broadway 3rd fl</td>
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<td>$16.00</td>
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<tr>
<td>78-21 Queens Blvd 2nd fl</td>
<td>5,500</td>
<td>$14.00</td>
<td>$77,000.00</td>
<td>$6,416.67</td>
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<tr>
<td>3rd fl</td>
<td>5,500</td>
<td>$14.00</td>
<td>$77,000.00</td>
<td>$6,416.67</td>
<td>NNN</td>
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<tr>
<td>89-22 Queens Blvd 2nd fl</td>
<td>5,600</td>
<td>$30.00</td>
<td>$168,000.00</td>
<td>$14,000.00</td>
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<tr>
<td>86-16 Queens Blvd 2nd fl</td>
<td>2,100</td>
<td>$31.00</td>
<td>$65,100.00</td>
<td>$5,425.00</td>
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<tr>
<td>118-35 Queens Blvd 3rd fl</td>
<td>11,000</td>
<td>$35.00</td>
<td>$385,000.00</td>
<td>$32,083.33</td>
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</tr>
<tr>
<td>4th fl</td>
<td>11,000</td>
<td>$35.00</td>
<td>$385,000.00</td>
<td>$32,083.33</td>
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ELMHURST HOSPITAL CENTER
Annual Operating P/L
Women’s Medical Center
59-17 Junction Boulevard, Corona, NY 11368
Cost Center 6122-09

PERSONNEL SERVICES (P.S.)

<table>
<thead>
<tr>
<th>TITLE</th>
<th>NAME</th>
<th>REIM. CODE</th>
<th>FTE</th>
<th>SALARY As of 9/20/14 PSER</th>
<th>ANNUAL BUDGET</th>
</tr>
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<tbody>
<tr>
<td>Patient Care Assoc.</td>
<td>BABAYEVA, ROZ</td>
<td>IOXL</td>
<td>1.00</td>
<td>38,053</td>
<td>38,053</td>
</tr>
<tr>
<td>Patient Care Assoc.</td>
<td>KAZIYEVA, STE</td>
<td>IOXL</td>
<td>1.00</td>
<td>38,053</td>
<td>38,053</td>
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<tr>
<td>Public Health Nurse LV 1</td>
<td>SHARMA, TARAM</td>
<td>IYLR</td>
<td>1.00</td>
<td>81,579</td>
<td>81,579</td>
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<tr>
<td>Clerical Assoc. - LV IV</td>
<td>POON, MANG YI</td>
<td>IOXL</td>
<td>1.00</td>
<td>39,529</td>
<td>39,529</td>
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<tr>
<td>Assoc. NP- lv. II</td>
<td>MADU, EDNAH</td>
<td>IOA1</td>
<td>0.20</td>
<td>109,893</td>
<td>21,979</td>
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<tr>
<td>Assoc. NP- lv. II</td>
<td>YU-TANG, CHIN</td>
<td>IOA1</td>
<td>0.60</td>
<td>91,342</td>
<td>54,805</td>
</tr>
<tr>
<td>HHC PS</td>
<td>4.80</td>
<td>273,998</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HHC F.B. @</td>
<td>55.33%</td>
<td>151,603</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>HHC PS + F.B.</td>
<td></td>
<td>425,601</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Midwife</td>
<td>TBD VS Mary Sahota. (Various Midwife Covage currently)</td>
<td>1.00</td>
<td>$103,882</td>
<td>103,882</td>
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<tr>
<td>Assistant Attending</td>
<td>Vanita Modi</td>
<td>0.30</td>
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<td>$139,276</td>
<td>41,783</td>
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<tr>
<td>AFFIL PS</td>
<td>1.300</td>
<td>145,665</td>
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<tr>
<td>AFFIL F.B @</td>
<td>22.39%</td>
<td>32,614</td>
<td></td>
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<tr>
<td>AFFIL Over Head</td>
<td>2.00%</td>
<td>3,566</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AFFIL PS + F.B. + OH</td>
<td></td>
<td>181,845</td>
<td></td>
<td></td>
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<tr>
<td>TOTAL PS + F.B.</td>
<td>6.100</td>
<td>607,446</td>
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OTHER THAN PERSONNEL SERVICES (O.T.P.S.) - Vouched FY 14

<table>
<thead>
<tr>
<th>NEC CODE</th>
<th>DESCRIPTION</th>
<th>BUDGET</th>
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<tbody>
<tr>
<td>490000</td>
<td>MEDICAL SURGICAL SUPPLY</td>
<td>857</td>
</tr>
<tr>
<td>510000</td>
<td>FOOD</td>
<td>111</td>
</tr>
<tr>
<td>560000</td>
<td>OFFICE/COMPUTER SUPPLY, PAPER</td>
<td>667</td>
</tr>
<tr>
<td>590000</td>
<td>NON-MED &amp; NON-SURG SUPPLY</td>
<td>322</td>
</tr>
<tr>
<td>790000</td>
<td>PURCHASED SRVICES/ FACILITY PLANT MAINT SERVICES</td>
<td>15,160</td>
</tr>
<tr>
<td>860000</td>
<td>EMPLOYEE TRAVEL</td>
<td>48</td>
</tr>
<tr>
<td>950000</td>
<td>LEASE/RENT-BUILDINGS</td>
<td>225,280</td>
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<tr>
<td>970000</td>
<td>LEASE/RENT-NON-MED SUR</td>
<td>1,812</td>
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<tr>
<td></td>
<td>TELEPHONE ($50 X 12MO X 7.125 FTE)</td>
<td>4,275</td>
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<tr>
<td></td>
<td>Dr. Villegas - sub lease / shared space (Half of LeFrak site rent is paid by Dr. Villegas)</td>
<td>(113,546)</td>
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<tr>
<td>OTPS</td>
<td>134,986</td>
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<tr>
<td>TOTAL DIRECT EXPENSES</td>
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<td>$742,432</td>
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ANCILLARY/MED. SURG COSTS ($15 per visit) | 5,708 | $85,620 |

TOTAL EXPENSES | $828,052 |

REVENUE COLLECTIONS (BASED ON DATA GPS RUN FY14)

<table>
<thead>
<tr>
<th>NEC CODE</th>
<th>Rate</th>
<th>VISITS/MEMBERS</th>
<th>Allocation</th>
<th>COLLECTIONS</th>
</tr>
</thead>
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<tr>
<td>FFS COLLECTIONS (Clinic Codes 231, 335, 454, 473, 488)</td>
<td>5,708</td>
<td>$362,567</td>
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<tr>
<td>PRIMARY CARE CAPITATION</td>
<td>650</td>
<td>$222,300</td>
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<tr>
<td>INPATIENT REVENUE CREDIT</td>
<td>84 Patients delivered at EHC FY13 (referred by clinic)</td>
<td>$6,706.50</td>
<td>84</td>
<td>32% Credit (based on fixed)</td>
</tr>
<tr>
<td>TOTAL COLLECTIONS</td>
<td>$765,138</td>
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<td></td>
</tr>
</tbody>
</table>

SURPLUS / (DEFICIT) | ($62,914) |
<table>
<thead>
<tr>
<th></th>
<th>FY 11</th>
<th>FY 12</th>
<th>FY 13</th>
<th>FY 14</th>
<th>FY14 vs FY11</th>
<th>FY14 vs FY11 as %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Clinic (OP) Visits</td>
<td>7,059</td>
<td>7,103</td>
<td>6,433</td>
<td>5,708</td>
<td>(1,351)</td>
<td>-19.1%</td>
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<tr>
<td>Total OBS Patients</td>
<td>168</td>
<td>135</td>
<td>142</td>
<td>133</td>
<td>(35)</td>
<td>-20.8%</td>
</tr>
<tr>
<td># Patients who delivered at EHC</td>
<td>115</td>
<td>93</td>
<td>92</td>
<td>84</td>
<td>(31)</td>
<td>-27.0%</td>
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<tr>
<td>% of PTS who delivered at EHC</td>
<td>68%</td>
<td>69%</td>
<td>65%</td>
<td>63%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** FY14 Deliveries are projected (63% applied to 133 OBS patients)
RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the “Corporation”) to execute a five year sublease agreement with Pediatric Specialties of Queens (the “Subtenant”) for 2,560 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Subtenant’s pediatric program at an initial rent of $112,640 per year or approximately $44 per square foot to increase at a rate of 2.75% per year but in no event less than half of all of the Corporation’s occupancy costs at the premises.

WHEREAS, the Corporation has been operating a community-based health care center managed by Elmhurst Hospital Center at this location that has been providing primary care services to residents of the Corona section of Queens since 1998; and

WHEREAS, the Subtenant has been providing pediatric services at this site since the late 1990s and the Corporation and the Subtenant maintain separate and distinct medical practices at the site; and

WHEREAS, the Subtenant has subleased half of the space rented by the Corporation and has paid half of the Corporation’s occupancy costs; and

WHEREAS, the Corporation proposes, pursuant to separate resolution, to renew and extend its lease for the premises and the Subtenant wishes to continue in occupancy of its half of the premises and to pay half the Corporation’s occupancy costs for the entire premises under a sublease with the Corporation.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a five year sublease agreement with Pediatric Specialties of Queens for 2,560 square feet of space at 59-17 Junction Boulevard, Borough of Queens, to house the Subtenant’s pediatric program at an initial rent of $112,640 per year or approximately $44 per square foot to increase at a rate of 2.75% per year but in no event less than half of all of the Corporation’s occupancy costs at the premises.
RESOLUTION

Reappointing Lloyd Williams as a member of the Board of Directors of MetroPlus Health Plan, Inc. ("MetroPlus"), a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York, to serve in such capacity until his successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

WHEREAS, a resolution approved by the Board of Directors of the New York City Health and Hospitals Corporation ("HHC") on October 29, 1998, authorized the conversion of MetroPlus from an operating division to a wholly owned subsidiary of HHC; and

WHEREAS, the Certificate of Incorporation of MetroPlus designates HHC as the sole member of MetroPlus and has reserved to HHC the sole power with respect to electing members of the Board of Directors of MetroPlus; and

WHEREAS, the Bylaws of MetroPlus authorize the Chairperson of HHC to select three directors of the MetroPlus Board subject to election by the Board of Directors of HHC; and

WHEREAS, the Chairperson of HHC has selected Mr. Williams to serve an additional term as a member of the Board of Directors of MetroPlus; and

WHEREAS, the Board of Directors of MetroPlus has approved said nomination;

NOW, THEREFORE, be it

RESOLVED, that the HHC Board of Directors hereby reappoint Lloyd Williams to the MetroPlus Board of Directors to serve in such capacity until his successor has been duly elected and qualified, or as otherwise provided in the Bylaws of MetroPlus.
EXECUTIVE SUMMARY

Pursuant to the Certificate of Incorporation of MetroPlus, HHC has the sole power with respect to electing members of the Board of Directors of MetroPlus. The Bylaws of MetroPlus authorize the Chairperson of HHC to select three directors of the MetroPlus Board subject to election by the Board of Directors of HHC.

The Chairperson of HHC has nominated Lloyd Williams to serve an additional 5 year term as a member of the MetroPlus Board of Directors.

Mr. Williams is currently the President and Chief Executive Officer of The Greater Harlem Chamber of Commerce. He is also the Chairman/Co-Founder of LMR Productions, HARLEM WEEK, Inc., Harlem Music Festival and is President of Greater Harlem Housing Development Corporation. Mr. Williams serves as a member of the Executive Board of NYC & Company, the official marketing and promotion organization for New York City dedicated to advancing the economic interests of all businesses and residents.

Mr. Williams has taught and is continuously invited to teach and/or lecture on courses in history, tourism, urban development, business and economics at several New York institutions.

Mr. Williams is also involved in several health care initiatives including HEALTHY EATING/HEALTHY LIVING (HLHE), which is a six-year program of The Greater Harlem Chamber of Commerce in partnership with Congressman Charles Rangel and The City of New York. It is the goal of HLHE to encourage people to make a conscientious choice and effort to strive toward healthier life styles.

Mr. Williams has extensive experience and MetroPlus is very pleased that he has agreed to serve an additional 5 year term on the Board.