

AUDIT COMMITTEE
MEETING AGENDA

September 8th, 2016

11:00 A.M.

125 Worth Street,
Rm. 532
5th Floor Board Room

CALL TO ORDER

- Adoption of Minutes June 9, 2016

Ms. Emily A. Youssouf

INFORMATION ITEMS

- Audits Update
- Compliance Update

Mr. Chris A. Telano

Mr. Wayne McNulty

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: June 09, 2016

TIME: 11:00 AM

COMMITTEE MEMBERS

Emily Youssouf, Chair

Josephine Bolus, RN

Mark Page

OTHER MEMBERS OF THE BOARD

Dr. Lilliam Barrios-Paoli

STAFF ATTENDEES

Antonio Martin, Executive Vice President/COO

Steven Bussey, Chief of Ambulatory

Salvatore Russo, General Counsel, Legal Affairs

Colicia Hercules, Chief of Staff, Chairman's Office

Patricia Lockhart, Secretary to the Corporation, Chairman's Office

PV Anantharam, Senior Vice President/Corporate Chief Financial Officer

Ross Wilson, Senior Vice President/Chief Medical Officer

Julian John, Corporate Comptroller

James Linhart, Deputy Corporate Comptroller

Gassenia Guilford, Assistant Vice President, Finance

Carol-Ann Rosado, Senior Director, EITS

Jackie Gelly, Director, Supply Chain Services

Angela Mariani, Director, Operations/Central Office

Anthony Rossano, Deputy Executive Director/Chief Financial Officer, Home Care

Wayne McNulty, Corporate Compliance Officer

Christopher A. Telano, Chief Internal Auditor/AVP, Office of Internal Audits

Devon Wilson, Senior Director, Office of Internal Audits

Chalice Averett, Director, Office of Internal Audits

Carol Parjohn, Director, Office of Internal Audits

Steve Van Schultz, Director, Office of Internal Audits

Delores Rahman, Director, Office of Internal Audits

Carlotta Duran, Assistant Director, Office of Internal Audits

Frank Zanghi, Audit Manager, Office of Internal Audits

Rosemarie Thomas, Audit Manager, Office of Internal Audits

Armel Sejour, Senior Auditor, Office of Internal Audits

Sonja Aborisade, Senior Auditor, Office of Internal Audits

Melissa Bernaudo, Senior Auditor, Office of Internal Audits

Sam Malla, Senior Auditor, Office of Internal Audits

Gillian Smith, Senior Auditor, Office of Internal Audits

Barbarah Gelin, Senior Auditor, Office of Internal Audits

Erica Nairne-Hamilton, Staff Auditor, Office of Internal Audits

Jean Saint-Preux, Staff Auditor, Office of Internal Audits

Linda Maldonado, Staff Auditor, Office of Internal Audits

Roshney Kaur, Staff Auditor, Office of Internal Audits

Conny Lizarazo, Executive Secretary, Office of Internal Audits
L. R. Tulloch, Senior Director, Office of Facility Development
Jay Weinman, Chief Financial Officer, NYC H + H/Bellevue
Timi Diyaolu, Controller, NYC H + H/Bellevue
Caswell Samms, Chief Financial Officer, NYC H + H/Harlem
Mark Sollazzo, Associate Director, NYC H + H/Harlem
Violetto Palmere, Assistant Director, NYC H + H/Harlem
Ronnell Boylan, Captain, NYC H + H/Harlem
Nadeem Aslam, Assistant Director, NYC H + H/Harlem
Anthony Saul, Chief Financial Officer, NYC H + H/Kings County
Ron Townes, Associate Director, NYC H + H/Kings County
David Baksh, Associate Executive Director, NYC H + H/Queens
Elsa Cosme, Chief Financial Officer, NYC H + H/Gouverneur
Tracy Green, Chief Financial Officer, NYC H + H/Metropolitan
Joseph Prabhaker, Associate Director, NYC H + H/Metropolitan
Mutiu Agbososa, Assistant Director, NYC H + H/Metropolitan
Lisa Scott-McKenzie, Deputy Executive Director, NYC H + H/Woodhull
Martin Novzen, Senior Executive Director, NYC H + H/Woodhull
Dona Chae, Senior Associate Director, NYC H + H/Woodhull
Robert Patterson, Associate Executive Director, NYC H + H/Woodhull
David Nunziato, Interim Chief Financial Officer, NYC H + H/Woodhull
Floyd Long, Associate Executive Director, NYC H + H/Carter/Coler
Manuela Brito, Chief Financial Officer, NYC H + H/Carter/Coler

OTHER ATTENDEES

CROTHALL: Michell Bonagura, Director; Shashi Avadhani, RNP
KPMG: Jim Martell, Lead Engagement Partner; Mike Breen, Engagement Partner, Joseph Bukzin,
Lead Senior Manager
PAGNY: David N. Hoffman, Compliance Officer; Anthony Mirdita, Chief Financial Officer

**JUNE 9, 2016
AUDIT COMMITTEE MEETING
MINUTES**

An Audit Committee meeting was held on Thursday, June 9, 2016. The meeting was called to order at 11:05 A.M. by Ms. Emily Youssouf, Committee Chair. Ms. Youssouf then asked for a motion to adopt the minutes of the Audit Committee meeting held on April 12, 2016. A motion was made and seconded with all in favor to adopt the minutes. An additional motion was made and seconded to hold an Executive Session of the Audit Committee to discuss matters of personnel and potential litigation.

Ms. Youssouf then stated that first thing we are supposed to be doing is having the audit plan, but KPMG is running late, therefore we will initially start with the Audit update.

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

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

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

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

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

When we took it over, we were concerned that there were a lot of opportunities for improvement, and part of the many changes that we put in place was to request an audit to actually find out what else we were not finding. For general contextual comments, this audit has been helpful in confirming things that we already knew, some things we were

already fixing. It provided a deeper look at some things we didn't fully understand. So that's the context of improvement. A lot has changed since this is occurring and some is still changing, but I think I just want the Committee to be clear that this is part of the journey around improving and strengthening what we regard as an important component of care coordination.

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

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

Ms. Youssouf said great – I am happy to hear all this. She asked if there were any questions or comments. She thanked them and wished them good luck.

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

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

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

One-to-One is primarily for safety reasons. Residents and patients may pull out their trachea tubes and they could have immediate consequences. Elopements, residents who are confused leaving the building could potentially be in immediate harm if they went to the public unescorted, so there are a number of reasons that One-to-Ones arise. Oftentimes the patient or resident is admitted on a One-to-One order, so it's our objective to evaluate that patient and

look for alternatives, use technology such as the transmitter bracelet equipment as well as some type of padding device to assist the resident in being safe in their area.

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

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

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

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

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

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

Ms. Matias answered yes, we have some admissions from acute with One-to-Ones, and even those who are successfully able to leave off by creating some countermeasures such as providing more diversional activities for opportunity and individualized care. We also are looking to something out of the box, which includes specialty mattresses and specialty beds that allows for prevention of falls without restriction of or restraining the resident. We have put in local alarms to supplement our monitoring system to prevent elopements, and with those combinations we were able to reduce by 55 percent.

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

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

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

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

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

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

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

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

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

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

Mr. Telano continued and stated that the last audit I will be discussing is on page 11 of my briefing related to the medical/surgical inventory controls at Harlem. He asked for the representative to come to the table and introduce

yourself. They introduced themselves as follows: Ebone Carrington, Chief Executive Officer/Chief Operating Officer; Caswell Samms, Chief Financial Officer; Ronnell Boylan, Hospital Police; Mark Sollazzo, Materials Management; Violeto Palmiere, Finance.

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

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

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

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

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

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

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

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

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

Ms. Youssef asked if they are doing periodic checks.

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

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

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

Mr. Telano added right, that is the problem.

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

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

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

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

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

Mr. McNulty introduced himself as Wayne McNulty, Senior Assistant Vice President/Chief Compliance Officer. He started with page three of the Corporate Compliance Report (the "Report") by discussing the *Monitoring of Excluded Providers*. He reported to the Audit Committee of the NYC Health + Hospitals Board of Directors (the "Committee") that there were no excluded providers during the period of February 2016 to May 2016. Mr. McNulty moved along to Section II of page four of the Report - *Privacy Incidents in the First Quarter of Calendar Year 2016, January 1st to March 31st of 2016*. Mr. McNulty stated that his office received 27 complaints of violations of HIPAA policies and procedures. He informed the Committee that, after investigation, ten of those complaints were found to be actual violations of HIPAA's policies and procedures and five would be breaches of confidential protected health information.

Mr. McNulty asked the Committee to turn to the bottom of page five of the Report, and then he proceeded to go through the five breaches of protected health information starting with Coney Island Hospital. He explained that the Coney Island incident occurred when a nurse employee went into the records of another employee who was a patient at the facility. He informed the Committee that disciplinary charges were pending with respect to the subject nurse. Mr. McNulty moved along to Kings County, explaining that two incidents occurred there. The first incident, he stated, involved the disclosure of protected health information to an attorney. He stated that the disclosure was pursuant to a patient authorization; however, the patient limited the information that was to be disclosed, and more information was disclosed to the attorney than was intended by the patient, resulting in, he further explained, a breach of protected health information. Mr. McNulty informed the Committee that the second incident with respect to Kings County occurred when an attorney received the wrong information – specifically that the attorney received information from the wrong patient, not the patient the attorney was representing. This, Mr. McNulty stated, led to a breach notification being sent to the affected patient.

Mr. McNulty turned to page seven of the Report, and noted that two incidents occurred at Lincoln Medical and Mental Health Center. In general, he explained that, the two incidents were unrelated but the same type of incident. He further explained, in pertinent part, that one incident involved a prescription given to the wrong patient, which occurred in the Pain Management Department, and a different incident occurred in the Emergency Department where a prescription was given to the wrong patient, both of which resulted in a breach in protected health information. In summary, Mr. McNulty commented that with the new electronic prescription law, the chances of incidents of this nature happening again in the future was slim. He further commented that this was the first time he had seen this happen at any facility.

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

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

Mr. McNulty moved along to Section III on page eight of the Report - *Compliance Reports for the First Quarter of 2016*. Mr. McNulty stated that the OCC received 98 compliance complaints during the first quarter. One of those complaints, he explained, was a Priority A complaint, which means a complaint that is of a very serious nature. He alerted the Committee that this complaint would be discussed in executive session because it involved an ongoing investigation.

Mr. McNulty continued onto page 11 of the Report and discussed the actions that have been taken in Health and Home Care to reduce the risk of falsification of records. Mr. McNulty called the Chief Nursing Officer of the System, Lauren Johnston, to discuss this matter. Before Ms. Johnston discussed said matter, Mr. McNulty explained that, by way of background, the System has a Compliance Committee that focuses on Home Care, and at the Compliance Committee identified as part of the corporate-wide risk identification process the potential risk of individuals falsifying

records. Mr. McNulty informed the Committee that Ms. Johnston would talk about the different strategies that have been taken in Home Care to reduce that risk.

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

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

Mr. McNulty noted for the record, in summary, that the incident discussed is one of the Priority A reports that would be discussed in executive session.

Mr. McNulty continued with Section V, *Compliance Training*, on page 12 of the Report. In general, he stated that the Office of Corporate Compliance had made available compliance training System-wide to the entire members of the workforce including the following:

- Physicians;
- Healthcare Professionals;
- Group 11 employees; and
- Members of the Board of Directors.

Mr. McNulty continued by stating that: (i) 13 of the 16 members of the Board of Directors had completed compliance training; and (ii) seven of the nine designee members had completed the compliance training. Mr. McNulty then moved forward by discussing the training status of System healthcare providers, who he explained, in sum and substance, is any individual who is licensed under Title VIII of Education Law - such as nurses, occupational therapists, and respiratory therapists. He elaborated that 16,000 out of the 18,000 workforce members [in this category] were trained for 90 percent System-wide. With regard to the training of physicians, he stated, in summary, that 4,700 out of 5,300 of the physicians were trained amounting to 89 percent System-wide. He then moved on to discuss General workforce training, which he explained was the System's group 11 employees. In summary, he stated that 5,000 out of 7,000 general workforce members were trained. In sum and substance, he explained to the Committee that the general workforce training module was just implemented in November. In general, he informed the board that the general workforce completion rate was 71 percent and the efforts are being made to push this training forward. He informed the Committee that he reached out to all the hospital CEOs to make sure that that number goes up.

Mr. McNulty then turned to page 13 of the Report and provided an update on *DSRIP/OneCity Health Compliance Activities*. He informed the Committee that the DSRIP/OneCity Health Compliance Committee convened in May and was chaired by him and Dr. Jenkins, who is the executive director of OneCity Health. In summary, he informed the Committee that the DSRIP Compliance Committee included Ms. Johnston, Dr. Wilson, and Mr. Russo. In sum and substance, he advised the Committee that the DSRIP compliance committee discussed DSRIP compliance training. In general, Mr. McNulty informed the Committee that Greater New York Hospitals Association made training available that it developed through its membership so that DSRIP partners who do not have compliance programs in place could

utilize that training. He further advised the Committee that the System/OneCity Health has taken that training and supplemented the same. He advised the Committee that the training will be made available to those DSRIP partners that do not have a compliance program in place.

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

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

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

Mr. McNulty moved on a discussed the DSRIP compliance line. In sum and substance, he explained to the Committee that, although the System currently has a compliance line, the DSRIP committee agreed that it would be better to separate the DSRIP compliance line from the NYC Health + Hospitals compliance line so DSRIP partners could access a specific number and not the NYC Health + Hospitals compliance number. He stated, in summary, that this separate line would be put into place.

Mr. McNulty then continued his report on the bottom of page 13, Section VII, by providing an update of *HHC ACO Compliance Activities*. He advised the Committee that CMS had granted the HHC ACO a three-year extension of participation in the Medicare Shared Savings Program. He alerted the Committee that the quality indicators had increased in 2016 from 33 in 2015 to 34 in 2016.

Mr. McNulty moved on to page 14 of the Report and discussed the ACO compliance plan. He stated that the regulations call for the compliance plan being regularly reviewed and updated or periodically reviewed and updated. He informed the Committee that the process of updating the compliance plan had commenced and would be presented to the Audit Committee in September. Mr. McNulty then reminded the Committee that he previously reported that there were corrective action plans in place to remediate the deficiencies of previously reported quality measures that were reported to CMS. He advised the Committee that it was reported to him that those measures and remediation are on track. Mr. McNulty closed this topic by announcing that, with respect to the participating providers, the HHC ACO has expanded to include the Community Healthcare Network, which is a FQHC and the first non-affiliated participating providers in the ACO.

Mr. McNulty continued onto Section VIII of the Report, *The United States Department of Justice Yates Memorandum*. In September 2015, he stated, the Deputy Attorney General Sally Quillian Yates issued a memorandum, and the subject of the memorandum was the individual accountability for corporate wrongdoing. The memo, he explained in pertinent part, covered the following key points:

- Corporations must reveal all relevant facts relating to responsible individuals to the Department of Justice to be eligible for cooperation credit;
- Both criminal and civil investigations should focus on individual wrongdoers as opposed to the corporation itself;
- It is expected that criminal and civil attorneys shall establish an open channel of communication, which allows the government to better understand each individual case and determine available remedies;
- Culpable individuals may not be released from their respective liability; and

- An individual wrongdoer's ability to pay should not be a factor into whether suit is brought against that individual.

Mr. McNulty continued by posing the following question: What is the significance to board of oversight responsibilities? Mr. McNulty answered that, generally, the Board should be aware that the Yates memo states that absent extraordinary circumstances the Department of Justice will generally not release culpable individuals from civil or criminal liability when resolving a matter with a corporation. He further stated that, it is the understanding of the Office of Corporate Compliance that this reflects a change from prior practice when releases of a corporation's officials, agents and employees may have been more routinely included in settlement agreements with the Department of Justice. He closed his discussion of this topic by stating that Senior Vice President and General Counsel, Mr. Russo, would discuss any questions regarding the Yates Memo during executive session.

Mr. McNulty continued by discussing Section IX of the Report - *The Development of Written Policies and Procedures*. In sum and substance, Mr. McNulty reminded the Committee that he had previously reported several times that the development of written policies and procedures for the following system-wide compliance risk areas were being developed:

- Mandatory Reporting and Overpayments;
- Excluded Provider Screening;
- Overview of the Civil Monetary Penalties Law; and
- The Prohibition of Acts that Constitute Criminal Healthcare Fraud;
- Overview of Stark Law and Anti-Kickback Statute and the prohibition of improper business arrangements and referrals and;
- Overview of the False Claims Act and the prohibition of the submission of false claims.

He stated, in summary, that the aforementioned operating procedures, were: (i) in the process of being finalized; (ii) being checked for grammar; (iii) under the review of outside counsel; and (iv) the majority of these operating procedures were expected to be ready by the end of June. Mr. McNulty then stated that the Stark and Anti-Kickback is a very complicated procedure, so we'll probably have that in July, hopefully by the end of July. In summary, he added that a plan for education with respect to these operating procedures would be undertaken to make sure there's a plain language version for each of the same.

Mr. McNulty then discussed Sections X and XI of the Report. He informed the Committee that the OCC met with the Gotham Health FQHC Board of Directors in April and in May of 2016. In sum and substance, he explained that in April the OCC met at the Segundo Ruiz Belvis Diagnostic and Treatment Center at which time compliance training was provided to all members of the Gotham Board of Directors. He told the Committee that the OCC provided an overview of the NYC Health + Hospitals and Gotham FQHC co-applicant agreement, a general overview of compliance and the importance of board member compliance training and an overview of fraud, waste and abuse.

Mr. McNulty then continued by discussing his meeting in May of 2016 with the compliance committee of the Gotham Board. He advised the Committee that the compliance committee of the Gotham Board has adopted the NYC Health + Hospitals Principles of Professional Conduct ("POPC") by official resolution. He added that the full board of Gotham is expected to adopt the POPC June of 2016.

Moving onto item number XII of the Report, Mr. McNulty informed the Committee that the Guide to Compliance at NYC Health + Hospitals (the "Guide") was revised. The Guide, he elaborated, covers all areas of fraud, waste and abuse, workplace violence and safety, human-subject research, and an overview of all the policies that the System has in place. Mr. McNulty remarked that a full presentation will be made before the full Board of Directors in July at the Board of Directors meeting.

Mr. McNulty continued on to Section XIII of the Report and discussed an item that was previously reported Committee - *The Medicare Claims Denials Received from the National Governmental Services*. Mr. McNulty informed the Committee that the National Governmental Services ("NGS") is the Medicare subcontractor that evaluates Medicare claims throughout the country. In summary, he explained to Committee NGS sent the OCC numerous notices on page 19 with respect to Medicare claims that were denied, and as you recall, the head of Revenue Management, Maxine Katz, came before the Audit Committee a couple months ago to talk about the different activities that have been taking place in Revenue Management to reduce the number of denials.

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

Mr. McNulty concluded his Report to the Committee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms. Youssouf asked about 76? Mr. Bukzin answered that 76 really just structures the financial reporting rules if you will, the hierarchy and gives some credence to, hey, look, there's some un-authoritative guidance out there that if you can't find your particular set of circumstances in the authoritative guidance, maybe use some analogies and look to some of the non-authoritative pieces as well. It's really just structuring where to look and how to interpret and apply to generally accepted accounting principles.

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

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

Ms. Youssouf thanked KPMG and asked if there were any questions. Then started executive session.

Ms. Youssouf stated that during executive session we discussed matters that had legal advice to the Corporation. There being no further business, the meeting adjourned at 1:15 PM.

Submitted by,

Emily Youssouf
Audit Committee Chair



**AUDIT COMMITTEE OF THE
NYC HEALTH + HOSPITALS
BOARD OF DIRECTORS**

**Corporate Compliance Report
September 8, 2016**

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I. Monitoring of Excluded Providers

Overview

- 1) Federal regulations provide that “no payment will be made by Medicare, Medicaid or any of the other Federal health care programs (e.g., Medicaid, Medicare) for any item or service furnished . . . by an excluded individual or entity, or at the medical direction or on the prescription of a physician or other authorized individual who is excluded when the person furnishing such item or service knew or had reason to know of the exclusion.”¹
- 2) Similarly, New York State regulations also provide that “no payments will be made to, or on behalf of, any person for the medical care, services or supplies furnished by or under the supervision of the person during a period of exclusion” from participation in the Medicaid program.²
- 3) Further, to maintain an active enrollment status in the Medicare program, NYC Health + Hospitals must certify that it does not employ or contract with individuals or entities that are “excluded from participation in any Federal health care programs for the provision of items and services covered under the programs”³
- 4) To adhere to these regulations, and consistent with the recommendations of the NYS Office of the Medicaid Inspector General (“OMIG”)⁴ and the United States Department of Health and Human Services Office of the Inspector General (“OIG”), each month the Office of Corporate Compliance (“OCC”) confirms that none of the NYC Health + Hospitals’ (the “System”) workforce members (e.g., employees, board members, affiliates, personnel, volunteers, and medical staff members), vendors, and DSRIP partners are excluded from participation in Federal healthcare program such as Medicaid and Medicare.

¹ Scope and Effect of Exclusion 42 CFR § 1001.1901 (b); *see also* 42 CFR § 1002 (the authority of State agencies to exclude on their own initiative, regardless of whether the OIG has excluded an individual or entity).

² *See* 18 NYCRR 515.5; *see also* 18 NYCRR 515.2(b) (7) (includes employment of and submitting a claim for services rendered by a suspended or disqualified from participation in the program as an unacceptable practice under the medical assistance program and conduct which constitutes fraud or abuse.)

³ *See* 42 CFR § 424.516 (a) (3); *see also* 42 CFR § 424.535(a) (2) (regarding CMS’ option to revoke enrollment and billing privileges due to exclusion from Medicare, Medicaid or any federal program). *See also* 42 USC 1320c-5 (Regarding obligations of health care practitioners and providers and the Secretary of Health and Human Services’ right to exclude a person or entity for failing to meet the obligations.)

⁴ DOH Medicaid Update April 2010, Vol.26, No. 6 and the NY OMIG webinar #22 OMIG Exclusion and Reinstatement Process <https://omig.ny.gov/resources/webinars/811-omig-webinar-22>, Slide 20 (Sept 2014), accessed March 29, 2016.

Exclusion and Sanction Screening Report for June 2016 through August 2016

5) Since the OCC last reported excluded provider activities at the June 2016 Audit Committee, there have been no new verified exclusions of workforce members from Federal health care programs to report.

6) Notwithstanding the above, NYC Health + Hospitals' August 2016 sanction screening uncovered the July 2016 statutory debarment of one of the System's vendors from contracting with the Department of Veterans' Affairs.⁵ The debarred vendor provides limited non-patient-related services at NYC Health + Hospitals. The debarred vendor was found to have misrepresented its status as a service-disabled veteran owned small business. This debarment has resulted in the vendor being placed on the System for Award Management's Government Services Administration's list of Excluded Parties List System. At this juncture, NYC Health + Hospitals has suspended its business with the subject vendor. The OCC is consulting with legal counsel to determine if any overpayment exists due to this exclusion.

II. Privacy Incidents and Related Reports for the Second Quarter of Calendar Year 2016 (April 1, 2016 to June 30, 2016) ("2nd Quarter of CY16")

Background

1) The Office of HIPAA Privacy and Security within the OCC is responsible for reviewing, investigating, and responding to potential and confirmed breaches of PHI.

Reportable Privacy Incidents for the Second Quarter of Calendar Year 2016 (April 1, 2016 to June 30, 2016 – hereinafter "2nd Quarter")

2) During the period of April 1, 2016 through June 30, 2016, thirty (30) complaints were entered in the ID Experts RADAR Incident Tracking System. Of the 30 complaints entered in the tracking system, twenty (20) were found after investigation to be violations of NYC Health + Hospitals HIPAA Privacy Operating Procedures; four (4) were determined to be unsubstantiated; two (2) were found not to be a violation of System HIPAA Privacy Operating Procedures; and four (4) are still under investigation.

⁵ See 38 U.S.C. 8127(g) Small business concerns owned and controlled by veterans. "Any business concern that is determined by the Secretary to have misrepresented the status of that concern as a small business concern owned and controlled by veterans or as a small business concern owned and controlled by service-disabled veterans for purposes of this subsection shall be debarred from contracting with the Department for a reasonable period of time, as determined by the Secretary." *Id.*

OFFICE OF CORPORATE COMPLIANCE

- Of the 20 incidents confirmed as violations, 9 were determined to be breaches. A total of 28 individuals were affected by the 9 confirmed breaches.

Breach Defined

3) A breach is an impermissible use, access, acquisition or disclosure (hereinafter collectively referred to as “use and/or disclosure”) under the HIPAA Privacy Rule that compromises the security and privacy of PHI maintained by the Corporation or one of its business associates.⁶

4) Pursuant to 45 CFR § 164.402 [2], the unauthorized access, acquisition, use or disclosure of PHI is presumed to be a breach unless NYC Health + Hospitals can demonstrate that there is a low probability that the PHI has been compromised based on the reasonable results of a thorough risk assessment, that is completed in good faith, of key risk factors.⁷

Factors Considered when Determining Whether a Breach has Occurred

5) Under HIPAA regulations, at a minimum the following four key factors must be considered to determine whether there is greater than a low probability that a privacy and/or security incident involving PHI has resulted in the compromise of such PHI:⁸

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the protected health information or to whom the disclosure was made;
- Whether the protected health information was actually acquired or viewed; and
- The extent to which the risk to the protected health information has been mitigated.

Reportable Breaches in the 2nd Quarter

6) As stated above, there were 9 reportable breaches in the 1st Quarter. Below is a summary of some of these breaches.

⁶ 45 CFR § 164.402 [“Breach” defined].

⁷ See 45 CFR § 164.402[2]; see also 78 Fed. Register 5565 at 5643 and 5695 [January 25, 2013]

⁸ See 45 CFR § 164.402 [2][i-iv].

- *Lincoln Medical Center - May 2016*

Incident: The incident involved a patient complaint that a NYC Health + Hospitals/Metropolitan employee accessed her NYC Health + Hospitals/Lincoln record and released her laboratory results to two unauthorized individuals. The audit of the patient's record confirmed that an unauthorized access did occur. Additionally, the employee acknowledged that she improperly accessed said record and disclosed the patient's information to two unauthorized individuals

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Breach notification was sent to the affected individual on July 1, 2016.

Mitigation: The employee was immediately suspended pending an HR conference to determine final disciplinary actions. The employee's access to the Lincoln Quadramed system was also terminated immediately.

- *Jacobi Medical Center – May 2016.*

Incident: This incident occurred when a portion of a package containing copies of a patient's medical record was lost in transit by the U.S. Postal Service. The U.S. Postal Office performed an investigation of this matter. To date, the remaining portion of the package has not been located.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach. Breach notification was sent to the affected individual on July 15, 2016.

Mitigation: The incident was caused by the mishandling of a package by the U.S. Postal Service. Notwithstanding the statutory timely reporting of this incident, facility employees were reminded to promptly report any future losses of packages containing patient information to the Privacy Officer as soon as they become aware so that an investigation can be conducted and notice may be sent out to affected individuals in a timely manner.

- *Gouverneur Health Services – May 2016.*

Incident: This incident occurred when 21 blood specimens pertaining to 19 patients were lost while in transit (via a Gouverneur courier) to Northwell Health laboratory. The Gouverneur Laboratory Department records indicate that the specimens were dispatched from the facility but department staff were unable to track the location of the specimens after dispatch. The incident was reported by Northwell Laboratory via

facsimile, which provided that the specimens were not received by Northwell. The patients were contacted and called for retesting. The facility stated that no additional billing or charges would occur due to the error.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individuals on July 11, 2016.

Mitigation: The Gouverneur Laboratory has implemented a new process to ensure that laboratory specimens remain accounted for at all times. The process includes the creation of a log book that requires laboratory staff to note when laboratory specimens have been picked up by a courier as well as a signature from the courier confirming receipt.

- *Gouverneur – March 2016.*

Incident: The incident occurred when an employee, in responding to a request from a worker's compensation insurance company for the medical records of a patient, mistakenly sent information that was not related to the injury reported to the company. The insurance company notified the patient directly about the incident but stated that they could not destroy the records as they had already been submitted to the worker's compensation board as the patient's official record. The patient, in turn, filed a complaint with Gouverneur and is currently in litigation with Health + Hospitals.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on May 16, 2016.

Mitigation: The employee who disclosed the information has been retrained on proper procedures for disclosing health information and maintaining patient confidentiality. In addition, the department has implemented a new quality assurance process to ensure that an incident such as this does not reoccur.

- *Kings County Hospital – May 2016.*

Incident: The incident occurred when an employee disclosed a patient's treatment information to a mutual acquaintance of the employee and the patient. The mother of the patient filed a complaint with the facility when she became aware of the disclosure. An investigation confirmed that the employee inappropriately discussed the fact that the patient was an inpatient of the behavioral health unit of the facility with an unauthorized individual.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on July 21, 2016.

Mitigation: Disciplinary action was taken against the employee and included retraining on HIPAA policies and procedures regarding patient confidentiality.

- *Coney Island Hospital – June 2016.*

Incident: The incident occurred when a patient mistakenly picked up another patient's discharge documents along with his own admission documents. The patient made a complaint to the facility stating that he was given the documents of another patient. Surveillance tapes of the department location showed that the patient was not handed the documents by any department staff but instead showed that he himself picked up the documents by accident.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on August 8, 2016.

Mitigation: The employees responsible for monitoring patient records were retrained on proper procedures for ensuring that the correct documents are given to the appropriate patient. In addition the discharge and admission processes has been separated so that an event such as this does not happen again.

- *Lincoln Medical Center – June 2016.*

Incident: This incident occurred when an employee accessed the record of a patient in order to obtain their personal cell phone number and attempted to contact the patient for personal reasons unrelated to the employee's job functions. The patient made a complaint to the facility and an investigation was conducted. An audit report confirmed that the employee accessed the record without authorization.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on August 8, 2016.

Mitigation: The employee who accessed the record was suspended and is pending formal disciplinary action.

- *Lincoln Medical Center – June 2016.*

Incident: The incident occurred when an employee accessed the record of a patient in order to obtain their personal cell phone number and attempted to contact the patient after the employee was no longer part of the patient’s treatment team. The patient made a complaint to the facility and an investigation was conducted. An audit report was run and concluded that the employee accessed the record without authorization after the patient had been admitted and moved from the ER.

Breach Determination: Based upon the facts found during the investigation, the incident was determined to be a breach and notification was sent to the affected individual on August 19, 2016.

Mitigation: The employee who accessed the record was immediately placed on administrative leave. All staff within the unit were retrained on the importance of complying with HIPAA privacy rules and Health + Hospitals standards of professionalism.

III. Privacy and Security Awareness Training at NYC Health + Hospitals Facilities and Program Units

Overview

1) Pursuant to the HIPAA Security Awareness and Training’ Standard (45 CFR §164.308(a)(5)), the training requirements under HIPAA’s administrative requirements (45 CFR § 164.530(b)) and NYC Health + Hospitals Operating Procedure (“OP”) 250-09 and 240-16, the OCC has implemented an education and outreach program throughout the System to ensure System-wide compliance with HIPAA Security and Privacy Rules. This is complementary to the mandatory computer-based HIPAA training and the mandatory periodic compliance training assigned to all System workforce members and designated workforce members, respectively.

2) The outreach program includes a combination of: (i) in-person HIPAA presentations by the Senior Assistant Vice President/Chief Corporate Compliance Officer (“CCO”), the Corporate HIPAA Privacy and Security Officer (“CPSO”), and their key staff members to the various System facilities; (ii) site walkthroughs; and (iii) focused group education sessions.

Live HIPAA Educational Awareness Sessions

3) The OCC has conducted numerous HIPAA awareness presentations at the various System facility Chiefs of Medical Services meetings, town hall meetings, and/or administrative departmental meetings.

Thus far, the OCC has presented at the following System facilities:

- NYC Health + Hospitals/Coney
- NYC Health + Hospitals/Lincoln
- NYC Health + Hospitals Harlem
- NYC Health + Hospitals Bellevue
- NYC Health + Hospitals/Metropolitan
- NYC Health + Hospitals/Coler-Carter (joint meeting held at the Carter site)
- NYC Health + Hospitals/Queens
- NYC Health + Hospitals/OneCity Health (DSRIP privacy matters discussed)
- NYC Health + Hospitals/ Home Health

4) The scope of the presentation initially included HIPAA and the major NYS laws that govern patient confidentiality and had several slides on “Do’s and Don’ts” with regard to privacy and data security activities. The presentation also had a breakdown of the fines levied by the Office of Civil Rights (“OCR”) of the Department of Health and Human Services (“HHS”) on numerous healthcare organizations across the nation that were the source of privacy and security violations and/or deficiencies. The presentation was recently expanded to provide a greater emphasis on New York State privacy laws in response to the various questions that were raised during the presentations from the facility staff.

Additional Walkthroughs

5) The OCC has instructed the System’s Facility Privacy Officers (“FPO”) to conduct regular and thorough site walkthroughs of their respective facilities. The walkthroughs include physically traversing the sites to check for any HIPAA privacy and security gaps. The assigned walkthroughs include, for example, the following:

- verification that facility HIPAA Notice of Privacy Practices signs are appropriately placed in admitting and other patient visiting areas;
- verification that computer workstations at heavily trafficked areas, such as nursing stations, do not have any unlocked or otherwise unsecure computers;
- verification that paper patient records are secured appropriately in the medical record departments or other limited authorized secured areas of the facility;

6) Additionally, during his most recent presentation at the Coler-Carter facility meeting, the CCO along with his staff and the FPO conducted an additional walkthrough, which included a visit to the Carter medical records area, records storage sites, and a several internal departments. During the visit to the departments, the CCO met with the attending medical staff and other health professionals and discussed, among other things: (i) HIPAA privacy issues; and (ii) details regarding the Privacy Program operation (e.g., contact information of relevant privacy personnel).

Summary

7) The collective efforts to ensure that HIPAA awareness is disseminated on the ground level in conjunction with the NYC Health + Hospitals Data Loss Prevention program (“DLP”) are ongoing and appear to be yielding positive results. More particularly, it should be noted that, many of the questions raised by the staff at the HIPAA outreach meetings focused on process as it relates to handling protected health information and the appropriate manner in which one may transmit or store protected health information when carrying out his/her job functions. As such, the OCC is pleased to report that, based on the scope of the questions raised during the HIPAA outreach efforts, the System is on the right track toward maintaining a strong HIPAA compliance and data security program.

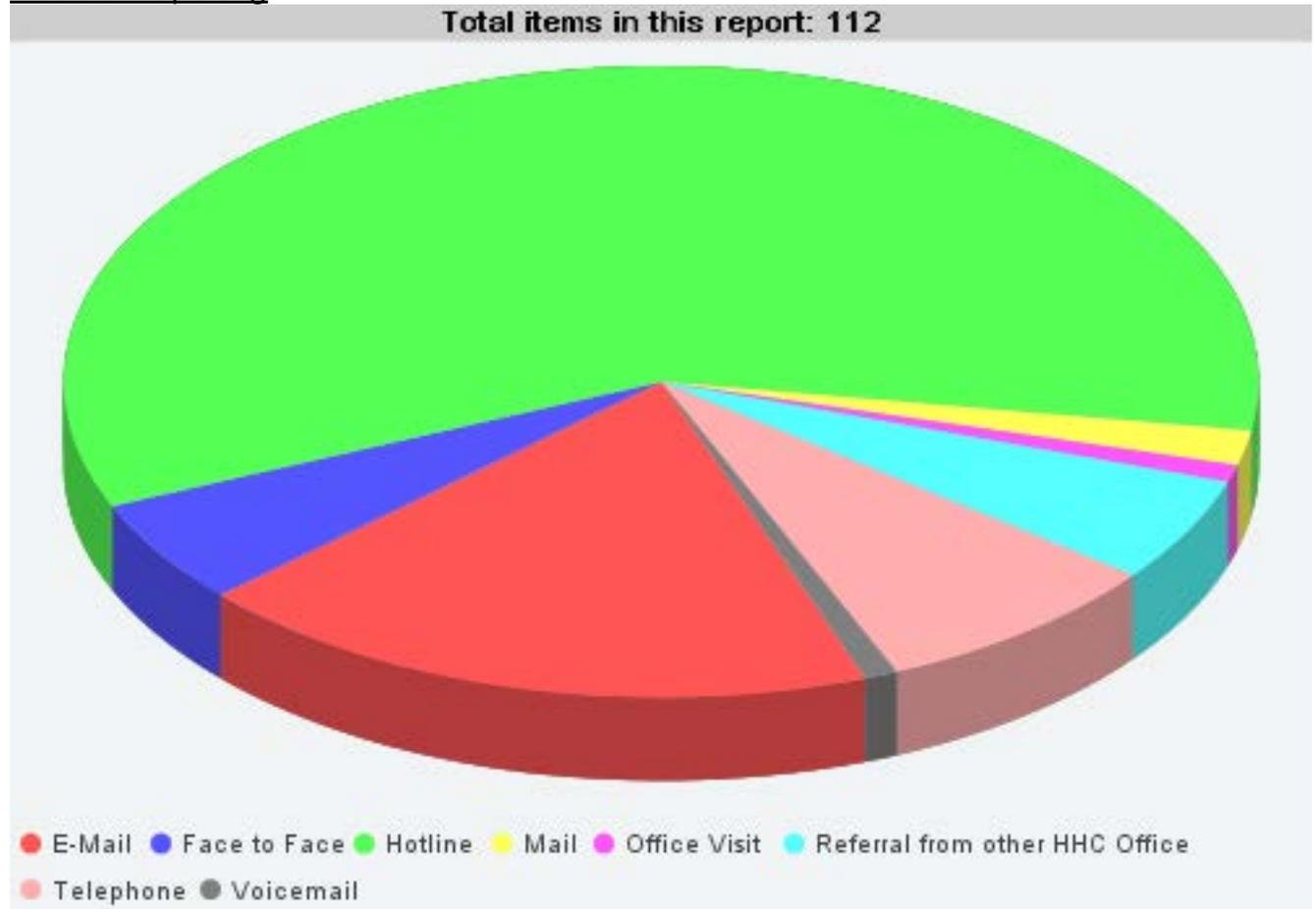
IV. Compliance Reports for the Second Quarter of Calendar Year 2016 (April 1, 2016 to June 30, 2016)(“2nd Quarter of CY16”)

Summary of Reports

1) For the 2nd quarter CY2016 (April 1, 2016 to June 30, 2016), there were 112 compliance-based reports of which none (0) were classified as a Priority “A” report,⁹ 49 (or 43.8%) were classified as Priority “B” reports, and 63 (or 56.2%) were classified as Priority “C” reports. For purposes here, the term “reports” means compliance-based inquiries and compliance-based complaints. Of the 112 reports received during this period, 66 (or 58.9%) were compliance complaints received on the OCC’s anonymous toll-free compliance hotline.

⁹ There are three (3) different report categories: (i) Priority “A” reports - matters that require immediate review and/or action due to an allegation of immediate threat to a person, property or environment; (ii) Priority “B” reports – matters of a time-sensitive nature that may require prompt review and/or action; and (iii) Priority “C” reports – matters that do not require immediate action.

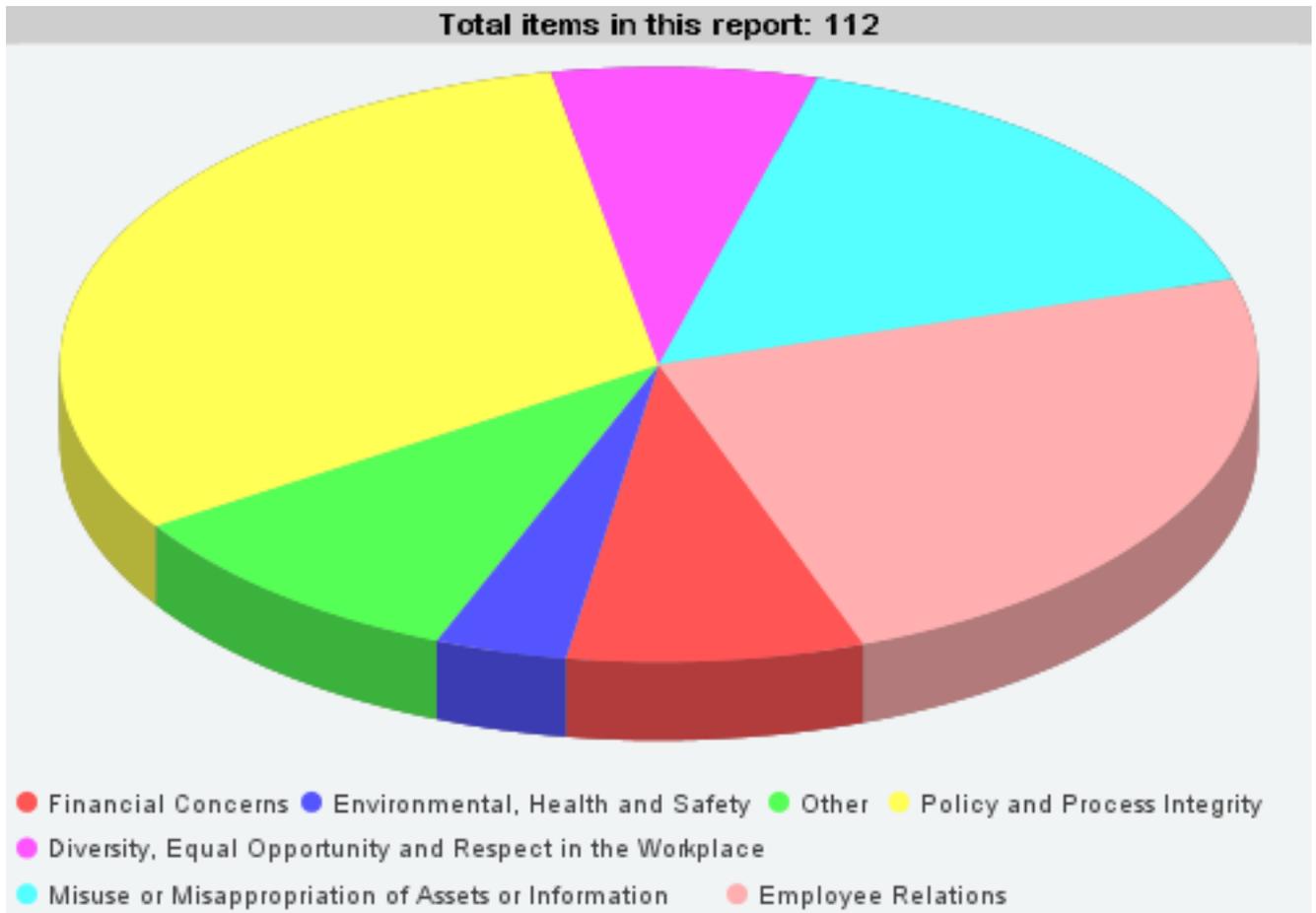
Mode of Reporting



2) Below is a summary of how the OCC received the 112 CY2016 2nd quarter reports:

- a. 66 (58.9%) were received on the Help Line;
- b. 21 (18.8%) were received via E-mail;
- c. 9 (8%) were received via Telephone;
- d. 6 (5.4%) were received via Face-to-Face;
- e. 6 (5.4%) were received via Interoffice Mail (referral from other System Office);
- f. 2 (1.8%) were received via Mail;
- g. 1 (0.9%) was received via Office Visit;
- h. 1 (0.9%) was received via Other Means.

Allegation Class Analysis



3) The breakdown of the allegation classes of the 112 reports received in the second quarter of CY 2016 is as follows:

- a. 18 (16.1%) Patient Care;
- b. 12 (10.7%) Inappropriate Behavior;
- c. 10 (8.9%) Unfair Employment Practices;
- d. 9 (8%) Falsification or Destruction of Information;
- e. 8 (7.1%) Billing and Coding Issues;
- f. 6 (5.4%) Accounting and Auditing Practices;
- g. 6 (5.4%) Other;
- h. 5 (4.5%) Conflict of Interest – Personal;

OFFICE OF CORPORATE COMPLIANCE

- i. 5 (4.5%) Disclosure of Confidential Health Information – HIPAA;
- j. 5 (4.5%) Guidance Request;
- k. 4 (3.6%) Customer Relations;
- l. 4 (3.6%) Discrimination;
- m. 4 (3.6%) Harassment – Workplace;
- n. 4 (3.6%) Misuse of Resources;
- o. 2 (1.8%) Conflict of Interest – Financial;
- p. 2 (1.8%) Theft;
- q. 2 (1.8%) Threats and Physical Violence;
- r. 1 (0.9%) Environment, Health and Safety;
- s. 1 (0.9%) Fraud or Embezzlement;
- t. 1 (0.9%) Gifts, Bribes and Kickbacks;
- u. 1 (0.9%) Promotion and Advertising – Pharmaceutical;
- v. 1 (0.9%) Substance Abuse;
- w. 1 (0.9%) Unauthorized Discounts or Credit.

Review of Priority “A” Report

As noted above, there were no Priority “A” reports in the 2nd quarter.

Review of Priority “B” and “C” Reports

Out of the 112 Priority “B” and “C” compliance reports combined, there was one (1) Priority “B” case and one (1) Priority “C” case that due to the nature of allegations reported, warrant further discussion. Because these cases are ongoing investigations, they will be discussed briefly in Executive Session.

V. Compliance Training

Overview:

1) Pursuant to internal training policies, Members of the NYC Health + Hospitals Board of Directors, all healthcare professionals (“HCP”), physicians (PHYS) , and Group 11 employees and designated Group 12 employees (“General Workforce” or “GWF”), must undergo computer-based (or live) compliance training on fraud, waste and abuse and other compliance-related matters and topics.

Compliance Training Status for NYC Health + Hospitals Board of Directors

2) As of August 29, 2016, the compliance training status for the Board of Directors BOD is as follows:

- Members of the BOD: 81% (13/16)
- Designee Members of the BOD: 78% (7/9)
- Total: 80% (20/25)

Compliance Training Status for HCP, PHYS, and GWF

3) As of August 24, 2016, the compliance training completion status is as follows:

- HCP: 94% (16,492/17,514)
- PHYS: 94% (4,546/4,820)
- GWF: 87% (5,948/6,822)

VI. Update on DSRIP/OneCity Health Compliance Activities

OneCity Health Training on DSRIP HIPAA Privacy and Security Matters

1) On July 21, 2016, the Office of Corporate Compliance (“OCC”) provided a PowerPoint presentation on DSRIP-related HIPAA Privacy and Security matters to the management and administrative staff of OneCity Health. The topics covered included the following:

- Overview of Federal and New York State (“NYS”) Privacy and Data Security laws including the Health Insurance Portability and Accountability Act (“HIPAA”) including, without limitation, the three key HIPAA rules: Privacy Rule, Security Rule and Enforcement Rule;
- The oversight role of the OCC with respect to HIPAA Privacy and Security matters;
- The data breach notification requirements (e.g., notification to affected patients, HHS Office of Civil Rights and other regulators, and the media) under the Health Information Technology for Economic and Clinical Health Act (“HITECH”) regulations;
- The HITECH requirement that Business Associates (“BAs”) comply with HIPAA privacy and security laws and implementing regulations;

- Examples of recent large fines imposed for HIPAA privacy breaches;
- List of “top” risks that affect HIPAA Privacy and Security compliance;
- NYC Health + Hospitals’ Data Transmission Security Standards;
- Federal regulations that govern the confidentiality of patient substance abuse records; and
- Patient rights under NYS laws regarding confidentiality of HIV, mental disability, and genetic predisposition medical records.

NYS Department of Health (“DOH”) “Guidance Document: Privacy and Data Sharing within DSRIP” (June 2016)

2) During the July 21, 2016 DSRIP/OneCity Health Training on HIPAA Privacy and Security matters, the OCC also presented information regarding the NYS DOH’s June 2016 “Guidance Document: Privacy and Data Sharing within DSRIP” which addresses the requirements for data sharing of PHI from different sources within Performing Provider Systems (“PPS”) and the various different “data streams” relevant to DSRIP.

DSRIP/OneCity Health Performance Requirements for DSRIP Year One

3) DSRIP/OneCity Health is currently in the second quarter of DSRIP Year Two. For DSRIP Year One, which ended on March 31, 2016, DSRIP/OneCity Health met 99.9% of its commitments and earned \$185 million for DSRIP Year One.

Next DSRIP/OneCity Health Compliance Committee Meeting

4) At the next DSRIP/OneCity Health Compliance Committee meeting scheduled for September 2016, the following topics will be on the agenda:

- Discussion of the recommendation by the OneCity Health Board of Directors that it retain an independent auditor;
- Final approval of the revisions to the December 2015 DSRIP/OneCity Health Compliance Plan; and
- Final approval of the DSRIP/OneCity Health compliance training slides.

VII. Update HHC ACO, Inc. Compliance Activities

A. *Quality Performance Results*

1) Each Medicare Shared Savings Program (“MSSP”) quality measure benchmark has a 30th percentile minimum performance threshold. The 33 quality measures are divided into four domains: Patient/Caregiver Experience (8), Care Coordination/Patient Safety (10), Preventive Health (8), and At Risk Population (7). CMS expects ACOs to exceed the minimum performance threshold on 70% of the performance measures within each of these four domains.

Quality Performance Results for 2014 Compared to 2015

2014 Quality Performance Results

2) As previously reported to the Audit Committee, in calendar year 2014, the NYC Health + Hospitals/HHC ACO Inc., (hereinafter the “ACO”) did not exceed the minimum threshold on four of the 33 measures, including three from the Care Coordination/Patient Safety domain: Ambulatory Care Sensitive Admissions for Chronic Obstructive Pulmonary Disease (“COPD”) or Asthma; Ambulatory Care Sensitive Admissions for Heart Failure; and Percent of PCPs who qualified for EHR Incentive Payment (the only double-weighted performance measure). Because these cluster in a single domain, which had 6 performance measures in total, ACO met the performance threshold for 2 of 6 (33%) measures in that domain, short of CMS' expectation of 70%. In the other domains, the ACO performance greatly exceeded these thresholds.

3) As a result, ACO received a warning letter from CMS, which advised that the ACO did not currently meet MSSP minimum attainment requirements. In the letter, CMS recommended that the ACO ensure that policy and process changes to improve performance were put in place.

2015 Quality Performance Results

4) NYC Health + Hospitals ACO's (“ACO”) overall calendar year 2015 quality performance score was 94%, up from 76% in 2014. This increase was more than double the quality performance improvement of any other ACO in New York State.

5) In 2015, the percentage of PCPs who qualified for EHR Incentive Payment increased from 16.4% to 100%, a 509% improvement. COPD/Asthma admission scores improved from 2.4 to 1.9, a 22% improvement and Heart Failure admission scores improved from 1.9 to 1.6, a 15 percent improvement.

6) Notwithstanding the big improvement in the ratio of observed discharges to expected discharges for patients with a diagnosis of COPD/Asthma and Heart Failure, both performance measures failed to meet the 30th percentile minimum performance threshold. Accordingly, ACO met 4 of the 6 (66%) minimum performance measures in the Care Coordination/Patient Safety domain, just short of CMS' expectation of 70%. CMS has not communicated to the ACO concerning this slight shortfall.

Cost Savings

7) ACO demonstrated \$13 million in cost savings for 2105, resulting in a shared savings payable to the ACO of \$6 million. This is the second highest shared savings amount payable to an ACO in New York State.

B. Compliance Oversight Activities

8) The ACO Compliance Committee, which is co-chaired by System's Senior Vice President and Chief Transformation Officer/Chief Executive Officer of the ACO Ross Wilson, M.D., and the System's Senior Assistant Vice President and Chief Corporate Compliance Officer/ACO Chief Compliance Officer Wayne A. McNulty, Esq., will meet in late September 2016 or early October 2016 to address compliance issues related to the ACO operation including, without limitation, any identified compliance risks or vulnerabilities associated with the ACO operation.

C. The ACO Compliance Plan

9) As required by federal regulation, the current ACO Compliance Plan is in the process of being updated and will be presented to the ACO Compliance Committee at its next meeting in September 2016 or October 2016. The finalized compliance plan will be included in the December 2016 Audit Committee of the NYC Health + Hospitals Board of Directors Corporate Compliance Report.

VIII. Update on Gotham Health FQHC, Inc., Compliance Activities

A. HRSA Audit of NYC Health + Hospitals/Cumberland FQHC

Overview

- 1) The Health Resources and Services Administration ("HRSA"), an agency of the U.S. Department of Health and Human Services, conducted an audit of the Cumberland FQHC during the period July 26, 2016 through July 28, 2016. Although the findings listed below stem directly from the audit at the Cumberland FQHC, many of the findings would be applicable

to the other facilities in NYC Health + Hospitals/Gotham FQHC, Inc. (“hereinafter “NYC Health + Hospitals/Gotham” or “Gotham”).

Audit Findings

- 2) The following findings, which are preliminary in nature and subject to the final written report of HRSA and NYC Health + Hospitals/Gotham’s management response to the same, were verbally presented to the Gotham Staff and Gotham Board Members at the conclusion of the audit:
- Of the 19 Key Health Center Requirements under HRSA regulations, HRSA concluded that 8 Requirements were not completely satisfied. However, HRSA was generally satisfied with the overall status of Cumberland’s compliance with the 19 Requirements. The 8 Requirements that were not in full compliance were as follows:
 - **Requirement # 3: Staffing Requirement:** HRSA raised some issues with the credentialing of non-professional staff. HRSA stated that there should be a policy that sets forth how the nurses, technicians, etc., are credentialed. The OCC will work with NYC Health + Hospitals/Gotham Health management to remediate this issue.
 - **Requirement #5: After Hours Coverage:** The after-hours phone at Woodhull did not pick up or roll over to voice mail when HRSA had called several times and let it ring over 17 times. It was subsequently verified that there was an information technology issue which is being addressed.
 - **Requirement # 6: Hospital Admitting Privileges and Continuum of Care:** HRSA stated that it required a policy and/or contract requiring that the affiliated medical staff is responsible for patient continuity of care, but HRSA was unable to verify the existence of such language in NYC Health + Hospitals/Gotham Health policies or affiliation agreements. The OCC and Office of Legal Affairs will work with NYC Health + Hospitals/Gotham Health management to remediate this issue.
 - **Requirement # 7: Sliding Fee Discounts:** HRSA found that Gotham Health was not strictly following the Federal Sliding Fee Scale. The Gotham Health patient fees were

generally lower than the federal patient fees. HRSA also found that the Gotham Health sliding fee scale had different breakdowns of poverty levels for determining patient fees than the federal guidelines. Gotham Health management has agreed to adopt the Federal Sliding Fee Schedule. HRSA also noted that the Gotham Health Fee Scale restricted access to residents of New York City or specific contiguous counties (e.g., Westchester County and Nassau). HRSA indicated that could not be done using federal funding. Gotham Health has amended its bylaws to remove said restrictions.

- **Requirement # 13: Billing and Collections:** HRSA identified concerns related to the waiver of certain patient fees which was not in compliance with the Billing and Collections Requirement.
- **Requirement 16: Scope of Project:** HRSA found that there were some deficiencies in Gotham Health's maintenance of its funded scope of project (sites, services, service area, target population and providers) including the hiring of clinical staff at the Cumberland clinics presented on Form 5 A. These services had already been implemented but did not appear on the form as completed. The Forms 5A are being remediated.
- **Requirement # 17: Board Authority:** The same issue as Requirement #7 above, regarding the Gotham Health Fee Scale restricting access to residents of New York City or specific contiguous counties. Gotham Health has amended its bylaws to remove said restrictions.
- **Requirement #18. Board Composition:** The Gotham Board did not meeting the HRSA requirement that a majority of the Gotham Health board members must utilize Gotham facilities for care and treatment purposes.
- HRSA raised an issue under **Requirement #9 - Key Management Staff** - with respect to the Gotham Health CEO and Chief Medical Officer being the same individual. HRSA did not issue a finding and will allow him to continue to hold both positions but indicated that it would further consider this issue as Gotham continues to grow.