

BOARD OF DIRECTORS MEETING
THURSDAY, APRIL 19, 2012

A-G-E-N-D-A

<p>Call to Order - 4 pm</p> <p>1. Adoption of Minutes: March 22, 2012</p> <p><u>Chairman's Report</u></p> <p><u>President's Report</u></p> <p> >>Action Items<<</p> <p><u>Information Item</u></p> <p> > <i>icis</i> Project Update</p> <p><u>Committee Reports</u></p> <p> > Audit</p> <p> > Finance</p> <p> > Governance</p> <p> > Equal Employment Opportunity</p> <p> > Medical & Professional Affairs / Information Technology</p> <p> > Strategic Planning</p> <p><u>Facility Governing Body / Executive Session</u></p> <p> > Elmhurst Hospital Center</p> <p> > Queens Hospital Center</p> <p> >>Old Business<<</p> <p> >>New Business<<</p> <p>Adjournment</p>	<p>Dr. Stocker</p> <p>Dr. Stocker</p> <p>Mr. Aviles</p> <p>Mr. Bert Robles, Senior VP - Information Technology Services</p> <p>Ms. Youssouf Mr. Rosen Rev. Lacey Mrs. Bolus Dr. Stocker Mrs. Bolus</p> <p>Dr. Stocker</p>
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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (hereinafter the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 22nd of March 2012 at 4:00 P.M. New York time, 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. Michael A. Stocker
Rev. Diane E. Lacey
Mr. Alan D. Aviles
Josephine Bolus, R.N.
Dr. Vincent Calamia
Ms. Anna Kril
Mr. Robert F. Nolan
Mr. Bernard Rosen
Ms. Emily A. Youssouf

Ian Hartman-O'Connell was in attendance representing Deputy Mayor Linda Gibbs, and Linda Hacker was in attendance representing Commissioner Robert Doar, each in a voting capacity. Dr. Stocker chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on February 29, 2012 were presented to the Board. Then, on motion made by Dr. Stocker and duly seconded, the Board unanimously adopted the minutes.

- 1. RESOLVED**, that the minutes of the meeting of the Board of Directors held on February 29, 2012, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

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

Dr. Stocker updated the Board on approved and pending Vendex and will report on the status of pending Vendex at the next Board meeting.

Dr. Stocker informed the Board that the survey by the Joint Commission on the Accreditation of Healthcare Organizations of Coney Island Hospital went exceptionally well.

PRESIDENT'S REPORT

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

Kenneth Raske, President of Greater New York Hospital Association, reported to the Board on the State of New York's budget and how it affects healthcare.

ACTION ITEMS

RESOLUTION

2. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable license agreement with **Con Edison Company of New York, Inc.** for use and occupancy of space for the operation of a radio communication system at **Harlem Hospital Center**.

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

RESOLUTION

3. Authorizing the Executive Director of **MetroPlus Health Plan, Inc.**, to negotiate and execute a contract with **Healthplex, Inc.**, to provide administration of **dental services** for a term of three years (3) years with two (2) options to renew for one (1) year each, solely exercisable by MetroPlus, for an amount not to exceed \$4.9 million per year.

Arnold Saperstein, M.D., Executive Director of MetroPlus, explained that in January 2012, New York State mandated that dental services for Medicaid recipients be moved into managed care plans. MetroPlus only covered dental costs for Child Health Plus, Family Health Plus, and Medicare Advantage members previously and are now in the position to transfer an additional 350,000 individuals into a dental benefit by July 2012 with as little disruption as possible. He stated that Healthplex, Inc. had a lower disruption rate than the incumbent vendor.

Mr. Rosen moved the adoption of the resolution which was duly seconded and unanimously adopted by the Board.

BOARD COMMITTEE AND SUBSIDIARY BOARD REPORTS

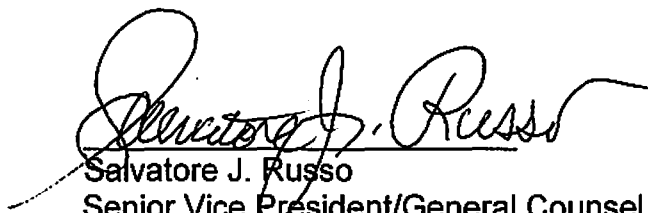
Attached hereto is a compilation of reports of the HHC Board Committees and Subsidiary Boards that have been convened since the last meeting of the Board of Directors. The reports were received by the Chairman at the Board meeting.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Stocker reported that the Board of Directors as the governing body of Metropolitan Hospital Center and Bellevue Hospital Center reviewed, discussed and adopted each of the facility's reports presented.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:15 P.M.



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

COMMITTEE REPORTS

Capital Committee – March 1, 2012 As reported by Ms. Emily Youssouf

Assistant Vice President's Report

Alfonso Pistone, Assistant Vice President, Office of Facilities Development, advised that there were two action items scheduled for consideration. The first, a request for work order funding to permit the Dormitory Authority to begin investigation, reporting and design phase engineering services to address Local Law 11 conditions at Woodhull Medical and Mental Health Center, and the second, seeking approval for the renewal of an existing license agreement with Consolidated Edison (Con Ed) to continue operation of a radio communications system at Harlem Hospital Center.

Mr. Pistone noted that there were four information items on the agenda; a status update on the major modernization project at Harlem Hospital Center, a brief update on the efforts to secure additional parking for the Goldwater North facility, a report on Minority, and Women Business Enterprise (MWBE) statistics relating to the Harlem Hospital Center major modernization project, and, as a follow up to a request at the February 9, 2012, Capital Committee meeting, a reconciliation of the costs associated with the Goldwater North project. Mr. Pistone explained that a supporting document (Attachment A), outlining the Goldwater North reconciliation, represents a collaboration between HHC and the Economic Development Corporation (EDC) to memorialize the significant changes in cost and scope from the initial Certificate of Need (CON) application to the most recent CON application and budget for the project.

Lastly, Mr. Pistone advised that there were two projects included in the Project Status Reports (PSRs) that were reported as in delay by six (6) months or more. He explained that updated information had been added to the PSRs to reflect any changes or progress on those projects.

This concluded the Assistant Vice President's Report.

Dr. Stocker advised those in attendance that Antonio Martin, Executive Vice President, would be representing Alan Aviles, President, as a voting member of the Committee.

Josephine Bolus, RN, requested that at the next Capital Committee meeting a brief update be provided on the Woodhull Clinic project that she had previously been concerned with. Mr. Pistone said that would be provided at the April 5, 2012, meeting.

Prior to addressing the action items Dr. Stocker requested that the Goldwater North project update by the Economic Development Corporation (EDC), an information item, be discussed. Dr. Stocker advised that after meetings with EDC discussing the original Certificate of Need (CON) and its estimated cost for the project and the current CON, parties have come to an agreement on where the discrepancies are seen, as evidenced in a handout provided to members of the Committee (Attachment A). Dmitri Konon, Emil Martone and Zac Smith, EDC, agreed.

Action Items

Authorizing a work order in the amount of two hundred ninety five thousand dollars (\$295,000) to the Dormitory Authority of the State of New York (DASNY) to provide funding for investigation, reporting, and design phase engineering services required to address Local Law 11 conditions at Woodhull Medical and Mental Health Center.

Lisa Scott-McKenzie, Senior Associate Executive Director, Woodhull Medical and Mental Health Center, read the resolution into the record on behalf of George Proctor, Senior Vice President, Central/North Brooklyn Health Network. Ms. Scott-McKenzie was joined by Kein Anderson, Associate Executive Director, Woodhull Medical and Mental Health Center.

Mrs. Bolus asked how many inspections had been performed at the facility since its construction in 1972. Mrs. Scott-McKenzie said the facility had been checked according to schedule and although some minor issues had been identified over the years the continued deterioration is presently allowing water to seep inside the building and therefore must be fixed. Mrs. Bolus asked whether it would be sealed appropriately this time to prevent water seepage. Mrs. Scott-McKenzie said yes.

Mrs. Bolus asked for confirmation that this \$295,000 work order would fund preliminary investigatory and design work and the actual construction work would be approximately \$2 million. Mrs. Scott-McKenzie said yes and advised that the Committee would have to approve any additional project funding. Mr. Pistone noted that the \$2 million project budget was an estimate and could change after preliminary research is complete.

Mrs. Bolus asked whether the building issues had come strictly from water damage or had been caused by shaking from the nearby subway. Mrs. Scott-McKenzie stated that there are no vibration issues that are known and the necessary work is a result of caulk breaking down and water seeping into the building.

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 work order.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Landlord") to execute a revocable license agreement with Con Edison Company of New York, Inc. (the "Licensor"), for use and occupancy of space for the operation of a radio communication system at Harlem Hospital Center (the "Facility") for five years without further authorization by the Board of Directors of the Corporation. Current agreement expires April 30, 2012.

Dion Wilson, Assistant Director, Office of Facilities Development, read the resolution into the record on behalf of Lynda Curtis, Senior Vice President, South Manhattan Health Network. Mr. Wilson was joined by Michael Jordan, Consolidated Edison.

Mr. Wilson provided a summary of the agreement noting that the Consolidated Edison (Con Ed) had been operating a radio communications system on the roof of the Martin Luther King (MLK) Pavilion since 2002. He advised that the system involves installation of an equipment cabinet and omni-directional antennae that operate at either 800 or 900 megahertz frequencies. The system facilitates data monitoring enabling local power usage demands to be communicated to Con Ed's central operations and its digital channel capability allows for effective radio communication. The annual occupancy fee \$27,007 represents a three (3) % increase over the current rate. He noted that the equipment complies with all FCC requirements and does not interfere with hospital communications.

Mrs. Bolus asked what data monitoring entails. Mr. Jordan advised that it is a distributed automation system resulting from above ground control systems in Queens or the Bronx. It monitors various stations to see what levels the power flow is operating at. He added that it also supports when equipment goes out by allowing alternate feeders to handle possible issues.

Mrs. Bolus asked where the system is monitored from. Mr. Jordan said there are two sites, one in Westchester County, and one at Irving Place.

Mrs. Bolus asked how many people are located in the monitoring stations. Mr. Jordan said typically three people but if there are shortages or outages then additional staff is brought in for support. There are approximately 23 other Con Edison sites similar to the one at Harlem Hospital Center.

Mrs. Bolus asked whether all the equipment signals to the same two sites. Mr. Jordan said yes.

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.

Information Items

Harlem Hospital Center – Major Modernization – Status Report

Denise Soares, Executive Director, Harlem Hospital Center, provided the status report. Ms. Soares was joined by Anita O'Brien, Associate Executive Director, Harlem Hospital Center, and Trevor Henry, Assistant Executive Director, Harlem Hospital Center.

Ms. Soares stated that Phase I of the project, the New Patient Pavilion (NPP), is nearing substantial completion. Phase I includes the sixth (6th) floor, adult medical surgical and intensive care units, the fourth (4th) floor, which houses central sterile supply and outpatient dialysis, the third (3rd) floor, where peri-operative services are located, the second (2nd) floor, which is where women's health imaging and surgery and bariatric clinics are located, and the first (1st) floor, which includes the atrium and mural gallery and will eventually house adult and pediatric emergency units.

Ms. Soares advised that the facility is conducting breakthrough vertical value streams in order to complete move-in and relocations appropriately. The process is including all parties that will be moving into the NPP. The mural gallery build-out is nearing completion, reinstallation will take another four (4) to six (6) months and the illuminated mural façade is complete. She stated that the facility is preparing to bid and award for the build-out of the remaining Emergency Department space and are in process of reviewing medical equipment purchasing. The facility is waiting for the Fire Department of the City of New York (FDNY) to complete inspection of the fire alarm system. The Department of Buildings (DOB) inspections for the Certificate of Occupancy should take place in March and by May hopefully the Department of Health (DOH) pre-occupancy survey will take place.

Mrs. Bolus asked where the Emergency Medical Service (EMS) station will be located. Ms. Soares and Ms. O'Brien advised that the old facility was not completely demolished but the station has already been relocated.

Ms. Soares provided a brief slideshow of progress photos.

Ms. Bolus asked which murals were located in the auditorium. Ms. Soares advised that the images are depictions of the actual murals that will be reinstalled at the facility.

DASNY Report on MWBE Statistics

Michael Clay, Director, Office of Opportunity Programs, Dormitory Authority of the State of New York (DASNY), reported on the Minority and Women Business Enterprise (MWBE) statistics related to the Major Modernization project at Harlem Hospital Center.

Mr. Clay explained that the employment program started at the assistance of HHC/Harlem Hospital Center and that while DASNY does have their own MWBE requirements it was HHC and the facility that went beyond the norm. He noted that through construction of this project approximately 217 residents had been employed and thousands more had been referred to other programs, been provided OSCHA training and/or had been referred to other programs. He acknowledged that partnering with various organizations helped to not just build a building but really support the community.

Mr. Clay stated that project report details display that through the project DASNY has been able to afford contracts or sub-contracts to New York State certified MWBEs, in total, 35% of those working on the project or what will amount to approximately \$52 million worth of business. He advised that this is an ongoing process and final numbers are based on completed work and payments not on estimates. He noted that the modernization project could possibly have the highest MWBE participation in a Harlem based project and maybe even in the City of New York, to date.

Mrs. Bolus asked whether the businesses listed had all been paid to date. Mr. Clay said no, \$18 million had been paid to date and that by the end of the project, when all payments are completed, it is estimated that payments to MWBE firms will amount to approximately \$52 million.

Mrs. Bolus asked about the issues that subcontractors face regarding receiving payments. Mr. Clay advised that DASNY has the right to refuse payment so if they are aware of an issue where a subcontractor is not being paid they will be proactive, review the situation and can decide not to pay a contractor if they are not paying a sub-contractor that has in fact completed work.

Mr. Clay then referenced the workforce participation chart that had been distributed, explaining that it shows participation rates and noting that where goals are typically 40%, on this project they are running 59% on minority participation relative to work force. He advised that the outline also included a community hiring piece and that number is 15% for individuals that live in the area and work on the project. He referenced a pie chart that detailed who has been working on the project; over 50% of the workforce is made up of minorities, females and those of diverse backgrounds. A testament, he said, to efforts made by the Harlem administration and HHC. Mr. Clay noted that without such support and participation this kind of success would not be possible.

Mrs. Bolus asked what some of the subcontractors do. Mr. Clay advised that they have been responsible for painting, performing drywall, excavating, any and all aspects of the project. Each contract is required to have an MWBE component he explained.

Mrs. Bolus asked if the workers would be able to take this experience on to another job. Mr. Clay said yes, this is a project of such great magnitude that it will definitely be beneficial to have worked on it. Mr. Clay said that there have been eight (8) OSCHA training classes, so workers are going through that, but while non-union members can have difficulty affording that training DASNY has sponsored seven (7) trainings to date in the Harlem community and there is a waiting list of 300 men and women even though there have already been 350 that have completed training.

Mrs. Bolus stated that she was very pleased to hear this information and would like to have Mr. Clay come to the Equal Employment Opportunity (EEO) Committee to share the information. Mr. Clay said he would be happy to do that.

Goldwater North – Parking Update

Dion Wilson, Assistant Director, Office of Facilities Development, provided the update on parking. Mr. Wilson was joined by Robert Hughes, Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility and Michael Buchholz, Senior Associate Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility.

Mr. Wilson advised that it is anticipated that parking for the Goldwater North site will need to be available by October 2013. He explained that the two lots already secured under the viaduct on 121st and 122nd streets will accommodate approximately 70 cars, combined with reserved curbside parking for doctors, the total number currently available is 85, but the facility will require approximately 125 parking spaces during peak demand hours. A consultant is working on identifying additional space and HHC is working on issuing a Request for Proposals (RFP) for a parking vendor, which should happen in late 2012 or early 2013.

Dr. Stocker asked is there was additional space in the neighborhood. Mr. Wilson advised that there are some spaces that are managed by a private concern that may provide the 40 spaces needed.

Mrs. Bolus asked whether the MD parking is really strictly reserved for doctors or is it is in fact all providers in general. Mr. Wilson advised that the Department of Transportation (DOT) had distinguished the spots as MD parking but he said would follow-up with the DOT to determine if that will cover other providers as well.

Mrs. Bolus asked whether stackers would be used to increase the available spaces. Mr. Wilson said the spaces under the viaduct will not allow for stackers but it is possible that they may be used in another area, if and when one is identified.

Mr. Wilson added that there has also been discussion about adding chargers for electric vehicles, so that issue has not been forgotten. Mrs. Bolus was pleased to hear that.

Mrs. Bolus asked if the parking are will be paved. Mr. Wilson said yes.

EDC Update on Goldwater North Project

As noted, the Goldwater North project update was provided earlier in the meeting.

Project Status Reports

Central/North Brooklyn Health Network

Generations+/Northern Manhattan Health Network*

Queens Health Network*

* Network contains project(s) that require a delay report

Mr. Pistone provided a brief overview of the Project Status Reports in his Assistant Vice President's Report.

Community Relations Committee – March 6, 2012

As reported by Josephine Bolus, RN

Chairperson's Report

Mrs. Bolus opened the meeting with a warm welcome to everyone in attendance. She shared with the Committee members her excitement for participating yesterday at the Patient Safety Final Jeopardy: Battle of the Networks 2012 held at Coler/Goldwater Specialty Hospital (Goldwater Campus). She stated that there actually was a Jeopardy Board on the screen and the winning teams from last month's contest had to vote their answers to the questions on the screen. Mrs. Bolus noted that it was a fun-filled, energy-driven experience and encouraged all the facilities to replicate this wonderful experience for everybody knows and would like to do something like Jeopardy.

Mrs. Bolus stated that she had recently visited a few facilities at their Legislative Breakfasts. She added that, while she enjoyed participating in the legislative forums, she was unable to attend the ones scheduled on Friday morning because of their conflicts with the Quality Assurance Committee. Mrs. Bolus concluded her report stating that she would encourage these facilities to rather hold their Legislative Forum on Saturday as she would be able to attend.

Mrs. Bolus turned the meeting over to President Aviles for his report.

President Remarks

Mr. Aviles began his remarks by referring to the hot issue in the media reports about the recent Hospital "Safety Ratings" by Consumer Reports, a reputable consumer organization. Mr. Aviles explained that Consumer Reports released a set of ratings that supposedly indicated how hospitals stacked up in New York City and around the country in connection with patient safety. Mr. Aviles stated that the report was quite shocking to the Corporation because it listed Jacobi Hospital Center in particular at the very bottom of the ratings' list. In addition, according to Consumer Reports' ratings, of the 50 lowest rates in hospitals in the country, 30 of them are in New York City. According to these ratings, there is no hospital in New York City, public or private that even scores at average. Mr. Aviles noted that even New York University (NYU) Hospital, the highest rated hospital of all the hospitals in New York City, was 10% below average on Consumer Reports' rating score. Mr. Aviles questioned the validity of these ratings considering that people travel across the country and internationally to New York City to come to its many academic medical centers. In addition, Mr. Aviles noted that while so many awards are won throughout the HHC system and by Jacobi Medical Center particularly over the last few years, this rating purports to say that of all New York City Hospitals, Jacobi Medical Center in particular, is not a safe hospital compared to other hospitals.

Mr. Aviles clarified that the problem is trying to treat hospitals as if they were toaster ovens. He reminded Committee members of Consumer Reports' process of rating appliances or cars. He stated that the Consumer Reports staff would pick a couple of attributes such as: is the dial easy to use? Is the heat even? And the scores are represented with color-coded circles. A red circle means better than average; half red circle, a little better than average; a blank circle, average; half black circle a little worse than average and a full black circle, way worse than average. Mr. Aviles stated that, by focusing on only four factors, Consumer Reports used that same approach to rate the hospitals. Mr. Aviles noted that while HHC tracks about 100 quality assurance safety indicators, only one of them was among the four Consumer Reports' choice of patient safety indicators.

Mr. Aviles reported that one of the four indicators was readmission within 30 days for Medicare patients with heart attack, heart failure or pneumonia. Mr. Aviles commented that he is unsure why this indicator fell under a patient safety measure. Nevertheless, Mr. Aviles stated that it is an area of challenge for all the hospitals in New York City and particularly for HHC. Mr. Aviles noted that, while the Corporation is not trying to make excuses based upon the fact that HHC serves disproportionately low income patients with behavior health and cognitive problems, the reality is that 70% of HHC's Medicare patients also qualify for Medicaid. The readmission issue has always been a challenging issue for HHC as some socio-economic issues come into play for these patients who may not have social support at home to continue their plan of care at home or, in some instances, may not even have a home and this may have an impact on whether they are likely to be readmitted.

Mr. Aviles reported that two other measures used by Consumer Reports were from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. Mr. Aviles confessed that, in general, HCAHPS scores for all the hospitals in New York City are below the national scores, a condition that may be related to the diversity of the population in New York City. Nevertheless, upon looking at HCAHPS scores in New York City, HHC has some of the best HCAHPS scores in three of the four boroughs. He noted that the number one hospital with the highest overall HCAHPS score is an HHC facility and the third highest for the borough of Manhattan is also an HHC facility. He added that, comparatively speaking, the Corporation does very well on the HCAHPS scores and was puzzled by Consumer Reports' finding of Jacobi's poor rating.

Mr. Aviles explained that HCAHPS, the hospital survey instrument, has 10 to 12 questions. However, Consumer Reports only focused on the following two questions: 1) did you understand the medications that were given to you? 2) Did you understand the discharge instructions when you left the hospital? Mr. Aviles commented that, considering that English is not the primary language to many of HHC's patients and because HHC has an incredibly diverse population that speaks more than 100 languages, the meanings of these questions may vary greatly depending on how the questions were phrased. For example, these questions may well mean for some patients: 1) Do you know when to take your medication? Or did somebody explain in details what this medication is and exactly what effect it will have on my body? 2) Do you understand what you are supposed to do when you get home in terms of the treatment you need to follow and what symptoms might lead to come back to the emergency room?. Mr. Aviles noted that, unfortunately, these questions were not phrased that way and because HHC did not score well on those two questions, we were penalized across the system for those scores and Jacobi Medical Center, in particular.

Mr. Aviles reported that only the last measure was a real patient safety measure: the rate at which you may have gotten an infection at the hospital that you did not come in with. Mr. Aviles noted that it is a very tricky measure for they looked at three types of infection: blood stream, colon surgery and hip surgery infections and only took the worst score. Mr. Aviles informed Committee members and invited guests that, for many parts of the country, the State does not require reporting on neither hip surgery infections, nor colon surgery infections. Therefore, the central line infection number is used for those states. And because these two infections are reported in New York, these scores were used. Mr. Aviles agreed that Jacobi had a high colon surgery infection rate for the three periods they looked at, which is due in part of the minimal number of colon surgeries performed at Jacobi and any relatively few infections automatically give a higher rate. Mr. Aviles challenged that Jacobi would have been nowhere near the bottom of the list if these scores were based on last year's period instead.

Mr. Aviles reiterated that patient safety is not about picking poor indicators randomly, (one of which does not even sound as a patient safety indicator), but it is rather about tracking 100 different things as there are so many risks and so many issues of safety in the hospitals. He clarified that patient safety is about whether the patient is getting pressure ulcers, ventilator-associated pneumonia and whether the patient is at risk of falls. Mr. Aviles stated that, as supported by the data, HHC staff has worked on and made tremendous progress in achieving so many different practices of patient safety.

Mr. Aviles emphasized that patient safety is about so many different practices. He reiterated that the data reflects that HHC has made tremendous progress. Mr. Aviles noted that the Consumers Report article selected four indicators and painted with a broad brush. It has unfairly targeted all the hospitals in New York City, but it was particularly unjust to Jacobi Medical Center.

Mr. Aviles stated that Jacobi Medical Center has received several unsolicited letters from patients, one of which from parents whose daughter was seriously injured in an automobile accident and underwent seven (7) separate surgeries at Jacobi and never acquired a single infection. Mr. Aviles reported that the patient is alive and doing well today, because of Jacobi Medical Center. He informed the Committee that the parents had shared their testimony by writing a letter to the editor of the Daily News and the New York Post with copies to HHC. Mr. Aviles stated that he has personally revisited carefully all the patient safety indicators (particularly at Jacobi) to ensure that nothing was missing. He

added that, because we can always do better, we all need to continue working on improving patient safety across the board. He reassured the Committee that Jacobi does well and, in some instances, extremely well on the most significant patient safety indicators. For example, over the last two years, blood stream infections were dramatically reduced below national benchmark, and ventilator-associated pneumonia infections and pressure ulcers were also reduced below national benchmark in Jacobi's surgical intensive care unit. In addition, last year, Jacobi Medical Center received two national awards for their work in the OB Department to reduce complications in the delivery suites.

Mr. Aviles stated that HHC, along with some of the other trade associations in New York that represent the voluntary hospitals, is reaching out to Consumer Reports to convene a meeting to talk about this issue. Mr. Aviles commented that, If Consumer Reports is getting into the business of rating hospitals around the quality of care and patient safety, in particular, they at least need to sit down with the expert organizations across the country such as: the National Quality Forum, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Agency for Healthcare Research and Quality (AHRQ), all of which have spent years looking at all the quality indicators, to try to put together a series of indicators that together do form some kind of a report card that would at least allow to make some generalizations about patient safety. Mr. Aviles stated that it is important for HHC to continue to advocate around this issue as Consumer Reports is getting so much press in the New York Media Market. He added that, unless we persuade them that they really have to revisit which indicators make the most difference and make the most sense and how to view them in context, Consumer Reports will come back again next year using the same exact indicators. Mr. Aviles informed Committee members and invited guests that enclosed in their CRC package is a copy of a message he sent to all staff on Friday, March 2, 2012, as well as a copy of a message from the Network's Senior Vice President and Jacobi's Executive Director, Mr. William P. Walsh.

Mr. Aviles ended his remarks by adding that, as Jacobi Medical Center was at the bottom of the list along with several other private hospitals (Mount Sinai, Beth Israel, St. Luke Roosevelt, Maimonides and Montefiore) that also take the patient safety issue very seriously, but reflected as performing poorly, is an indication that something must definitely be wrong with Consumer Reports' rating.

Mrs. Bolus invited Committee members and invited guests to observe a moment of silence in memory of Ms. Elsie Fulcher Thomas, who passed away. She was an active Auxiliary Board and CAB member at Cumberland Diagnostic and Treatment Center (D&TC).

Central Brooklyn Family Health Network

Kings County Hospital Center (Kings County) Community Advisory Board

Mrs. Bolus acknowledged Ms. Roslyn Weinstein, Acting Executive Director of Kings County Hospital Center. She introduced Ms. Agnes Abraham, Chairperson of Kings County Hospital Center's Community Advisory Board and invited her to present the CAB's annual report.

Ms. Abraham began her presentation by commending Mr. George Proctor, Senior Vice President, North and Central Brooklyn Family Health Network, Ms. Weinstein, Acting Executive Director, Kings County Hospital Center on their stellar leadership skills and thanking members of the Kings County CAB for their dedication and commitment to carry on the work of the CAB during her medical leave absence.

Ms. Abraham reported that most significant health care service needs or concerns for the Kings County community are: long wait time in the clinics, hypertension, diabetes, childhood obesity and a crowded emergency room. Ms. Abraham noted that the crowded emergency room is attributed to the closing of several hospitals in the borough of Brooklyn and patients using the emergency room for primary care visits, which also causes long wait time in the emergency room.

Ms. Abraham announced that Kings County Hospital Center has implemented a new program called Kings Against Violence Initiative (KAVI) to help teens and young men fight against violence and deal with issues. She explained that in recent years the Kings County community has seen an increase in teen violence.

Ms. Abraham stated that the Kings County Hospital's leadership is addressing these concerns by expanding Ambulatory Care Services and clinic hours to include Saturday clinics and evenings. Ms. Abraham added that several Breakthrough events were conducted to improve services in the clinics and reduce emergency room wait time. In addition, the Administration has requested approval to purchase a second Linear Accelerator to increase capacity for radiation therapy treatments, which will allow for additional referrals from Woodhull and Coney Island Hospitals. She noted that the projected cost of the total project to be \$6.5 million.

Ms. Abraham informed members of the Committee and invited guests that Kings County CAB members were inspirational in selling over one hundred (100) tickets for STAT! 2011 for NYC's Public Hospitals event that was held at Berean Baptist Church. Ms. Abrahams noted that Kings County CAB members also participated in the Annual Kings County Hospital Center and Dr. Susan Smith McKinney Nursing and Rehabilitation Center (DSSM) annual health fair.

Ms. Abraham reported that the Kings County CAB member's future goals and plans are to continue discussions with the hospital's administration on staffing, additional beds and health and wellness programs for the community.

Ms. Abraham concluded her report by informing members of the Committee, CAB Chairs and invited guests that Kings County Hospital Center received \$3.5 million from Councilmember Eugene Mathieu. Ms. Abraham added that the check was presented to Ms. Weinstein on Friday, February 24, 2012 during the CAB's Legislative Breakfast.

Mr. Robert Nolan congratulated Kings County Hospital Center on securing \$3.5 million from the City Council. Mr. Nolan informed the Committee that, based upon his prior years of working with the City Council, the allocation of \$3.5 million from a Council Member to one institution is an enormous commitment and inquired about the use of these funds.

Mr. Antonio Martin, Executive Vice President informed the Committee that the funds are to be used toward the purchase of a Linear Accelerator.

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

Mrs. Bolus introduced Fredrick Monderson, DUniv., CAB member, and invited him to present the CAB's annual report in the absence of May Thomas, CAB Chairperson of the Dr. Susan Smith McKinney Nursing and Rehabilitation Center (DSSM) Community Advisory Board.

Dr. Monderson began his report by stating that at DSSM the journey towards Culture Change continues. Dr. Monderson explained that this transformation towards patient –centered care includes personal direct choices. Dr. Monderson added that all employees were oriented and training is on-going for staff, residents and families.

Dr. Monderson concluded the report by informing members of the Committee and invited guests that the leadership of DSSM keeps the CAB informed of all activities and the DSSM CAB members share their input about the implementation and development of their strategic plans. He noted that, as patient safety remains a priority at the facility, continuing education on patient safety is provided for residents, families and staff.

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

Mrs. Bolus introduced Marie Harley, CAB member, and invited her to present the CAB's annual report on behalf of Ms. Jeanette Carter, Chairperson of the East New York Diagnostic & Treatment Center Community Advisory Board.

Ms. Harley began her presentation by thanking members of the Committee for the opportunity to present the ENYD&TC's CAB annual report.

Ms. Harley reported that the most significant health care service needs or concerns of the East New York community are: obesity, diabetes, hypertension, high cholesterol, heart disease, depression and asthma. Ms. Harley added that the staff of ENYD&TC is part of HHC's Chronic Disease Collaborative. The ENYD&TC team includes five providers, a nurse care manager, nutritionist, social worker and other nursing staff to improve the quality of care provided to diabetics, hypertensive's and patients with high cholesterol. She noted that MetroPlus and Health First have also provided care managers, who work in collaboration with ENYD&TC providers and clinic staff. Ms. Harley stated that in addition, a Registered Nurse in the Medical Clinic has been designated the Blood Pressure follow-up nurse. Her role is to work with patients referred to her by the medical clinic to ensure that these patients are following their hypertension treatment plan successfully.

Ms. Harley stated that the facility's strategic priorities are to: improve patient satisfaction; improve quality and safety of patient care; reduce costs and increase revenues; improve customer service and improve marketing strategies. Ms. Harley noted that over the last two years, ENYD&TC has been successful in reducing the facility's operation cost.

Ms. Harley reported that Ms. Patricia Hinds, Site Administrator, includes the CAB members in the planning and upgrading of the facility as well as on-going discussions pertaining to issues raised by community members.

Ms. Harley continued and reported that the facility has implemented the Breakthrough concept to develop changes in the delivery of services. Ms. Harley noted that one CAB member has participated in the Rapid Improvement Event that was successful in changing the way patients with appointments flow through the clinic. Ms. Harley added that this has resulted in a tremendous reduction in the amount of time a patient spends in the clinic. Ms. Harley stated that in addition, greeters were placed in the facility lobby to ensure that patients were properly acknowledged; their questions answered, and correctly directed to improve patient flow. Ms. Harley added that patients are satisfied with their care and the way they are treated in the facility.

Ms. Harley informed members of the Committee and invited guests that all renovations to ENYD&TC have been completed and the facility is beautiful.

Ms. Harley concluded her report by commending Ms. Hinds on several programs such as: the Child Birth classes, an eight (8) week program; the Teen Clinic, which invites the young parents to come, share and discuss any problems they may be experiencing; and, two (2)

new Jitney bus service that transport patients to Kings County Hospital Center every hour on the hour from 8:00 a.m. to 9:00 p.m. five days a week.

Special Presentation

WTC Health Program Survivors Steering Committee

Ms. Bolus introduced Terry Miles, Executive Director of the World Trade Center Environmental Health Center (WTC EHC) Program and invited him to proceed with the presentation on the World Trade Center Health Program Survivors Steering Committee.

Mr. Miles thanked the Committee Chairperson, Mrs. Bolus, President Aviles and Mr. Antonio Martin, Executive Vice President and Chief Operating Officer for the opportunity to present WTC EHC's community advisory group to the Community Relations Committee. Mr. Miles reminded the Committee of the 9/11 Health Bill, the James Zadroga 9/11 Health and Compensation Act, that was passed last year and that is now in the process of being implemented over the last several months. Mr. Miles noted that the Health Bill is a very complicated bill which requires the establishment of steering committees to facilitate the coordination of the medical monitoring and treatment programs for responders and the survivors. Mr. Miles introduced WTC EHC's advisors, Ms. Kimberly Flynn, Community Co-Chair and Mr. Robert Spencer, Labor Co-Chair and two constituents advocates: Ms. Mariama James and Ms. Lillian Bermudez, who will repeat the presentation they made last November to the Scientific/Technical Advisory Committee related to 9/11 health.

Mr. Spencer thanked the HHC's Community Relations Committee for the invitation to make this presentation. He noted that the presentation has been modified to give the Community Relations Committee a better understanding of the health problems of those called 9/11 survivors, residents, students and area workers affected by 9/11 and why the Health and Hospitals Corporation survivor services remains so critical even more than a decade out.

Ms. Flynn informed the Committee that the Survivors Steering Committee was created to play an advisory role to the health programs serving the non-responder community. She stated that the Committee gathers input from the community and the affected non-responders stakeholders which is in turn relayed to the health program with the goal of ensuring that it meets the evolving needs of the 9/11 survivors. In addition, the Survivors Steering Committee works closely with the medical administrative staff of the WTC EHC, the clinical centers of excellence serving non-responders. Ms. Flynn noted that 9/11 responders also have a steering committee.

Mr. Spencer referred to the "current and former survivors Steering Committee Groups" slide and underscores its diversity. As listed below, the list includes: residents groups, tenants associations, labor coalitions and a wide range of other involved groups. They are:

- 105 Duane Street Residents
- 125 Cedar Street Residents
- 9/11 Environmental Action
- Beyond Ground Zero Network
- Asian American Legal Defense & Education Fund
- Chinese Staff and Workers' Association, -Commission on the Public's Health System-
- National Mobilization against Sweatshops - Community Development Project of The Urban Justice Center
 - Civil Service Employees Association
 - Communications Workers of America (CWA) District One
 - Concerned Stuyvesant Community
 - District Council 37 AFSCME
 - Ecuadorian International Center
 - Good Old Lower East Side, Inc. (GOLES)
 - Henry Street Settlement
 - Independence Plaza North Tenants
 - Manhattan Community Board 1
 - Manhattan Community Board 2
 - Manhattan Community Board 3
 - New York From the Ground Up
 - New York Committee for Occupational Safety and Health (NYCOSH)
 - NY State Public Employees Federation, AFL-CIO, (PEF) Division 199
 - New York State Laborers' Union
 - Organization of Staff Analysts (OSA)
 - Rebuild Downtown Our Town
 - Rebuild with a Spotlight on the Poor
 - South Bridge Tower Residents Coalition
 - StuyHealth

- Stuyvesant High School Parents' Association
- United Jewish Council of the East Side
- University Settlement
- World Trade Center Community-Labor Coalition
- World Trade Center Residents Coalition

Mr. Spencer reminded the Committee that the goal of the Committee's presentation is to give a brief overview of the non-responder population comprised of residents, area workers and students affected by 9/11 along with their 9/11 exposures and health experiences. Because of time constraints, Mr. Spencer announced that, tonight's presentation only includes testimonies from two individuals who were and still are Lower Manhattan residents followed by brief comments from the Steering Committee members on how a downtown school was affected by 9/11. Mr. Spencer referred to Slide #4 showing the WTC collapse cloud which engulfs Lower Manhattan on 9/11.

Ms. Flynn stated that the collapse and burning of the WTC caused an unprecedented environmental disaster. She added that toxic dust and smoke permeated the densely populated urban area. In addition to the initial effects of the collapse cloud, the fires of the site persisted for many months generating a plume that shifted with wind direction and hung over Lower Manhattan Neighborhoods.

Mr. Spencer stated that, while throughout the Ground Zero clean up, WTC dust and contaminants entered buildings in multiple routes, many of the residents in the affected areas were not evacuating on 9/11 but remained in their homes throughout. Some area workers were brought back to locations as soon as two days after the attack. Mr. Spencer refers to Slide #8 and pointed out to the interiors of buildings that border the WTC site are among the most affected areas.

Ms. Flynn stated that, despite the fact that this cloud prevails over the affected areas, on September 18, 2001, Environment Protection Agency's Administrator, Christine Todd Whitman declared the 'air is safe,' putting the health of tens of thousands at risk. Consequently, residents, students and area workers who were evacuated returned to the area and were exposed to WTC dust and smoke, indoors and outdoors.

Mr. Spencer stated that The White House Counsel on Environmental Quality influencing EPA risk communications had transformed statements of caution and concern to ones that downplayed health risk. Mr. Spencer added that, as noted by the EPA Instructor's report in 2003, these altered communications misrepresented or concealed information that might have helped protect thousands from the contaminated air and dust.

Ms. Flynn added that, this past September, on the 10th Anniversary of 9/11, ProPublica working from documents obtained by the New York Committee on Occupational Safety and Health revealed just how far that interference went. Ms. Flynn quoted: "In one instance, a warning that people should not report to work on a busy thoroughfare in the financial district – Water Street – was rewritten and workers instead were urged to return to their offices as soon as the financial district opened on September 17th."

Mr. Spencer stated that the same day, September 17, 2001, the New York City Department of Health (DOH) had issued advisories such as: 1) "How should I clean the dust in my apartment when I move back in? DOH's answer was the best way to remove dust is to use a wet rag or wet mop. 2) "Do pregnant women and young children need to take additional precautions?" DOH's answer was equally questionable: No. Pregnant women and young children do not need to take additional precautions. Mr. Spencer noted that even to this day, there has been no comprehensive and scientific reevaluated assessment of indoor contamination ever done.

Ms. Flynn stated that, after a lengthy struggle, the EPA had announced a test and cleaning program in May 2002 for residences only in Manhattan, South of Canal Street, purely on a voluntary basis. Ms. Flynn noted that workplaces were excluded, buildings were not treated as systems and tests in the heating ventilation air conditioning (HVAC) systems and inaccessible areas most likely to harbor contamination were not conducted. Ms. Flynn added that, efforts by advocates to improve the program and extend the boundary above Canal Street and into Brooklyn were rejected. Ms. Flynn stated that, in August of 2003, EPA Inspector General's report criticized the clean up as flawed and inadequate and called on the agencies to reexamine the remaining risks to residents, students and area workers in Lower Manhattan and Brooklyn. Ms. Flynn reported that, after another lengthy struggle, the EPA created the WTC Expert Technical Review Panel to examine the first test and clean program and to develop a new program to address remaining health risks to survivors.

Mr. Spencer stated that after months of meetings, the EPA unveiled the second program similar to the first one and it was deemed unacceptable by the majority of the experts on its own panel and all the community and labor representatives. He added that the Government Accountability Office (GAO) conducted a review as summarized on Slide #15. Mr. Spencer stated that all the omissions and failures of public health policy and exposure assessment resulted in illness and a demand from affected communities initially led by Beyond Ground Zero Network for appropriate and needed 9/11 health care for survivors. Mr. Spencer noted that the World Trade Center Environmental Health Center is the outgrowth of those demands met by responsive public health professionals at the New York City Health and Hospitals Corporation.

Mr. Spencer stated that the following two presenters, Ms. Mariama James and Ms. Lillian Bermudez, will offer snapshots of the 9/11 survivor experience. First, he invited Ms. James to share her experience.

Ms. James greeted the Committee and invited guests. She introduced herself as a Member of the Youth and Education Committee of Manhattan Community Board #1, a member of the Financial District Committee and a member of the WTC Survivor Advisory Committee since its inception.

Ms. James stated that on the morning of September 11, 2001, she was eight (8) months pregnant with her third child and was returning home from a daily commute from her place of work in Long Island, which included two trains and a bus. She stated that as she neared home, she had to receive permission from NYPD Officers to get into her apartment located five blocks east and one block north of the Towers. She added that, dust had permeated the apartment and that she, along with her father and her two children were covered in dust. There was no power, no water and no phone service. Evacuation was not mandatory, but voluntary. She stated that, as her building is located across the street from the New York Downtown Hospital, she was advised by her doctor to stay in her apartment so that she will be able to get to the hospital quickly if need be.

Ms. James stated that, with small children in the apartment, cleaning had to be done. She noted that cleaning was done with non-HEPA vacuums and, as directed by the City Health Department, she wiped with wet rags. In addition, she got down on her hands and knees and ripped up her children carpet. Ms. James stated that, not too long after 9/11, the City Health Department had put out an advisory to residents stating: "in addition to cleaning with the wet rag and mop and throwing away spoiled food, pregnant women and young children do not need to take additional precautions."

Ms. James reported that her daughter was born on October 23, 2001, through induced labor at New York Downtown Hospital. At the age of 10 months, she was diagnosed with asthma and sinusitis. The other two children, who were in perfect good health before 9/11, have also developed the same health problems. Ms. James stated that, for several years all three children took daily treatments of Ventolin, Qvar, Zyrtec, Allegra, Singulair, Astmanex, Albuterol, Advair, Allegra d, and Percocet to combat the sinusitis and the asthma. In addition, she had to have a nebulizer at home.

Ms. James informed the Committee that there was no WTC-related treatment program available for children. Therefore, she first took her children to an ear, nose and throat (ENT) doctor, who was the head of the ENT Department at Beth Israel Hospital. Soon she needed the help of a pediatric pulmonary specialist on a monthly basis to better treat their condition. Ms. James noted, in addition to a \$50.00 co-payment for each of the aforementioned medications per month, per child, each monthly doctor's visit also required a \$50.00 co-payment per child through her insurance coverage; a situation that went on for several years until the WTC EHC program was established.

Ms. James stated that for the past few months, her children have been going to the WTC EHC program. She commented that her children loved the doctors who strike her as very committed and dedicated. In addition, the youngest and the oldest have developed sleep disorders. Ms. James ended her presentation by commending the WTC EHC program. She added that her children are on less medication and no longer need treatment on a monthly basis.

Mr. Spencer pointed on Slide #8 the location of Ms. James' building. He then turned the presentation over to Ms. Lillian Bermudez and invited her to share her 9/11 survivor experience.

Ms. Bermudez emotionally greeted members of the Committee and invited guests. She introduced herself as a Senior Police Administrative Aide with the New York Police Department. She added that she is a Lower East Side resident who lives north of Canal Street with her two children, Mitch and Amanda.

Ms. Bermudez stated that on September 11, 2001, Mitch was 12; Amanda was 9, with no prior health problems. Ms. Bermudez stated that after 9/11, fumes burning were intense and constant. Ms. Bermudez noted that she dismissed worries about health risks of breathing in the fumes because authorities said the 'air is safe.' In late October 2001, however, her son Mitch came down with a cold & cough. Ms. Bermudez stated that an ER visit resulted in Mitch being hospitalized at Bellevue's ICU for 3 days, with additional monitoring for 5 days until he was stabilized.

Ms. Bermudez stated that since then, her son has been diagnosed with asthma and takes many asthma medications. She added that Mitch continues to have asthma crises and has been hospitalized four times.

Ms. Bermudez stated that, in 2002, her daughter, Amanda was diagnosed with sinusitis, which has recurrences every time she gets a cold. She added that because of where they live (north of Canal Street), the children did not qualify for the Health Registry.

After an emotional account of her 9/11 survivor experience, Ms. Bermudez concluded her report stating that, in 2007, both children were treated at the WTC EHC and are now "doing great." She expressed her gratitude to the WTC EHC program.

Mr. Rob Spencer concluded the group's presentation by stating that while the WTC Health Program Survivors Steering Committee does not have a representative from a student in a lower Manhattan school on 9/11 present tonight, he did want to close with a brief summary of the impact on one school - Stuyvesant High School at West Chambers Street.

Mr. Spencer reported that the school was engulfed in the dust cloud on 9/11. Students, faculty and staff were called back to school before full remediation had taken place. Mr. Spencer directed members of the Committee's attention to the slide showing that the debris barge for WTC materials was directly outside the school's windows in the Hudson River. He added that the alumni are now widely dispersed nationally. Mr. Spencer stated that respiratory and gastrointestinal conditions are commonly reported to StuyHealth, an advocacy group formed by Stuyvesant students. Mr. Spencer noted that there are also reports of cancer and autoimmune diseases in the group.

New Business

Bette White, Harlem CAB member asked Mr. Alan Aviles if he could respond to the recent New York Times and The Chief Leader articles that implied Physician Affiliate Group of New York (PAGNY) is pulling out of the Health and Hospitals Corporation.

Mr. Aviles stated that it is a larger and more complicated story; however he will address the missed reporting surrounding the story.

Mr. Aviles explained that PAGNY is a new entity that was created in order to consolidate four (4) affiliation relationships including the Columbia Affiliation at Harlem Hospital Center, the University Group Medical Associates (UGMA) relationship at Coney Island Hospital, the Downtown Bronx Medical Associate (DBMA) relationship at Lincoln Medical and Mental Health Center and Metropolitan Hospital Center and the New York Medical Alliance (NYMA) relationship in the North Bronx into one (1) affiliate. Mr. Aviles added that this consolidation of physician services was done in part to try and streamline and make more efficient the administration of Physician Services.

Mr. Aviles reported that the affiliates that employ HHC's doctors work essentially full time for HHC. He stated that in the past, some doctors had divided loyalties. HHC was concerned that a lot of specialty procedures migrated to Columbia as opposed to staying at Harlem Hospital Center. Nevertheless, HHC maintained the academic affiliation relationships that existed so that the Columbia academic relationship prevailed and that physicians can continue to be trained.

Mr. Aviles continued and stated that in order to transition quickly, four (4) affiliations were consolidated into this new entity in a little over a year. Mr. Aviles added that HHC did it together with PAGNY's initial leadership who then suggested that they bring on a consultant group to help them provide leadership until the board could be constituted and pick its own leadership.

Mr. Aviles reported that Navigant Consultant Group was brought on via contract and they brought on Marc Bard, MD, Chief Executive Officer (CEO) who provided other support services. Mr. Aviles noted that in the beginning it was a bumpy ride as they continue to iron out some issues. Mr. Aviles explained that Harlem Hospital Center in particular had a tough transition because a number of physicians opted-out to go to the Columbia side or retire, which created forty (40) vacancies. Mr. Aviles added that in more recent months, those vacancies have finally been filled.

Mr. Aviles informed members of the Committee and CAB Chairs that the articles stated that Navigant and/or Dr. Bard abruptly quit. Mr. Aviles reported that the reality is that Navigant was put into HHC on a one (1) year contract: the time it was projected to create a new board; however, it took a longer than expected.

Mr. Aviles announced that there is now an eighteen (18) member board in place. He added that the board, elected by local council, is comprised of Physicians from the various facilities.

Mr. Aviles informed all that the new board has decided to extend Navigant a contract for six months until the end of June 2012; in that way giving them enough time to convene a selection committee to recruit a new and permanent CEO and filling some of the other executive positions in PAGNY. Mr. Aviles noted that it was deferred because it would be best if the new CEO was involved.

Mr. Aviles reported that Navigant continues in place; however, Dr. Bard and his partner are transitioning out. Mr. Aviles stated that Navigant has asked Dr. Bard to assume other accounts here in New York City; however, Navigant will provide other personnel to help run the organization while the board does searches for a CEO. Mr. Aviles reiterated that, Navigant's contract does run until the end of June, 2012. Mr. Aviles added that the Board has also invited HHC to be part of the selection committee. Mr. Aviles noted that this is about giving our physician a real voice in the strategic future of HHC.

Mr. Aviles concluded his response to Ms. White's inquiry by stating "HHC want PAGNY to be the democratic voice of physicians across the Corporation. Although it has been a rocky road, we are making strides." Mr. Aviles noted that the search may take a couple of months and PAGNY may look to appoint someone in the interim to help move things forward. Mr. Aviles emphasized that Navigant will soon phase out and that HHC does not need consultants running PAGNY, but physicians.

Finance Committee – March 13, 2012
As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Marlene Zurack informed the Committee that her report would include an update of two items, the status of HHC's cash flow and an overview of the recommendations that came out of the technical advisory group on indigent care. Currently, HHC's cash on hand is at 33 days, a slight increase from last month of 27 days. Although it is anticipated that the current cash on hand will increase by year-end, it is contingent upon the receipt of \$673 million in UPL payments of which CMS has approved the release of a portion of those funds. Overall, HHC's cash status is stable. Ms. Zurack moving to her next item stated that the MRT passed the findings reported by the subgroup on payment reform. However, one of the findings of the subgroup was that there needed to be another subgroup, the technical advisory group which concluded over a week ago is expects to make changes in the current legislative session. As part of that group, Ms. Zurack represented the public hospitals. The health disparity workgroup had already adopted its position on indigent care reform in its original subgroup meetings and the MRT passed the health disparity recommendations but acknowledged that the subgroup on payment reform team had the authority to opine on indigent care. In terms of the technical advisory group findings, there was an acknowledgement of two studies that came out from the Independent Consumer groups, both of which contributed to the debate that led to the technical advisory group findings. Additionally, there was a study that was done by the Commission on the Public's Health System that hired Alan Sager who looked at the current indigent care formulas and attempted to correlate current formulas to actual provision of care to the uninsured. The findings were that the current formulas do not adequately reward hospitals for taking care of the uninsured and recommended changes in the formulas to be more reflective of care to the uninsured. The second study was recently released and has received a lot of press from the Community Service Society. That study which was similar to a desk audit based on information included in their reports that the State Department of Health (SDOH) had been collecting, detailed how well hospitals were complying with the financial assistance law (FAL) which was passed in 2006 requiring that hospitals provide charity care. Based on the study, and five years after the implementation of the FAL, many of the requirements were not being universally met. Additionally, a number of problems were cited in the study. Accordingly these were major agenda items on the technically advisory committee's task list. The group's representation included consumer groups, hospital chief financial officers (CFO) and trade associations. Another piece of background, recent changes in federal law, the Accountable Care Organization, (ACO) changes the way Disproportionate Share (DSH) will ultimately be cut when the Secretary of HHS implements the cut federally in 2014, which will begin October 1, 2013. In the federal law, the Secretary must cut DSH, there are annual DSH cuts that must be implemented and the Secretary will have a choice in the way in which that cut will be implemented, based on the change in the number of uninsured in a given State, or based on how well a State targets its uninsured funding. Good is defined in terms of targeting uninsured funding as funding being targeted to high Medicaid and uninsured hospitals and targeting excluding bad debt in all of its calculations. Many of the hospital members of the trade associations initially started indigent care funding long before DSH funding was available. DSH funding is the federal matching funds that are being cut and originally those funds were a pool of surcharges that each hospital paid into and redistributed amongst them with no federal support. As part of that original creation, which is thirty years old, the funding was intended to support bad debt, and to help hospitals that were experiencing financial difficulties. However, over the years it changed when it started to provide federal DSH matching funds. However, the major change came in 2006 when the FAL passed which not only established what it means to provide charity care to individuals but meeting the minimum standards of provision of charity care is a precondition to receiving indigent care or uncompensated care funding. The department acknowledged based on the information received from the Community Service Society that a number of hospitals are not in compliance with the FAL and that applications are not accessible to patients; the data that is being reported is not accurate and enforcement needs to be strengthened. The department is scheduled to put forth administratively and may be legislatively the following recommendations: requiring that when hospitals deem patients accounts to be charity care a notification is sent to those patients; the notification must include the SDOH telephone number; there needs to be annual education of hospital staff and consumers on the FAL. Ms. Katz has already been asked by GNYHA to provide education to the voluntary hospitals on how to provide fee scaling, a charity care to patients. Also there will be an enhancement of the requirement that hospitals post their charity care policies on their websites which will be linked to SDOH website; and chief financial officers (CFO) will be required to attest annually compliance with the FAL. The State has hired KPMG as an independent auditor and will be conducting audits on FAL. Ms. Zurack stated that she recommended that the current bad debt audit be discontinued given that it is duplicative and is currently under consideration by the State. There will be a recommendation to have judgments in addition to liens reported on the websites and consideration is being given to some type of penalty for non-compliance.

Ms. Cohen asked if the recommendation was from the group of whether it is an accepted work plan of SDOH.

Ms. Zurack stated that although there very little difference in the two, it is the recommendation of the group. It appears that legislation is needed and is included in the recommendation. It is important to note that the SDOH was well represented and it may not all happen at once but it is the work plan. The second piece will require legislation that would be debated in this current session as part of the State budget that is due 3/31/12, is the elimination of bad debt from the indigent care calculation; using uninsured units of service similar to the current 10% but for 100% of the distribution so it would be based on the number of visits, ambulatory surgery and clinic visits and or inpatient stays for uninsured based on the Medicaid rate and CMI, etc. Ms. Zurack stated that she also recommended that a score is given to hospitals similar to managed care plans based on how well hospitals perform with financial assistance and that score would drive the targeting. If a facility scored high in its financial assistance compliance, the hospital would get a greater percentage of its uninsured need. The compliance scores

would be posted on the websites. Additionally, there is a need to protect rural and sole community hospitals that are very reliant on that funding. Given the federal DSH rules finding, a different mechanism to help those hospitals so it is not viewed by the federal government as NYS failing to be targeted. There is an option to provide transitional funding for those hospitals that will have the greatest losses in their revenue which would be a three year proposal. In terms of the urgency of this funding issue, NYS receives a large amount of DSH relative to the rest of the country. NYS receives 14% of the national DSH and has 8% of the uninsured. On the federal side, NYS received \$1.6 billion compared to some other states that receive very little funding. Having a formula that is not compliant would not be supported and would therefore require legislation to implement. Additionally, it's important to note that in some instances, one hospital losing funding could stop the entire bill. The group and the trade associations fully understand how vulnerable NYS is and that it is an important goal to retain the DSH funding for NYS.

Mr. Aviles asked if there is a sense of how much of the federal DSH that is now allocated based upon bad debt as opposed to servicing the uninsured.

Ms. Zurack stated that the information was not readily available but that perhaps it could be addressed in a different way. NAPH engaged a consultant to conduct a review of targeted and non targeted hospitals that were ranked by states. In one of their measures, if there is a cut off for DSH for only the Medicaid high end insured hospitals, is it for disproportionate share hospitals. NYS provides DSH funding to almost all hospitals in NYS which is problematic. In some ways NYS is fairly targeted due to the public hospitals but is it targeted because every hospital is getting a share not knowing how the Secretary of HHS, will define that metric would severely hurt NYS. The NAPH's report showing the rankings would be shared with the Committee.

Mr. Aviles asked if the definition of charity care services to the uninsured included services to the uninsured patients where a particular service is not covered by that individual's insurance or that bad debt is being considered as uncompensated care.

Ms. Zurack stated that it would be counted as a unit if it is a whole unit. The co-insurance and deductible would not be counted. After netting out the revenue that the hospital would be getting, it would be the unit of service times the Medicaid rate amount less revenue collected from patients. There are a few hospitals in NYS that make a profit on their self-pay population who are mostly wealthy and refuse to buy insurance and pay at full charges. In that instance, that hospital would be required to deduct that revenue from what is allowable to claim.

Dr. Stocker asked what it would mean for HHC if the Legislature should pass it the way it has been recommended.

Ms. Zurack stated that currently there are two separate pools, voluntary and public. The new formula will be used within each pool but the firewall between the two pools will remain. For example, HHC get approximately \$95 million out of the public pool that is \$139 million so HHC would get more of the public pool. In terms of the voluntary sector there is a significant redistribution. If a fair system is available. HHC would need to compensate for other hospitals failure to meet the FAL requirements. The public hospitals do get most of the DSH through the Intergovernmental Transfer (IGT) payment and insofar as the State is protected from cuts, the DSH that is used for the IGT payment would be protected as well.

Dr. Stocker asked if there is a way to quantify the impact to HHC. Ms. Zurack stated that at this time it is difficult to quantify the impact; however, at some point the SDOH will be issuing reports reflecting that data in order to get the legislation passed.

Ms. Zurack asked Wendy Saunders, AVP and John Jurenko, Senior AVP, Intergovernmental Relations and HHC's representatives at the State level to come forward given the timing of the legislative piece, they would be in a better position to address Dr. Stocker's question.

Ms. Saunders stated that the Legislature is on track at this point to pass not just on time but an early budget. Over the weekend both houses released their individual one house budget bills. The Assembly finished passing their proposals yesterday and the Senate is set to do the same today. The budget conference committees would also begin today. The plan is to conduct the budget conference committee process this week into next week and pass the budget bills next week.

Mr. Aviles asked if pension reform can still be a major factor.

Ms. Saunders stated that it would appear that it will go forward and that a press conference is scheduled for today by the labor leaders in the State to discuss the deal that was reported to have been reached on pension reform.

Ms. Zurack asked if the SDOH put language in on this issue. Ms. Saunders stated that they have not but both houses of the legislature seem to be aware that it will be forthcoming.

Dr. Stocker asked if the proposed pension reform is being called Tier 6. Ms. Saunders stated that it is.

Mr. Rosen asked if the pension reform will be reflected in the Governor's budget.

Ms. Saunders stated that it would appear that based on reports from yesterday some type of agreement has been reached and it will be included in the final budget. The reports on some of the political blogs have discussed this and the Governor has stated that the budget would not be done without it being included. There has been some discussion that the agreement on the pensions will be linked to the agreement on the legislative reapportionment.

Mr. Jurenko added that it is important to note that the Governor controls the language of the bill; therefore, as the Governor has stated that it has to be in or the budget will not pass without it. If March 31, 2012 comes and there's no budget, the Governor would put it in an extender and the Legislature would be forced to shut down the State if that language is not included.

Mr. Aviles asked what the deadline is for Secretary Sebelius to announce what will happen with the distribution.

Ms. Zurack stated that in order to meet the October 1, 2013 deadline, there has to be regulations. Therefore, the speculation is that by the fall of 2012 there will be a preliminary plan of what will be done and by April 2013 a draft would be expected.

Ms. Cohen following up on a previous question raised by Dr. Stocker regarding whether the impact of the distribution was quantifiable for HHC asked if there is any certainty of the impact to HHC.

Ms. Zurack stated that if it gets into the Legislation there will be an impact that the SDOH will release in a few weeks. Given that the data is not available for the other hospitals, it is difficult to speculate on the outcome for HHC. Moreover, it is not known at this time how many units of services there are for other hospitals; therefore, it is difficult to make that determination without actually doing the appropriate comparison of HHC to other hospitals. One estimate could be that it could go from a negative \$10 million to a positive \$10 million.

Ms. Cohen stated that even if this policy in isolation is net positive for HHC, there are other ways that the State could even out the impact using other methods for the other hospitals that will be impacted the most.

Ms. Zurack stated that the State has discussed including transition funding specific to this language from the pools and that she had suggested that the State uses other state funds but there has not been language forthcoming to address that recommendation which is key to pinpointing the impact. Notwithstanding, the State must resolve the problem of hospitals that will lose significant revenues and the individual providers who will lose substantial revenues. For some rural hospitals, a \$20,000 reduction in funding could be unacceptable for the State; therefore, there would be a need to make those hospitals whole.

Ms. Brown, Senior Vice President, Corporate Planning/HIV Services, Intergovernmental Relations, & Community Health stated that while in Albany meeting with the Assembly and Senate staff, the question that was asked is what will happen to those hospitals that will lose significant funds. Politically, there has to be a solution and politically unless there is a solution on the transitional funding there will be no movement on this issue, notwithstanding, the importance of there being conformity with the Affordable Care Act (ACA). There are legislators who are willing to stand down before moving forward on anything unless their rural hospitals or their safety net hospitals in the city, suburban, etc are addressed and that there is transitional funding. Their concerns are that their hospitals are allowed to make a one-two year transition in the process without severely impacting their hospitals financially.

Ms. Saunders stated that there is a possibility for this in the Senate's budget proposal where legislation is included that will include the critical access hospitals which are the way those rural hospitals are being defined and would be paid at the Medicare rates. There was legislation that was passed by both houses last year but was vetoed by the Governor but is included in the Senate's budget proposal that could potentially be a mechanism to address that issue.

Ms. Zurack stated that in the budget there was funding for vital access providers (VAP) and many of those hospitals for a number of reasons could be considered VAP which could be another alternative to addressing that issue.

Ms. Brown stated that the Medicaid to Medicare payment is for outpatient. It is a critical issue for everyone even though it is understood that the big issue is that NYS is disproportionately affected by the reduction in DSH funding due to non-targeting in terms of the deployment of the DSH funds.

Dr. Stocker asked if the downstate voluntary hospitals are in favor of that legislation. Ms. Brown stated that those hospitals would not be in favor of losing funding; however, those hospitals have been appropriately corralled by the trade associations, GNYHA and HANYS as well as the hospitals in the regions that they must accept the change in terms of creating a method to conform to the federal requirements. However, those hospitals are pushing the transitional piece but realizing that they do not want the State to lose more than what is already programmed into the ACA.

Dr. Stocker commented that the vulnerability that the hospitals are facing is at the federal level. Ms. Brown agreed.

Key Indicators/Cash Receipts & Disbursements Reports

Mr. Fred Covino reported that the Key Indicators Report as of January 2012 shows that acute discharges are down by 5% which has remained at that level for the last couple of months. There is a slight trend of improvement in the Diagnostic and Treatment Centers which are down by 5% from last year. However, there is an improvement from 11% earlier in the year. Nursing home days have remained down by 5%. The ALOS, all of the facilities are within 1/3 day of the corporate average with the exception of Coney Island and Lincoln, 4/10 and ½ day respectively. The case mix index (CMI) is up by .5% compared to last year based on an improvement of 10.5% over the last 2-year period.

Dr. Stocker asked how many years has there been an increase in the CMI.

Mr. Covino stated that for the last two years there has been an increase. Continuing with the reporting, pages 2, FTEs are down by 178 which are 235 below the target. Receipts are \$3.9 million better than budget while disbursements are \$36.8 million better resulting in a net positive surplus year-to-date (YTD) of \$40.7 million. Page 3, cash receipts and disbursements actuals, receipts are \$392 million worse than last year due to the timing of DSH and UPL payments. Expenses are \$80.3 million worse than last year due to the timing of City payments which are up by \$67 million YTD. Overall, receipts and disbursements are \$472 million worse than last year for the same period. Page 4, a comparison of actual to budget, inpatient receipts are up by \$8.2 million due to an increase in Medicare fee for service of \$31 million. Outpatient receipts are up by \$9.6 million due to Medicaid managed care, whereby a retroactive rate increase for the emergency room and ambulatory surg of \$26 million was received last month. All other receipts are down by \$14 million due to a 2009 retro rate take back in the appeals and settlements category. PS expenses are \$2.2 million over budget due to overtime. There is a \$4.6 million surplus in fringe benefits due to the timing of health and welfare fund payments. There is a \$35 million OTPS surplus due to the rollover from last year into this year and a surplus in IT due to the timing of projects.

Information Items:

Personal Services Key Indicators Quarterly Review 6/18/11 – 1/14/12

Mr. Covino stated that before beginning the report, it is important to put into context the impact of the reduction in FTEs on the various expense categories. FTEs are down by 576 which on an annualized basis represent PS and fringe benefit saving of \$50 million. A comparison of the current FTEs to FY 2009, FTEs are down by 2,500 which on an annualized basis represent \$218 million in savings. Therefore, it is important to recognize those savings in comparison to the current trends in nurse registry, overtime and allowances. Page 2, PS disbursements against the budget \$2.2 million over budget due to overtime as reflected in the report. Page 3, an FTE reduction by facility, Mr. Covino pointed out that the Enterprise IT was established this year so it is a new entity, whereby all of the staff from the facilities was transferred to a central office cost center. Page 4 FTE reduction by category, the reduction is primarily in environmental services aides and orderlies. Page 5, a comparison of overtime actual versus the budget, to-date expenses are up by \$4.9 million compared to last year of which \$2.5 million is due to expenses incurred for the hurricane earlier in the year. \$1 million in nursing overtime \$700,000 for primary care and techs and associates and \$300,000 for hospital security officer.

Dr. Stocker asked if the positive variance in techs/specs is related to the replacement of consultants.

Mr. Covino stated that it is and that some of those positions were consultant in IT, the remainder of that increase is related to an increase in HCIs of 33 FTEs. Page 6, comparison of overtime to the prior year which is \$4 million YTD, of which \$1 million was in nursing, plant maintenance \$.5 million and all other \$2.5 million. The increase is primarily in patient care techs/associates and special officers. Page 7, nurse registry is up by \$4 million due to the timing of replacement of staff, training at Lincoln in the ER for new nurses and the registry is being used to cover those staffing shortfalls. Page 8, allowances are down by \$1 million compared to last year.

Operating Financial Plan

Mr. Covino stated that the financial plan is a part of the City's overall budget process and for compliance with the State Public Authority Accountability Act (PAAA). The plan includes the actual results from FY 11, the budget for the current FY 12 and the Corporation's plan for FY 13-16. The plan is comprised of three sections, receipts on the first page followed by disbursements and the corrective actions on page 2. Page 1, the Medicaid fee for service revenues are forecasted based on the current YTD actual and adjusted for items that have not been reflected in the receipts such as retro rate adjustments and prior year appeals and settlements. The plan reflects a 4% reduction in workload based on the current utilization trends as reported which translates to a \$65 million annual reduction to the baseline. In accordance with the MRT, the plan assumes a 2% reduction which will be restored in the last quarter of FY 2013. Additionally, the plan includes a 2% trend increase from FY 2014. The UPL shows a decline in FY 12 compared to FY 11 due to a reduction in receipts on behalf of the prior years. In FY 11, \$943 million was received for prior year UPL payments and in the current FY 12 \$409 million. In FY 12, it is anticipated that the prior year balance will be received that will result in a stable baseline going forward. There are two components of the DSH payment, the base DSH of \$330 million and the DSH maximization which varies over the term of the plan. Projected DSH max payments range from \$305

million in FY 11 to \$387 million in FY 12. The change is based on the State DSH cap. In FY 14, the federal health reform will reduce the DSH payments by 5% per year. The DSH reduction also affects the pools in the out years as the BDCC pools are funded through the DSH.

Ms Cohen added that the pools are DSH but different formulas.

Mr. Covino continuing with the reporting stated that Medicaid managed care is projected to increase but the rate of growth is expected to decline resulting in a reduction of the growth from 5% per year to 3% annually. Medicaid managed care also includes enhancements of approximately \$100 million per year. It also includes the MetroPlus risk pool payments which are averaged at \$50 million per year.

Ms. Cohen asked if the assumption is that the growth in managed care will decline even though a number of individuals will be transferred from fee-for service into some form of managed care.

Mr. Covino stated that there has been a decline over the years. At one point it was as high as 20% and has slowly declined and the current projected trend is consistent with MetroPlus forecast in terms of their membership enrollment.

Mr. Aviles commented that in FY 16 a 5% straight-line reduction is reflected in DSH; even though it is projected that the DSH cut will become deeper in FY 16.

Ms. Zurack stated that it is in FY 17 for HHC, the federal FY is different.

Mr. Covino continuing with the reporting stated that in FY 17 it will be reduced and FY 21 there is a larger reduction. Medicare receipts are projected to be reduced in accordance with the federal health care reform in addition to a 2% reduction from the debt ceiling cuts which is 5% beginning in FY 14. Medicare managed care also reflects the same reductions. Managed care other includes HMOs and CHP which in total it is forecasted to remain flat. Year over year there are considerable fluctuations in those dollar amounts. City service in FY 12 payments are greater than the out-years due to City Council restorations of \$13 million for child health clinic, HIV Rapid funding; and mental retardation and developmental disabilities (MRDD) clinics and the FY restoration of the PEG program which will begin in FY 13. The City Council restorations are done annually; therefore, projected funding for the out-years is not reflected. Grants are projected to remain flat with minor variances due to anticipated timing of Medicaid administration. Expenses do not include projected savings related to the restructuring projects. The plan will be updated in the Executive Plan in the coming weeks. PS expenses are projected to remain flat with a 1.25% increase per year beginning in FY 15. Fringe benefits are projected to increase by 3% to 6%; however, the plan does not include the anticipated increase in pension of approximately 10%. When the plan was developed, the data was not yet finalized to allow for its inclusion. Overall, health insurance premiums are projected to increase by 8.6% per year or 40% over the life of the plan while pension increases are projected to increase by 3% to 10% before the 10% add-on for 23% over the life of the plan. OTRS expenses are projected to increase by 3% beginning in FY 13 and each year thereafter. Malpractice expenses in FY 12 include two payments, a prior year and the current year. In FY 13 the payments are projected to decrease to \$135 million which is the baseline and reflective of the MRT's savings that are anticipated as a result of malpractice reform. Affiliation expenses are projected to increase by 3% per year and debt service projected average of \$242 million per year of which 60% is City and 40% is HHC. The below the line actions include the anticipated receipts, disbursements, losses that are approaching \$1.2 billion by the last year of the plan. The corrective action plan includes the remainder of the cost containment and saving initiatives of \$25 million to \$30 million per year and restructuring savings as previously mentioned. Although these savings are below the line to-date a significant portion has been achieved which will be moved above the line in FY 12 after the completion of the analysis in the Executive budget. In addition there are significant savings for State and federal actions scheduled to begin in FY 13 of \$215 million growing to \$850 million by the end of the plan, FY 16.

Mr. Aviles stated that it is important to note that those savings for the State and Federal are yet to be determined.

Ms. Zurack stated that while HHC has some plans that will yield some savings in State and Federal actions, if not achieved, HHC will need to substitute more cost containment initiatives which will be further discussed with Mr. Aviles on how and when those actions will be taken for next year.

Ms. Cohen asked for clarification of HHC savings initiative cost containment versus restructuring.

Mr. Covino stated that it is primarily revenue enhancements

Ms. Zurack stated that from a mechanical perspective, the first line was done in 2009 and second was last year.

Mr. Rosen stated that the incorporation of the State and Federal actions is essential to the overall plan.

Medicaid Eligibility Report

Ms. Zurack informed the Committee that the Eligibility Report would be given by Mr. Frank Donno, Senior Director, Revenue Management due to Ms. Katz's laryngitis.

Mr. Donno stated that this year through January 2012, eligibility compared to submissions represents about 88.5% compared to last year's 85.8%. A number of the facilities are over 90% in terms of their eligible rate compared to last year for the same period. There were only two facilities that were over their target last year compared to four facilities this year that are over 90% of their eligibility target.

Dr. Stocker stated that some of the facilities such as Bellevue are down, whereas Kings County is up.

Ms. Zurack stated that it is important to put into context what the information that is being reported represents in terms of improvements. To that point, last week a Rapid Improvement Event (RIE) was held at Bellevue and based on that event it is anticipated that Bellevue will show improvement in the months ahead.

Dr. Stocker asked how soon after the RIEs are completed the progress improvement will begin to show in the numbers.

Mr. Donno stated that the two models have been running at Lincoln and Elmhurst since early January 2012 and it is expected that by the end of March 2012 a decision will be made as to which of the models will be implemented based on the level of improvement. Preliminarily, the models are very close in terms of their benefits. Therefore, there may be two models going forward. There is a final event scheduled for April 23, 2012 to focus on physician documentation, Form 4471, emergency Medicaid certification and Form 486 for disability certification.

Dr. Stocker asked what the expected time frame is for choosing the improvement model.

Mr. Donno stated that a number of the facilities have either viewed or used both models and some have begun implementing portion of the models. For example, Kings County has shown significant improvement by making use of both models that has resulted in an improvement in their process flow in terms of the rotation of staff assigned to retrieving applications from the emergency department as well as covering the multiple pick-ups throughout the day.

Dr. Stocker added that from month to month there is a slight improvement.

Ms. Zurack asked Mr. Donno what the lag time is for application submissions.

Mr. Donno stated that it is from a month to a year; however, based on a review of the submissions as part of the model, the application submission time frames are shortening.

Ms. Zurack stated that it would not be reflected in the monthly reporting given that the report is reflective of the decisions on the activity that took place months ago as far back as September 2011. Therefore, the big improvements are around that time period. The report is lagging improvements by 3-4 months. For example, at an RIE report-out at Bellevue, it was noted that the facility had already implemented a number of the improvements during that week and their plan is scheduled for completion by May 31, 2012. Therefore, the impact of those changes would not be reflected in the data until September 2012.

Statement of Revenues & Expenses as of 12/31/11 to 12/31/10

Mr. Jay Weinman stated that the report covered the second quarter of the current FY 12 through December 31, 2011. Overall, the Corporation's loss through that period is \$482 million compared to \$197 million last year for the same period. Operating revenues, net patient revenues decreased by \$252 million due to four items, \$54 million decrease in supplemental Medicaid managed care for MetroPlus; \$44 million additional revenue for the HMO for one GME case mix adjustment; \$15 million reduction for the 2% Governor's proposed cut effective 4/1/2011. Appropriations increased by \$5 million but remains negative which means the payments made to the City exceeded what HHC received from the City for services, a slight improvement over the last year. Premium revenue increased by \$231 million or 37% due to \$114 million for the pharmacy carve out effective 10/1 which is MetroPlus revenues for pharmacy costs; \$42 million IGT and \$50 million premium rate increased retroactive to 4/1 and \$26 million for enrollment growth. Operating expenses, PS expenses decreased by \$15 million which is reflective of the 640 FTEs reduction last year of 24%. Other Than Personal Services (OTPS) expenses increased by \$157 million primarily due to the increase in MetroPlus of \$114 million for pharmacy and rate increases/membership growth. After deducting those items from the OTPS expenses, expenses decreased by 1.4%. Fringe benefits and employees payroll taxes increased by \$33 million or 6.8% health insurance increased by 10%; pension by 19.5% and post employment benefits increased by \$65 million, accruing annually at \$700 million for the year up from the \$620 million reported at the end of last year due to anticipated increases, interest rates and the increases over the past years. Affiliation expenses increased by \$19 million or 4.7% slightly down from the increase last quarter but relatively consistent from period to period.

Ms. Zurack stated that a large portion of the non-cash expenses are driving the size of the deficit and that if those items were excluded, it would be significantly different not to diminish the impact of the post employment benefit which is becoming very large.

Mr. Rosen stated that it is huge for the City as well. The numbers are becoming astronomical.

Ms. Zurack stated that the rating agencies and actuaries have discussed this as being a national problem; however, it does address the issue of health insurance for retirees and the impact of that as an expense.

Mr. Weinman added that the \$700 million accrued annually less than \$100 million is actually cash pay-go.

Medical & Professional Affairs / Information Technology Committee
February 29, 2012 – As reported by Dr. Michael Stocker

Chief Medical Officer Report:

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

Health Home

HHC has been designated as a Health Home by NYS DOH in the Bronx and Brooklyn, for patients with multiple chronic conditions, serious and persistent mental illness or HIV. We have applied for the same status in Manhattan and Queens; and have again done so as an explicit partnership between the HHC delivery system with the HHC health plan, MetroPlus. Patients will commence being assigned in the next month and appropriate staffing and protocols are being developed. They have reduced the scope of the program (60%) by removing a large segment of patients who were the least complicated and they wish to start off with the most complicated 5% of patients who are extremely complicated with no connection to ambulatory services. This does have significant complications to us operationally and we are in discussion with them as to how that will actually work.

Emergency Operations Plans

The HHC Office of Emergency Management presented a Request for Proposal (RFP) to the Contract Review Committee to select a qualified vendor to develop Emergency Operations Plans (EOPs) for HHC's 11 Acute Care facilities, 4 Long Term Care facilities and Central Office. The EOPs must meet all applicable Federal, State, City and other organizations regulatory requirements. The vendor will develop EOPs that are consistent in content and layout, however are customized to each facility based on their Hazard Vulnerability Analysis, services provided, patient mix, catchment area, campus, etc.

In addition, the vendor will develop and provide EOP training for key personnel and develop a PowerPoint training program for remaining personnel that is facility specific. Separate from this RFP but to be included in the overall project, we will purchase a new computerized Incident Command System (ICS), Emergency Alert system and computer equipment for each facility Command Center. The project will conclude with a Corporate-wide functional exercise and After Action Report which will test the EOPs, Command Center systems and interoperability, and the efficacy of the training programs.

Funding for this project is provided from a \$1,000,000 grant through the State Department of Homeland Security.

Credentialing

After many months of preparation and work we are nearing a significant milestone in our effort to have a single and consistent credentialing process for the Corporation. At a recent meeting with the HHC Medical Directors a presentation of the credentialing software was done by Medkinetics[™] - <http://www.medkinetics.com/contact.cfm>. Medkinetics is the vendor contracted by Anthem. (HHC contracts with Anthem as our CVO, or Central Verification Organization.) Their on-line product will enable central office and local views of credentials and privileges of all licensed physician and midlevel providers in the Corporation as well as Quality metrics meeting the Joint Commission criteria for FPPE and OPPE (Focused and Ongoing Professional Evaluation), as well as a consistent listing of privileges. The Medical Directors expressed clear support for the effort and look forward to the roll out over the next several months for every clinical department in each of the HHC facilities – Ambulatory, Acute and Long Term Care.

Drug Shortages

The issue of medication shortages has been in the press for well over a year. Unfortunately it is not getting better and in fact shows signs of getting worse. Chemotherapy, Anti-microbials and anesthetic agents are the most common category of medication in short supply. The state and federal governments are aware and a recent FDA Bulletin was issued to increase awareness (<http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm292658.htm>) and to announce a new effort to increase chemotherapy availability by permitting importation from Europe. Every facility is aware and the Pharmacy Directors and Medical Directors are coordinating those efforts. Medical staff are identifying alternative medications where feasible and restrictions are being placed on critical drugs in short supply to ensure optimum utilization. I would like to commend all HHC Pharmacy Directors who have been enormously resourceful in providing an ongoing supply of drugs – they have been amazing at what they have been able to achieve. Also physicians in authorizing

regularized substitutions for common drugs that are not available – ongoing review to ensure our formulary do line up with existing guidelines that we use and if they don't we put substitutions into the guidelines – lastly, we are not using the grey market to source replacement drugs.

Emergency Department Dashboard

The Emergency Department (ED) standardization project began in March 2010, as HHC recognized that we had a high degree of variation in data capture among the EDs that made comparative and throughput reporting difficult. This project utilized electronic monitors (whiteboards) and enabled the tracking of patient flow via real-time updates triggered by electronic clinical documentation and standardized the data capture for key ED processes - the last facility (ten in total) went live in November 2011.

Although data capture was made consistent across the Corporation, ED directors still required access to their key performance metrics easily and quickly to reduce bottlenecks to improve operational workflow, analyze trends to identify areas for improvement and, for executives, enable comparative reporting between the EDs in the Corporation. The ED electronic dashboards project was conceptualized to meet these needs and began being implemented in November 2011, in order to support decision making. This dashboard enables the EDs to better manage their throughput by providing a solution that identifies bottlenecks in their ED in near-real time. The active and dynamic management of the ED reduces patient wait time, increases provider productivity and increases patient satisfaction, all leading to improved patient care. Feedback from facilities has been highly positive. Facilities have commented the dashboard currently enhances team/area assignment, documentation, assessment of patient flow, and monthly reporting. Eight facilities currently have access to the dashboards. The last two facilities will have access by March 9, 2012.

Nurses Improving Care to Healthsystem Elders (NICHE) Program

Harlem Hospital Center, North Central Bronx Hospital, and Queens Hospital Center are participating in a grant funded by FanFox and the Hartford Foundation to improve the care of the elderly. They have all met and exceeded the goals for the first year for education, enhancing the structure of the multidisciplinary approach, and are currently working to enhance the environment to make it more conducive to caring for the special needs of the elderly. HHC has done so well that NYU, a partner in the grant has filed for an expansion to include Lincoln Medical & Mental Health Center, Elmhurst Hospital Center, Jacobi Medical Center and Coney Island Hospital in the upcoming new grant year. A pamphlet is attached for more information.

GNYHA Nursing Interns Preceptor Program

GNYHA has invited HHC to participate in a grant funded project to provide a six (6) month internship for new licensed RN's with BSN. Bellevue Hospital Center, Metropolitan Hospital Center and Kings County Hospital Center have expressed the desire to participate. Each site will get three (3) – four (4) "interns" who will be paid by the grant. The facilities will be provided the incremental costs for the precepting of the nursing interns. If positions are available when the internship is complete we may choose to employ them.

RN to BSN Program

The RN to BSN federal grant through HRSA (Health Resources and Services Administration) is ongoing at Kings County Hospital Center and Generation +/Northern Manhattan Network. Approximately 50 RN's are in the midst of pursuing their BSN's. The Kings cohort is on target to complete the program this year and the Bronx group in 2013. There is also training for all staff who are involved with the precepting of new and transitioning staff. The second session of three sessions over the life of the grant is a three day event scheduled in March at Metropolitan Hospital Center. This is a grant worth approximately \$850,000 - funds are administered through HHC, payable to St Francis College and the Vermont Nurses in Partnership who provides the precepting programs.

I PRO HAI Prevention Project

HHC acute care facilities are participating in a national project to reduce Healthcare Associated Infections. There has been a reduction in CLABS in nearly every unit participating. See attached report.

Patient Satisfaction

Press Ganey has commenced surveying our patients throughout the patient care spectrum - process is being perfected in English and Spanish, with plans to expand to 13 languages in many venues. Sample sizes have been increased, areas surveyed now include ambulatory surgery, rehab, outpatient testing areas and specialty clinics in addition to inpatient, outpatient, emergency department and behavioral health. Super-users have been identified, have received initial training and are assigning access at the facilities.

IT Psychiatric Emergency Services Project

In an effort to improve the efficiency and patient flow in HHC's eleven psychiatric emergency services, the Office of Behavioral Health is working with Central Office IT on the development of whiteboards for patient tracking. The project has been placed on a fast track with a 12-month completion deadline. Currently, all psychiatric emergency services use a standardized assessment form that was developed over 5 years ago as part of a legal settlement. The project incorporates communication with regard to patient status, alerts and clinical documentation. The Psychiatric Emergency Services Directors have been working together with IT to develop a more standardized workflow that will be incorporated in the project. It is widely recognized that individuals with serious and persistent mental illness die prematurely from chronic medical conditions. This project better integrates both psychiatric and medical care in the Emergency Department.

HHC Partners with the NYS Office of Mental Health to Provide Corporate Crisis De-escalation Training

In HHC's ongoing effort to reduce seclusion/restraint (S/R) use and increase the patient-centered rehabilitation focus in the delivery of care, HHC has partnered with the State Office of Mental Health to utilize their training resources to provide an intensive five-day train-the-trainer project entitled "Preventing and Managing Crisis Situations." The first of two training sessions was held this week. All HHC facilities are participating. As an outcome of the training, we look forward to continuing HHC's decreased use of S/R and reducing the number of inpatient assaults and fights.

MetroPlus Health Plan, Inc.

Dr. Arnold Saperstein, Executive Director, MetroPlus Health Plan, Inc. informed the Committee that the total plan enrollment as of February 1, 2012 was 425,439. Breakdown of plan enrollment by line of business is as follows:

Medicaid	356,923
Child Health Plus	17,823
Family Health Plus	36,265
MetroPlus Gold	3,089
Partnership in Care (HIV/SNP)	5,693
Medicare	5,646

Dr. Saperstein provided the Committee with 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. In addition, he provided a graph showing net transfers for the month of January 2012 for Medicaid and Family Health Plus (FHP).

Dr. Saperstein informed the Committee that MetroPlus has been ranked #1 in the City of New York for five (5) out of the last six (6) years based on overall quality and member satisfaction that is published in the Medicaid Consumer Guide. This year, Dr. Saperstein is pleased to announce that MetroPlus, for the first time ever, has been ranked #1 in New York State. Dr. Saperstein has attached the rankings of all 18 plans that have Medicaid patients and operate in New York State. This score is based on Quality, Consumer Satisfaction, Preventive Quality Indicators and Compliance. As the Committee can see on the attached document MetroPlus achieved a 100% score in quality and was ranked the highest overall of all the plans in the State. These results are a testament to the excellent high quality care and service provided by all of MetroPlus providers, as well as the excellent work performed by MetroPlus staff.

Dr. Saperstein provided the Committee with a copy of the MetroPlus final draft of the Strategic Plan for 2012 which summarizes goals and major projects for 2012. This Strategic Plan will be submitting to the MetroPlus Board of Directors for discussion and approval at the next meeting in March.

Dr. Saperstein informed the Committee that there is still much lively discussion occurring between the New York State Department of Health (SDOH) and health plans regarding the transition of the homeless population into managed care on April 1, 2012. MetroPlus' Chief Medical Officer, Dr. Van Dunn is on the State's implementation workgroup. There are significant challenges to manage a population that does not have a permanent residence and might be extraordinarily difficult to contact. In addition, the State has still not finalized their expectations of how the plans will work with, and pay the homeless shelters and other homeless services.

Dr. Saperstein noted that in November 2011, he advised the Committee of the MetroPlus' first month experience since they took over the management of pharmacy benefits for FHP and Medicaid. As a follow up to that report, Dr. Saperstein provided a spreadsheet detailing the monthly pharmacy trend for October 2011 through January 2012. It shows that after four months, pharmacy costs have become more manageable, and the plan is no longer experiencing losses, after one quarter of pharmacy management. MetroPlus is modifying some of its systems and operations to prepare for the Health Home initiative. The Plan is developing operations to assist in case finding outreach and consent to enroll individuals into the HHC/MetroPlus Health Home.

Dr. Saperstein concluded his report by informing the Committee that MetroPlus Medicare closed the 2011 Annual Open Enrollment Period with a total of 420 gross new members. As of February 1, 2012, MetroPlus has a total of 5,694 active enrollees in all Medicare products combined. As part of their 2012 Strategic plan, they are focusing most of their Medicare sales and marketing efforts on growing the two Dual Special Needs Plans, which offer competitive health care and value added benefits for the dual eligible population. MetroPlus is also in the process of reassessing their retention strategies for all Medicare lines. In general their retention rate has been maintained at over 97%.

Information Items:

Business Intelligence Analytics

Presenting to the Committee was Paul Contino, Chief Technology Officer. Mr. Contino provided the Committee with an update on Health Home's (HH) progress on its Business Intelligence (BI) initiative. First he described what Business Intelligence really is: which is the

processes, technologies, and tools that help us transform data into information, information into knowledge and knowledge into decisions and action. BI is various technologies for gathering, storing, analyzing and providing access to data to help enterprise users make better business decisions. BI is about getting the right information, to the right decision makers, at the right time.

The goals of BI is that it should: align with the enterprise goals and objectives of HHC; make the best use of information assets; enhance business processes with timely analytics; help enterprise with strategic, tactical and operational decision making; create a 'single source of truth'; deliver a predictable, complete, consistent, reliable and timely source of information; and transform data into information, information into insight, insight in action.

Swimming in data but gasping for information is a great way to categorize how we currently exist with data. There is a lot of disparity of data across multiple systems; data resides in silos resulting in multiple unsynchronized reporting solutions and shadow databases; there is few enterprise standards for data management; there is no data governance; there is a variety of metrics, methodologies and calculations that causes a lot of disparity in reports seen every day; more time is spent collecting/manipulating data than on analysis – some surveys conducted show that large groups of analysts are spending anywhere from 60-90% of their time just gathering data, manipulating it and creating presentations with very little time spent on analysis ; and there is an inability to reconcile data across the Corporation.

The benefits of BI include: improve efficiency of legacy financial and clinical systems and processes, including new electronic medical record and credentialing system; monitor and analyze key metrics and objectives, including quality, safety, risk, and compliance; provide insight and analytics around clinical performance and patient care; ultimate goal is to expand access to and availability of information to support decision-making; identify areas of competitive/comparative strength and weakness; and research opportunities.

Moving forward, the BI Executive Steering Committee was established to ensure that BI meets HHC's strategic needs and supports HHC's goals and mission. The importance of BI governance is to create a Business Intelligence Competency Center (BICC) that represents all lines of business; to create processes that enforce data integrity principles & support data quality initiatives; data / metric definitions & standardization, change control. The key strategy to BI will be the Enterprise Data Warehouse which is an integrated view of our data assets from across Corporation, from all sources such as clinical, financial, supply chain, and human resources and putting it into a an Enterprise Model from where we can actually do very sophisticated cross correlated analytics across our complete data set versus the silos of data sets that currently exist.

The Gartner CIO technology priorities for 2012, rank analytics and business intelligence as one of the top five. The study conducted in the fourth quarter of 2011 and entitled "Amplifying the Enterprise: The 2012 CIO Agenda," polled 2,335 CIOs covering 37 industries in 45 countries and representing some \$321 billion in IT budgets.

A lawyer was engaged to assist with conducting a current state assessment of HHC's enterprise BI environment including needs, support processes, data governance, data warehouses, information quality, and support services. The HHC BI team has conducted a preliminary assessment on the current state of BI's readiness, which was used as part of the BI Strategy definition. The future state visioning is being completed this week and will be presented to the BI Steering Committee. The future state visioning will include: future state recommendations required to support enterprise wide information and analytics needs, and initiatives through implementation of Enterprise Data Warehouse; outline a framework to develop data standards, link disparate data assets, consolidate discrete data silos (internal and third party) and further develop analytical capabilities; and recommendations to develop a service oriented support model for data governance and data analytics. The next step will be to develop a high-level business case which will define project investment, timing and resource requirements and to assess the associated tangible and intangible benefits. Projected completion date is the end of February. The last phase with a projected completion date of March 5th is roadmap development will encompass the development of a roadmap with current to future state transition plan that aligns information technology & business initiatives and to recommend data quality & integration techniques along with technologies that support a services oriented platform.

Mr. Contino then provided the Committee with a high level overview of what they are proposing in terms of a technical framework for BI. There are three tiers: 1) data integration tier in which all data sources will be linked. Currently there are 2,200 different databases and 17 different applications which the BI Steering Committee will prioritize what data we need access to in order to begin the integration process; 2) data warehouse tier in which data is structured and designed to provide analytics and reporting which is the; 3) presentation tier.

Mr. Contino informed the Committee that the value that BI provides HHC is a seamless drill down capability from the highest level of executive report all the way down to line management with transaction detail. We will be able to navigate up or down the value chain data. Right now most executive dashboards are comprised of cobbled analytics that are designed in a disparate manner and put together and if you try to actually navigate from those dashboards down to any transactional level of detail – you are lost.

Mr. Contino concluded his presentation by discussing the BIO planning and implementation timeline – as mentioned earlier, the first piece of this strategy is around connecting to all the data sources – after we finish the lawyer assessment one of the key pieces is that we will be acquiring the technology [Extraction, Transforming and Loading (ETL)] that will allow us to connect and then stage data to our warehouse, software. The challenge with the data warehouse is typically in the past one had to actually build the warehouse from scratch, which could

take three to four years. Fortunately the field has evolved and matured and there are vendors that have health care data models. We are currently evaluating the purchase of one of these health care models which gives us 60-80% of all the data definitions and data structure that is used in a typical health care organization. Goal is to have an ETL platform in place by the third quarter of this year and begin connecting to the different databases. Acquisition of Enterprise Healthcare System Data Warehouse will be completed by fourth quarter this year and then we will begin to migrate data which will occur in multiple phases but it is anticipated to be completed by the third quarter of 2013. By the second quarter of 2012 they will complete the evaluation, selection and acquisitions of a BI Analytics Reporting Software. In addition a Business Intelligence Competency Center was developed which drives priorities and use of analytics systems and provides ongoing governance. Overtime the number of data sources will be increased in the data warehouse and work with leadership on which dashboards and metrics need to be developed for each institution will continue to evolve.

Dr. Stocker stated that his fear is that these organizations, like many others, have local databases which people are very dependent on to make decisions and that if we have an overlying standard database staff will use that in addition to their local database. Mr. Contino responded that yes, this could potentially happen and in order to alleviate this what needs to happen is from the top level of the organization there has to be a system of truth and when you hold people to a standard they will come and present data it has to be from that source and not another database – ultimately it is about building trust in the enterprise and re-enforcing use of the system.

Dr. Stocker stated that the Corporation is now developing and thinking of new data needs such as for Health Home we have a data reporting requirement and inquired as to whether we can do it as this is new and can it be standardized across the Corporation. Mr. Contino stated, even though he is involved in Health Home in conjunction with Dr. Louis Capponi, Chief Medical Informatics Officer and Dr. Ross Wilson, Senior Vice President/Corporate Chief Medical Officer, that this is not a BI application it is actually a separate system that collects the data. Getting data governance and standardization in play is important so that we have a culture that supports it moving forward.

Electronic Medical Record (EMR) Vendor Selection Update

Presenting to the Committee was Louis Capponi, MD, Chief Medical Informatics Officer. The iCIS Selection Committee continues to meet regularly and consider the strengths of each Electronic Medical Record vendor finalist in our negotiated acquisition process. The results of this extensive and detailed selection process will be presented to this Committee for consideration in the coming months as the vendor of choice for HHC's next generation EMR.

The selection Committee and eight (8) expert work groups, consisting of over 150 nurses, doctors, pharmacists, clinical support staff, and leadership from around the corporation are near completion of a second round of due diligence reviews. They have intensively studied the functionality and fit of these software products; focusing most recently on departmental systems such as laboratory, pathology, the OR, Radiology, and Long term care.

The selection Committee and HHC IT staff are intensively reviewing contract terms and conditions as well as the total cost of ownership among the finalists. In addition to creating the master implementation plan, we will determine if there is significant variation in implementation costs among the vendors.

A detailed interrogation of the software capacity to handle HHC's high transaction volumes is also underway. Three site visits were conducted to stress test potential vendors system from a technology perspective, simulating tens of thousands of simultaneous users and millions of transactions to understand how the system would perform and to make sure the system would not break. HHC has engaged two independent parties with the specific expertise to review the results of system performance and scalability tests. The results of these reviews are anticipated later this month.

The team will be transitioning into the contract negotiation phase early next month in order to secure the most aggressive software pricing and service level agreements possible.

The high level master project plan referenced earlier is comprised of two to three thousand lines of tasks and major activities that must occur over the next five to six years. A component of the master project plan includes preparation of a detailed staffing plan as well as review of the implementation costs differences based on the use of consulting staff vs. HHC employees.

HHC will need to engage one or more likely several vendors to supply at least a portion of temporary IT resources to achieve this extensive implementation effort. To that end, HHC will be presenting to the board a separate requirements contract of pre-qualified vendors with a talent pool from which HHC can draw upon to conduct the implementation.

Finally, HHC is evaluating the potential for ongoing staff development and employment of entry level staff by developing local college and university outreach programs to attract young professionals for a career in Health care IT.

Dr. Capponi noted that staff has worked tremendously hard, and he has been very impressed with the level of participation of the clinical staffs, Councils and the support of administration and leadership.

Strategic Planning Committee – March 13, 2012
As reported by Josephine Bolus, RN

Senior Vice President Remarks

Ms. Brown greeted and informed the Committee that her remarks would include brief updates on federal, state and city issues and the Corporation's Breakthrough work.

FEDERAL UPDATE

Ms. Brown reported that, on February 17, 2012, both Houses of Congress had adopted the Middle Class Tax Relief and Jobs Creation Act of 2012, which was signed into law by President Obama on February 22, 2012. This law includes a 10-month extension of the Social Security payroll tax holiday as well as an extension of the temporary Medicare physician payment rates fix. Without the enactment of this law, there would have been a 27.4% cut to physicians' Medicare payments. Ms. Brown noted that this payment fix will be renegotiated at the end of the calendar year.

Ms. Brown explained that to offset this spending the new law includes a one year extension of the Medicaid Disproportionate Share Hospital (DSH) funding reductions that are already mandated by the Affordable Care Act (ACA) to federal fiscal year 2021. While this provision is proposed to save the federal government \$4.1 billion, the estimated HHC impact is a revenue loss of \$421.8 million for that year alone. Another offset that was included in the law is a reduction of the allowable reimbursement for Medicare bad debt payments from 70% to 65%. That 65% allowable reimbursement level will begin on October 1, 2012. This provision is projected to save the federal government \$6.9 billion over ten years but would cost HHC a total of \$1.9 million over that same time period.

Ms. Brown noted that the proposal to cut Medicare payments to hospital outpatient departments for evaluation and management services was not included in the new law due to Senator Schumer's leadership. This proposed cut could have resulted in a revenue loss for HHC of \$186 million over ten years.

President Obama's Proposed FFY 2013 Federal Budget

Ms. Brown reported that, on February 13, 2012, President Obama released the Administration's proposed federal fiscal year (FFY) 2013 budget that included reductions to both the Medicaid and Medicare programs totaling \$364 billion over ten years. Ms. Brown noted that the specific health care cuts that were included in the Administration's proposed budget mirrored those that had been submitted to the "Super Committee" in fall 2011. The Administration's proposals, if enacted, would result in a revenue loss for HHC of \$1.5 billion over 10 years.

Ms. Brown informed the Committee that there are three specific Medicaid proposals that were of primary concern to HHC. The first is a phase-down of states' current use of Medicaid provider taxes from FFY 2015 to FFY 2017 to 3.5% starting in FFY 2015. Currently, New York State's provider tax rate is 5.5%. The Administration's proposal would save the federal government \$22 billion. However, HHC is projected to lose an estimated \$687.5 million over 10 years, if this proposal is enacted.

Another component of the Administration's proposal is the reconfiguration of states' FMAP (Federal Medical Assistance Percentages) by replacing the individual matching rates for Medicaid and Children's Health Insurance Program with a single lower rate. This provision is projected to save the federal government \$18 billion over 10 years. While there are still no specific legislative details, it is estimated that HHC could lose another \$277 million over 10 years.

Ms. Brown explained that the third proposal is a two-year extension of the ACA-mandated Medicaid DSH cuts to FFY 2022, which is projected to save the federal government \$8 billion. Ms. Brown emphasized that the first year of this extension had been included in the Middle Class Tax Relief and Jobs Act of 2012, which would result in a loss for HHC of \$421 million for each of the two years. Ms. Brown clarified a statement that was made at the Finance Committee that was held at 9:00am. She described the impact of the already enacted ACA-mandated DSH cuts as the following:

DSH Cuts Already Enacted in the ACA and H.R. 3630

	FFY 2014	FFY 2015	FFY 2016	FFY 2017	FFY 2018	FFY 2019	FFY 2020	FFY 2021	Total
Estimated New York State Medicaid DSH Cut Percentage (GNYHA)	5%	5%	5%	16%	45%	51%	37%	37%	
HHC Losses-in millions	(\$56.5)	(\$56.5)	(\$56.5)	(\$180.8)	(\$508.4)	(\$576.1)	(\$421.8)	(\$421.8)	(\$2,278.4)

Ms. Brown informed the Committee that there were several Medicare specific proposals that were of major concern to HHC that she would not present in her remarks but would include in the meeting's minutes. These Medicare specific proposals are the following:

- A reduction of Indirect Medical Education (IME) payments by 10% starting in FFY 2014. This proposal would save \$10 billion nation-wide but would cost HHC \$93.8 million over 10 years.
- A reduction of the Medicare bad debt reimbursements from the current rate of 70% to 25% over three years. This provision is projected to save the federal government \$36 billion but would cost HHC an estimated \$15.3 million over 10 years.
- Proposals targeting long term care facilities that would save the federal government an estimated \$63 billion and cost HHC \$36.7 million over 10 years. These proposals include:
 - Reducing payments to inpatient rehabilitation facilities (IRFs), long-term care hospitals, skilled nursing facilities (SNFs), and home health agencies by 1.1% beginning in FFY 2014 through FFY 2021.
 - Equalizing payments for IRF with SNF payments, beginning in FFY 2013, for three conditions involving hips and knees, as well as other conditions selected by the Secretary of Health and Human Services; and
 - Reestablishing the Medicare policy in FFY 2013 that required at least 75% of patients admitted to an IRF to have conditions that meet one or more of 13 designated severity conditions in order for that facility to qualify as an IRF.

Ms. Brown shared with the Committee that HHC's Washington, D.C., Lobbyist, Judy Chesser, had met with every single member of the New York Congressional Delegation and their staff to discuss the Administration's proposed budget and its impact on HHC. They raised their concern of the lack of alternative strategies given the current environment in Washington, D.C.

STATE UPDATE

Ms. Brown reported that State Budget negotiations were proceeding ahead of schedule. Both the Assembly and Senate have prepared their respective one-house budget bills and will be working out the differences between them and the Governor's Executive Budget. Ms. Brown presented a brief summary of the items in the Executive Budget that were of interest to HHC with the Senate's and Assembly's response to these budget items. This summary is provided below:

Executive	Assembly	Senate
Housing		
\$75M (\$150 M All Funds) for Affordable Housing	\$50M (Memo indicates program delayed for \$25M savings. Budget language includes \$125M All Funds)	\$22.5M + \$5M for DHCR (Memo indicates program delayed for \$52.5M savings and \$5M to DHCR. Budget language includes \$92.5M All Funds)
Supportive Housing fund created from portion of funds resulting from hospital and nursing home closures/bed reductions. Funding cannot exceed savings, with annual adjustments.	Limits applicants to local governments or 1+ year old NFPs primarily engaged in supportive housing programs. Includes all savings from closures/bed reductions without creation of methodology or downward adjustments	Requires DOH to issue report with proposed legislation by 1/1/13 after stakeholder's consultation. Funding methodology to include all savings from closures/bed reductions, with downward adjustments to reflect actual savings
DOH to issue non-competitive grants	Requires Competitive grant process	Need legislative approval to distribute funds.
Can be used for housing development & "other programmatic activities to ensure a stable system of supportive housing." Can include maintenance of existing providers	Funds can be used for same purpose as Executive, but does not include maintenance of existing providers in grant criteria	Funds can be used for "maintenance of existing supportive housing and development of new supportive housing"
Excess Medical Malpractice Pool		
Makes changes that would disqualify HHC	Rejects proposal	Modifies proposal to require legislation to be passed after budget to ensure viability of pool.
Nursing Home Transition and Diversion Funding		
Includes current year funding only (\$2.3M)	Current year + \$2.3 M from 2011-12 with HHC-Barrier Free Living Demonstration Program	Current Year + \$2.3M from 2011-12. No demonstration language.
State Inmates to HHC Facilities (730s)		
State could require HHC to take inmates	Modifies language to remove placement in	Rejects proposal

	HHC Hospitals. Maintains language to allow for out-patient restoration.	
Behavioral Health Provisions		
Broad language allowing closure of Kingsboro and consolidation of Children's Psychiatric Centers in Bronx, Brooklyn & Queens	Rejects proposal	Rejects proposal and requires a Legislative MOU & report from the Behavioral health Services Council (old Mental health Services Council) before any service reductions affecting mentally ill or DD population with stakeholder input & legislative MOU
Extends CPEP authorization for 4 years;	Accepts proposal	Accepts proposal
Merges Mental Health Services Council with other to create new Behavioral Health Services Council (affects HHC's two PHHPC appointees)	Accepts proposal	Modifies proposal
Sets up framework for DOH and OMH to jointly operate Behavioral Health Agencies and allows them to waive regulations or determine compliance with another agency's regulations;	Accepts proposal but adds requirement for annual report	Modifies proposal
MRT		
Extends Global Cap & "Super Powers" by one year (through 2013-14), for total of three years	Accepts proposal	Rejects proposal and 1) requires OSC to conduct audit of current cap & 2) establishes a methodology to share savings under cap
Provides Medicaid reimbursement for podiatry for diabetes patients, lactation consultants, harm reduction, coordinated hepatitis C care, prenatal care coordination and enteral formula for HIV/AIDS patients;	Accepts proposal	Rejects harm reduction, coordinated hepatitis C care, prenatal care coordination.
Requires pharmacies to provide translation services or other assistance to patients with language access issues;	Accepts proposal	Rejects proposal
Establishes a Primary Care Services Corp Loan Repayment Program;	Accept proposal	Rejects proposal
Managed Care		
Provides facilitated enrollers for movement to mandatory MLTCP. DOH can award non-competitive contracts	Modifies to require mini-bid process	Modifies to requires competitive contracts
Requires MLTCPs to offer the consumer directed personal care program;	Accepts	Modifies proposal to allow, but not require
Health Insurance Exchange		
Includes the Health Benefits Exchange legislation that represented a 3-way agreement with the Legislature last year	Accepts with minor changes to findings	Rejects proposal

Ms. Brown added that there was still more work to be done to have some of the language tightened up for those positions that are currently not in the best shape in terms of HHC's interest.

CITY UPDATE

Ms. Brown reported that President Aviles would be testifying before the City Council Health Committee on HHC's preliminary budget on March 19, 2012. She noted that President Aviles' testimony would include a review of HHC's financial state, fiscal challenges and would also provide an update on the progress HHC is making to close its budget gap. Additionally, Mr. Aviles' presentation will also include the status of HHC's major initiatives including HHC's work to develop innovative care models, implement more efficient processes, and upgrade HHC's infrastructure (including clinical information technology) to transform into a more integrated health system that is patient-centered, efficient and ensures better patient outcomes through coordinated care delivery. Ms. Brown noted that it was important to share this information with the Council to demonstrate that HHC remains committed to excellence in spite of its significant financial challenges. Ms. Brown noted that the

Council will also be reminded that those HHC programs that they had funded in the past will require funding restoration this year. Ms. Brown also reported that the Council would hold a second set of budget hearings later in the spring, in late May or early June.

BREAKTHROUGH UPDATE

Ms. Brown reported that Harlem Hospital Center had successfully launched Breakthrough at the end of calendar year 2011. Accordingly, Harlem Hospital will be deploying Breakthrough tools to aid with the implementation of the move to the new patient pavilion. Ms. Brown also reported that there had been a tremendous Breakthrough event focused on how the Corporation would roll out care management services at all HHC's Emergency Departments (EDs). The Executive Sponsor of that event was Anne Sullivan, M.D., the Senior Vice President of the Queens Health Network. This was a unique Breakthrough event because it involved a supersized number of team members with representation from all HHC hospitals from across all the disciplines. It also included medical and administrative staff participation from the EDs. Mr. Aviles added that the event included 32 team members who tackled the flow redesign in the EDs around care management. He explained that, in the course of that one week, a very detailed work plan was developed including a marketing and communications plan so that staff in the various EDs could understand why these changes were being undertaken. Mr. Aviles added that, over the course of the subsequent two weeks, each facility will be working on their facility specific gap analysis and implementation plan. Mr. Aviles commented that this was the first time that HHC has taken on something so ambitious in terms of fundamental changes in the creation of standard work across the entire enterprise simultaneously. Ms. Brown reported that the team had also developed a model that will be reviewed at each of the local sites as part of their implementation plan. She noted that the staff wholly understands the importance of what they are doing as it relates to reducing readmissions, helping patients to extend their community tenure, making sure that discharge plans are effective and linking patients to primary care.

Information Item

World Trade Center Health Program Survivor Program Update
Joan Reibman, M.D., Medical Director, HHC WTC Environmental Health Center

Ms. Brown informed the Committee that there had been a lot of discussion in the press about a new registry, new surveys relating to the health concerns of individuals who had been affected by the World Trade Center disaster. She noted that HHC's WTC EHC team had been in the middle of the discussions over these last several years around the health care implications and research related to the same. She informed the Committee that she had invited Dr. Reibman, who conducted this presentation several months ago for national program representatives, to present the findings of her work to the Strategic Planning Committee and to discuss the implications for HHC's work in terms of treating individuals who had been affected by the WTC events.

Mr. Terry Miles, Executive Director, WTC Environmental Health Center informed the Committee that the implementation of the James Zadroga 911 Health and Compensation Act in July 2011 included the establishment of a Scientific Technical and Advisory Committee. The first meeting of this Committee occurred in the fall. It is comprised of physicians, attorneys, and laypersons from all over the country including the New York area. Dr. Reibman was asked to prepare a presentation for the first meeting. Mr. Miles stated that Dr. Reibman would be providing a modified version of that presentation. Mr. Miles acknowledged individuals who had been integral to the program from the beginning. He recognized Judy Wessler of the Commission on the Public's Health System (CPHS), Andy Cohen of Deputy Mayor Linda Gibbs' office and LaRay Brown.

Dr. Reibman began her presentation by sharing how the World Trade Center Environmental Health Center (WTC EHC) was established. She stated that the WTC EHC represents a special collaboration between the public hospital system, the academic community, community groups and the City. This collaboration provides a model for responding to emergencies and disasters in the future.

Dr. Reibman stated that what is now dogma is the understanding that the WTC destruction was an environmental disaster. Dr. Reibman described the characteristics of the particles/fumes that had been released from WTC destruction. She stated that, through a lot of work conducted by the academic community, the WTC dust was determined to be alkaline (pH level at 9-11) and include the following:

- Construction materials (cement, concrete, wallboard)
- Particulate matter (calcium sulfate, calcium carbonate, crystalline silica)
- Fibers
- Combustion products (polycyclic aromatic hydrocarbons, hydrocarbons)

Dr. Reibman informed the Committee that a lot was learned about the WTC dust composition from a firefighter who was brought to Bellevue Hospital two weeks after the WTC event. The firefighter was deathly ill and was placed in the intensive care unit. The patient was bronchi scoped and his lungs were washed out. She reported that they were able to pull out from the washings of his lungs pieces of asbestos, fly ash and fibrous glass. The importance of this finding is that these particles were larger than what was normally anticipated that can get down into the lung. Dr. Reibman added that they learned that there were a lot of products in the dust. An individual can breathe in these particles not only the very small ones but also the large particles which produce the potential for damage. She reported that the work including lessons learned had been published.

Dr. Reibman informed the Committee that through the enormous efforts from the Fire Department (FDNY) and multi hospital consortium (including Bellevue Hospital Center), ongoing medical and mental health illness in this responder population have been documented. As a public and community-based hospital, it became clear that there was a population at risk that included at least 60,000 local residents, maybe 300,000 building evacuees/local workers and 15-25,000 children. She noted that this fact was not really recognized and to understand this took a huge battle.

Dr. Reibman described the community impact of the 9/11 event. She stated that what is now known is the fact that the community had enormous exposure and potential risk of exposure. To illustrate this point, Dr. Reibman shared pictures of students, community residents, and local workers who were caught in the dust on 9/11. Dr. Reibman described the classification of the potential types of community exposures to WTC dust/fumes as:

- Acute exposures
 - Dust Cloud
- Chronic exposures
 - Settled dust inside buildings/ventilation systems
 - Re-suspended dust from incompletely cleaned ventilation systems
 - Fumes from fires that burned through December 2001

Dr. Reibman described how HHC got involved in this work. Dr. Reibman informed the Committee that she is a pulmonologist and a researcher. She has also served as the director of Bellevue Hospital Center's innovative asthma program since 1991. Dr. Reibman recalled being invited to a panel discussion at Pace University after 9/11. She stated that she was asked what the problems were for local residents but had to admit that she was not aware of the problems. Following this discussion, Dr. Reibman worked with the New York State Department of Health to conduct first studies of local residents and was later able to document some adverse respiratory health effects in that community. Around that time there were many community residents who were very concerned about these issues. As a result, community residents later coalesced to form a number of community groups to begin looking at these issues. One such organization that was formed was called the Beyond Ground Zero Network. Key leadership staff at HHC was approached about doing something to care for residents who became ill. A pilot program was set-up to care for these patients in collaboration with BGZ and other community organizations.

Dr. Reibman described the funding history of the WTC Environmental Health Center since the program's inception:

- 2005: Private Philanthropy
 - American Red Cross
 - New York Times Neediest
- 2006: New York City Mayor's Office
- 2008: Federal Government
 - Centers for Disease Control, National Institute of Occupational Safety and Health
- 2011: Federal Government
 - World Trade Center Healthcare Program
 - (WTCHP) as a result of the Zadroga Act

Dr. Reibman described the work and the focus of the WTC Environmental Health Center as the following:

- Treatment program for individuals with presumed WTC-related illness
 - Had to have potential exposure (geographic boundaries)
 - Had to have symptom (initially physical, subsequently mental health or physical)
- Target populations: Community members
 - residents
 - local workers
 - students
 - clean-up workers
- Multidisciplinary treatment program (medical, mental health, social services)
- 5,600 individuals enrolled between September 2005 to September 2011 for treatment

Dr. Reibman provided a summary of the characteristics of the first 1,898 WTC EHC members, 9/2005 – 5/2008 as described below:

Characteristic	Total
Gender, %	
Male	53
Female	47
Age, mean \pm SD	48 \pm 12
Race, %	
White	46
Black	17
Asian	11
Ethnicity, %	
Hispanic	42
Dust cloud, %	40

Dr. Reibman reported that the symptoms were similar among all potential exposure groups in the WTC EHC. She described the symptoms as including coughing, wheezing, chest tightness, sinus/nasal and gastrointestinal. She reported that the physical disease heterogeneity in response to environmental exposure included cough, asthma, airway damage (bronchiectasis), sarcoidosis, and interstitial lung disease (i.e., NSIP, UIP, HP.). Dr. Reibman reported that it is not yet understood which patients would get specific illness but individual susceptibility plays a role.

Dr. Reibman described a typical (classic) WTC EHC patient as the following:

- 37 year old resident of Lower Manhattan (Beekman Street)
- Previously healthy (training for marathon), no history of childhood asthma/lifelong nonsmoker
- Not in dust cloud
- Stayed in apartment and cleaned dust-covered apartment
- Onset of shortness of breath and wheezing 6 months later
- Presented to WTC EHC in 2006 with persistent upper airway symptoms (nasal congestion, post nasal drip) and daily lower airway symptoms (shortness of breath, wheezing)
- Treated aggressively for asthma
- Continues to need therapy to control symptoms

Dr. Reibman informed the Committee that it had been difficult to recruit children for the WTC EHC program. The preliminary data on children ≤ 18 on 9/11 is provided below:

Characteristic	Prevalence or mean
<i>Exposure characteristics, %</i>	
Caught in dust cloud	38.5
Heavy dust in home (n=140)	21.4
Residence in home at least 1 day in the period September 11-18, 2001 (n=145)	80.0
School <1 mi to WTC site (n=64)	78.1
<i>Clinical conditions</i>	
Provider-diagnosed asthma	21.4

Dr. Reibman explained that younger age on 9/11 was associated with provider diagnosed asthma; and presence in the dust cloud was associated with lower lung function.

Dr. Reibman described the mental health status of WTC EHC patients as the following:

- ~ 40% score positive for PTSD symptoms, depression or anxiety
 - Risk factors
 - sex (female),
 - low income,
 - exposure (dust cloud),
 - physical symptoms (upper and lower respiratory symptoms, and severity of shortness of breath)

Dr. Reibman explained that mental health services were a big part of the program and was currently in high demand.

Dr. Reibman described the effectiveness of the WTC EHC has been over time. She stated that lung function over time in community members enrolled in WTC EHC was being monitored by the program. There have been improvement in lung function in group as a whole; however, improvement t not complete in those with abnormal lung function. Additionally, local workers had the least improvement compared to residents and clean-up workers

Dr. Reibman explained that there were many unanswered questions in the "survivor" population. The questions focused on medical care included the following:

- o Cancer risk
- o Lung disease – long term progression, types, how to treat
- o Connective tissue disorders
- o Neurologic sequela – headaches, neuropathy
- o Vulnerable populations – children

Regarding mental health, the questions included the following:

- o who is at risk for persistent PTSD
- o long term outcomes
- o treatment of PTSD in civilian populations and associated with complex mental health and physical co-morbid conditions and socioeconomic issues
- o risk for cognitive defects with intractable PTSD

SUBSIDIARY BOARD REPORT

MetroPlus Health Plan, Inc. – March 13, 2012
As reported by Mr. Bernard Rosen

Chairperson's Remarks

Chair Rosen welcomed everyone to the MetroPlus Board of Directors meeting of March 13, 2012. Mr. Rosen advised the Board that the one resolution would be to authorize MetroPlus to submit a resolution to the HHC Board of Directors to negotiate a contract with Healthplex, Inc. to provide administration of dental services. This resolution, if approved, will be presented at the HHC Board of Directors meeting on March 22nd. Mr. Rosen stated that the order of the agenda would be changed and that the action items would be presented first.

Mr. Rosen stated that there would be two information items presented. The first was Dr. Saperstein's presentation of the MetroPlus 2012 Strategic Plan. The second presentation was by Ms. Lauren Leverich on the HHC – MetroPlus Health Home.

Action Item

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

Authorizing the submission of a resolution to the Board of Directors of the New York City Health and Hospitals Corporation, to authorize the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to negotiate and execute a contract with Healthplex, Inc. ("Healthplex") to provide administration of dental services for a term of three (3) years with two (2) options to renew for one (1) year each, solely exercisable by MetroPlus, for an amount not to exceed \$4.9 million per year.

Dr. Saperstein gave the Board some background of the services Healthplex will provide to the Plan and how they were chosen through a negotiated acquisition process. Dr. Saperstein stated that this contract is separate from the IPA contract; this is for administrative services only. The following people were in attendance from Healthplex: Dr. Martin Kane - President, Ms. Sharon Zelkind - Senior Vice President, Mr. Frank DiGiovanni – Director of Quality Management/Compliance and Michael Latko – Director of IT. Mr. Hagler asked if HHC facilities were included in the Healthplex network and Dr. Saperstein replied yes. There was a brief discussion regarding savings from last year and disruption rates. Dr. Kane and Ms. Zelkind both provided a detailed overview of Healthplex services and their network capabilities.

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

Executive Director's Report

Dr. Saperstein reported that total plan enrollment as of February 1, 2012 was 425,439. Breakdown of plan enrollment by line of business is as follows:

Medicaid	356,923
Child Health Plus	17,823
Family Health Plus	36,265
MetroPlus Gold	3,089
Partnership in Care (HIV/SNP)	5,693
Medicare	5,646

Attached to his report Dr. Saperstein attached a graph showing net transfers for the month of January 2012 for Medicaid and Family Health Plus (FHP).

MetroPlus has been ranked #1 in the City of New York for 5 out of the last 6 years based on overall quality and member satisfaction that is published in the Medicaid Consumer Guide. This year, Dr. Saperstein was pleased to announce that MetroPlus, for the first time ever, has been ranked #1 in New York State. Dr. Saperstein attached, to his report, a list of the rankings of all 18 plans that have Medicaid patients and operate in New York State. This score is based on Quality, Consumer Satisfaction, Preventive Quality Indicators and Compliance. MetroPlus achieved a 100% score in quality and was ranked the highest overall of all the plans in the state. Because of the results, MetroPlus will receive an incentive of approximately 34 million dollars above its base revenue. This is the highest incentive of any of the health plans. These results are a testament to the excellent high quality care and service provided by all of MetroPlus providers, as well as the excellent work performed by Plan staff.

At the end of the meeting Dr. Saperstein stated that he will be doing a short presentation on the final draft of MetroPlus' Strategic Plan for 2012. The plan summarizes the goals and major projects for 2012.

Dr. Saperstein reported that there is still much lively discussion occurring between the New York State Department of Health (SDOH) and health plans regarding the transition of the homeless population into managed care on April 1, 2012. MetroPlus' Chief Medical Officer, Dr. Van Dunn is on the state's implementation workgroup. There are significant challenges to manage a population that does not have a permanent residence and might be extraordinarily difficult to contact. In addition, the state has still not finalized their expectations of how the plans will work with, and pay the homeless shelters and other homeless services.

Dr. Saperstein advised the Board that attached to his report was the new population carve-in timeline from the Medicaid Redesign Teams Managed Care Benefit and Population Expansion. This report summarizes all of the current fee for service populations that are being carved into Medicaid Managed Care programs in the next nine months.

In his report in December, Dr. Saperstein advised the Board of the Plan's first month experience since it took over the management of pharmacy benefits for FHP and Medicaid. As a follow up to that report, Dr. Saperstein attached a spreadsheet detailing the monthly pharmacy trend for October 2011 through January 2012. It shows that after four months, pharmacy costs have become more manageable, and the plan is no longer experiencing losses.

MetroPlus is modifying some of its systems and operations to prepare for the Health Home initiative. The Plan is developing operations to assist in case finding, outreach and consent to enroll individuals into the HHC/MetroPlus Health Home.

Dr. Saperstein stated that MetroPlus Medicare closed the 2011 Annual Open Enrollment Period with a gross of 420 new members. As of February, 1, 2012, the Plan has a total of 5,694 active enrollees in all Medicare products combined. As part of the Plan's 2012 Strategic plan, it is focusing most of its Medicare sales and marketing efforts on growing the two Dual Special Needs Plans, which offer competitive health care coverage and value added benefits for the dual eligible population. MetroPlus is also in the process of reassessing its retention strategies for all Medicare lines. In general the Plan's Medicare retention rate has been maintained at over 97%.

Dr. Saperstein reported that SDOH is requiring that all Medicaid Health Plans transition coverage of dental services into the benefit packages by July 1, 2012. MetroPlus has been engaged in a Negotiated Acquisition for an appropriate vendor to cover its dental benefit. Two vendors pre-qualified, DentaQuest, the Plan's current vendor, and Healthplex. Both vendors were carefully reviewed and Healthplex was chosen as the vendor. The annual estimated costs will be approximately 56 million dollars for dental services and up to 5 million for administrative costs. This contract was approved by the MetroPlus Finance Committee in February and is being brought to the MetroPlus Board today for approval to submit to the HHC Board of Directors on March 22nd.

Medical Director's Report

Dr. Dunn presented the Board with copies of the winter 2012 edition of the MetroPlus Gold Health News. Included in this issue are health articles on: what you need to know about fat in your diet; are you at risk for diabetes; important tips to help you maintain a healthy blood pressure; preventing eye strain, headaches, neck aches and shoulder pain from prolonged computer usage; and that Asthma can develop at anytime and our case managers are available to help manage your asthma.

Dr. Dunn reported that the Quality Management Department completed several recent mailings as part of the Plan's ongoing educational campaign to members and providers. During this time period MetroPlus sent out Children Immunization Reminder to all children ages 6 months to 17 missing 3 or more vaccines encouraging them to see their doctor for the necessary immunizations. All MetroPlus Medicare members over the age of 65 received a postcard with information about importance of physical activity and home fall prevention tips. All MetroPlus Medicare members over the age of 65 received a postcard with information about the risk of osteoporosis and the importance of bone density screening.

Dr. Dunn stated that the Office of Health Insurance Programs has calculated the 2011 Quality Incentive for Medicaid managed care plans. There are three levels of Incentive awards that could be achieved by plans (2.5 percent, 1.5 percent or 0.5 percent per member per month premium increase, excluding the pharmacy portion). MetroPlus was awarded the top ranking on the SDOH Quality Incentive Award and thus received the 2.5 percent per member per month premium increase as April 1, 2012.

The data used in determining the results included QARR 2010, the most recent Medicaid CAHPS survey conducted in fall 2009, two adult and two pediatric prevention quality indicators (PQI) using 2010 inpatient admissions, and compliance information from 2009 and 2010 as indicated by the program areas. The maximum number of points available for the Incentive is 150, with 100 points from quality measures, 30 points from satisfaction measures and 20 points from the four PQIs. Points from compliance are subtracted from the Plan's total points for statements of deficiency associated with specific compliance areas. MetroPlus' total points were 126.5 out of a possible 150 points which equates to an 84%. Neighborhood Health Providers, the closest competitor, scored 100.4 total points or 67%. Plan's performance in the Quality Incentive also affects the auto-assignment algorithm. Since MetroPlus achieved the Quality Incentive award, a proportion of auto-assignees will be directed to plans that qualified for the preference.

2011 Quality Incentive Awards

Incentive Premium Award	Plan Name	Quality Points	Satisfaction Points	PQI Points	Compliance Points	Total Points	Percent
		100 points Possible	30 points Possible	20 Points Possible	-20 Points Possible	150 Points Possible	100% Possible
2.5	MetroPlus Health Plan	100.0	20	8.5	-2	126.5	84
1.5	Neighborhood Health Providers	85.4	5	10	0	100.4	67
1.5	Fidelis Care New York	73.4	15	11.5	0	99.9	67
1.5	HIP (Emblem Health)	97.4	10	0	-8	99.4	66
1.5	Hudson Health Plan	56.9	30	14	-2	98.9	66
1.5	Health Plus	79.4	10	12.5	-6	95.9	64
0.5	UnitedHealthcare Community	58.4	15	12.5	-6	79.9	53
0.5	Affinity Health Plan	65.9	15	6	-10	76.9	51
0.5	HealthNow New York Inc.	50.8	20	6.5	-6	71.3	48
0.5	Healthfirst PHSP, Inc.	43.4	15	13.5	0	71.9	48
0.5	CDPHP	35.4	25	10	-2	68.4	46
0.5	Univera Community Health	38.5	25	10	-6	67.5	45
0.0	Independent Health's MediSource	30.8	30	10	-6	64.8	43
0.0	Amerigroup New York	43.4	10	13.5	-6	60.9	41
0.0	MVP	36.0	20	10	-6	60	40
0.0	Excellus BlueCross BlueShield	33.8	20	8	-6	55.8	37
0.0	WellCare of New York	50.8	0	10	-6	54.8	37
0.0	Total Care	24.6	5	11.5	0	41.1	27

Dr. Dunn advised the Board that SDOH released the 2011 SNP eQARR performance data in the areas of provider network, child and adolescent health, women's health, adult living with illness, behavioral health, and satisfaction with care. Areas where the PIC was significantly better than the statewide average was Adult BMI Assessment (88%); Breast Cancer screening (73%); Cervical Cancer screening (92%); Chlamydia Screening (83%); Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors or ARBs (100%) and Diuretics(99%)); Follow-up after hospitalization for mental illness within 30 days (68%); Adolescent Well-Care Visits (59%). MetroPlus was above the statewide average for HbA1C testing, lipid profile, and dilated eye exams. The Plan had less diabetes with poor HbA1C control than the statewide average.

Information Items

The first information item was a presentation by Dr. Saperstein about the MetroPlus 2012 Strategic Plan.

Dr. Saperstein reported that MetroPlus' Strategic Plan has been designed to ensure that MetroPlus is a fiscally sound plan that is viewed as the number one health plan by its customers, staff, HHC, providers, members, government and other outside entities. The foundation of the Strategic Plan is built in six major areas: growth and development, maintain financial stability, improve medical outcomes, continued focus on compliance, and improving organizational effectiveness in both technological excellence and people and processes. Dr. Saperstein went into greater detail of each of the six areas for the Board.

The second information item was a presentation by Ms. Lauren Leverich about the HHC - MetroPlus Health Home.

Ms. Leverich stated that a Health Home is a care management service model whereby all of an individual's caregivers communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. The goal is to be able to control future health care costs and improve health outcomes for this population through improved care coordination. Section 2703 of the Patient Protection and Affordable Care Act (ACA) provides stated, under the state plan option or through a waiver, the authority to implement health homes effective January 1, 2011. It also provides the opportunity to receive additional federal support for the enhanced integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons with chronic illness.

Ms. Leverich reported that the eligible population will be Medicaid persons who have complex medical behavioral and long term care needs that drive a high volume of high cost services including inpatient and long term institutional care. Eligible patients are being identified through claims and encounter data. The State will use a combination of clinical risk groups (CRG), and an algorithm that predicts hospitalizations, and behavioral health indicators. Members will then be assigned into 1-3 Tiers; Tier 3 meaning the most acute and complex patients with highest intensity level.

Ms. Leverich stated that because of the Plan's partnership with HHC during the application phase, MetroPlus is given a unique opportunity to actively participate in some of the key operational functions of the Health Home. Outreach for Enrollment into HHC Health Home is currently being coordinated by MetroPlus. This includes both managed care and fee-for-service Members. HHC will be performing all Care Management functions for the Health Home Membership which includes: 24/7 on-call Case Management teams, telephonic Care Management and face to face Case Management.

Ms. Leverich explained that two boroughs are involved in phase 1 and they are Brooklyn and the Bronx. The phase is starting with Tier 3 Members and due to state tier 3 phase in – only 863 MetroPlus members are actually eligible for outreach at this time.

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

**ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
MARCH 22, 2012**

JOINT COMMISSION SURVEY EARNS HIGH PRAISE FOR CONEY ISLAND HOSPITAL

Last week, The Joint Commission completed its triennial accreditation survey of Coney Island Hospital. The survey team was very complimentary of Coney Island front line staff and leadership, and impressed by the strong relationship between the medical and nursing staff. Once again, the survey team leader recognized the commitment of the HHC Board of Directors to quality and safety and praised Mrs. Josephine Bolus for her participation in the Leadership Interview. The survey team commented that Coney Island does a phenomenal job taking good care of very complex patients.

"Staff care about their patients, and this seems to reflect the mission and vision of the organization and the strong leadership. In many areas, the organization's processes exceeded the intent of the standards, the lead surveyor said at the close of the survey." The administrator surveyor noted that if he fell sick, he would come to Coney Island Hospital. Although the survey included some limited findings for improvement, none were related to patient care, a terrific accomplishment.

Several Leading Practices were identified by the surveyors including: the Palliative Care program, the Wound Care program, Code Grey for Crisis Prevention, and the Emergency Management Plan that was used to coordinate the evacuation of patients during Hurricane Irene in 2011.

I know the Board joins me in congratulating Senior Vice President Arthur Wagner, Medical Director Dr. John Maese, Chief Nurse Terry Mancher and the staff of Coney Island Hospital for a job well done.

Kings County and Lincoln Hospitals and Sea View Nursing and Rehabilitation Facility remain to be surveyed by The Joint Commission this year.

**NURSE PRACTITIONER AT CONEY ISLAND HOSPITAL RECEIVES
PRESTIGIOUS SLOAN PUBLIC SERVICE AWARD**

Last week, in ceremonies at Coney Island Hospital Center and Cooper Union, the Fund for the City of New York announced that Donna Leno Gordon, a nurse practitioner from Coney Island who led the effort to formalize HHC's corporate-wide palliative care program, has won the prestigious Alfred P. Sloan Public Service Award for 2012. Since 1973, the Fund for the City of New York has annually presented the Sloan award to outstanding civil servants whose accomplishments and commitment to public service are truly extraordinary; Sloan awardees are selected from among more than 250,000 eligible City employees. Donna is one of six winners this year, and her recognition marks the third consecutive year that an

HHC employee has been chosen for the award, considered by many to be the "Nobel Prize" of City government.

Ms. Leno Gordon's commitment to improving the lives of some of our most vulnerable patients exemplifies HHC's mission. In her more than 20 years of service to Coney Island, she has redefined the standards of care across two disciplines. As a champion of palliative care, she has worked to standardize palliative care programs across our system, bringing specialized services to chronically and terminally ill patients citywide. She was a founding member and currently serves as the chair of HHC's Palliative Care Council.

She has also dedicated her expertise and resourcefulness to advancing behavioral health services. Under Ms. Leno Gordon's guidance, Coney Island established a nationally recognized psychiatric crisis prevention program, which employs multi-disciplinary care teams to meet the needs of mentally ill patients. The Sloan award selection committee recognized and saluted Donna for her life-long learning, her tireless and courageous service, her inspiration to other staff, and her commitment to her patients, the Coney Island community, and public service.

Please join me in congratulating Ms. Gordon for her outstanding accomplishments and on this well-deserved recognition.

KINGS COUNTY HOSPITAL ACHIEVES NATIONAL RECOGNITION FOR BREAKTHROUGH PERFORMANCE IMPROVEMENT IN EMERGENCY DEPARTMENT

Kings County Hospital was recognized nationally for using Breakthrough methodologies to transform its Emergency Department, improve efficiency and patient flow and shorten the time it takes for a patient to see a doctor. A Kings County medical team describes the improvement process in an article published this month in a special issue of the peer-reviewed *Journal for Healthcare Quality (JHQ)*, which recognizes innovative and evidence-based care efforts at a select number of safety net hospitals across the country.

Kings County was among four U.S. public hospitals recognized on March 15 by the National Association for Public Hospitals and Health Systems (NAPH) and the National Association for Healthcare Quality in Washington D.C. The hospitals were singled out for programs that demonstrate that effective quality improvement measures adopted by safety net hospitals can help address healthcare disparities, improve overall patient care and achieve high standards of quality. All four hospitals published articles in the *JHQ* describing their programs.

Although the median number of ER patient visits rose 7.3 percent during the period involved, the total time a patient spent in the ER was reduced by 36 minutes. The amount of time it took for a patient to be triaged was cut in half, to a median of 18 minutes, and the amount of time it took to see a doctor was reduced by 30 minutes.

HHC has been applying the Breakthrough process in New York City public hospitals since 2007, making quality, efficiency and financial improvement an ongoing and permanent

process throughout our system. Congratulations to Kings County for the excellent job they've been doing in using Breakthrough tools to increase efficiency, eliminate waste and improve the patient and staff experience.

KINGS COUNTY HOSPITAL RECEIVES \$3.5 MILLION FOR CANCER CARE

Late last month Kings County Hospital received \$3.5 million to purchase a new linear accelerator to provide radiation therapy at the KCHC Cancer Care Center. The generous grant was from New York City Council Members Mathieu Eugene and Darlene Mealey, on behalf of the City Council Brooklyn delegation. The new machine will be used to accommodate the more than 600 cancer patients who are coming to KCHC for treatment and support services every year. The hospital's Cancer Care Center, which opened in 2010, provides comprehensive, one-stop shop services including oncology, chemotherapy, surgery, medicine, pharmacy, nutrition, social services and psycho-social support. The new linear accelerator will provide 200 additional cancer patients with more precise and advanced radiation treatment modalities. It will be one of two linear accelerators used at the cancer center.

FEDERAL UPDATE

On Tuesday, March 20, House Budget Chairman Paul Ryan released his proposed House Budget Resolution for federal fiscal year 2013. Chairman Ryan's proposed budget would dramatically reshape the Medicare and Medicaid programs. It is likely that his budget will pass the House in the form of a budget resolution. However, it will not be taken up in the Democratically-controlled Senate. Ryan's budget sets discretionary spending at \$1.028 trillion for federal fiscal year 2013, less than the \$1.047 trillion cap agreed upon by both parties last year in the Budget Control Act (BCA). Although this is a difference of only \$19 billion, what is significant is that many cuts are shifted from defense to domestic discretionary and entitlement programs.

As he proposed last year, Chairman Ryan would change Medicaid into a federal block grant program, giving the states more latitude in designing their programs. Medicaid spending would be slashed by \$810 billion over ten years, a larger cut than the \$771 billion cut in proposals Ryan made last year. The Ryan budget would also repeal the Affordable Care Act, including the Medicaid expansion components.

Ryan's Medicare proposal is similar to a proposal he championed in December 2011. However, unlike last year's proposal, which would have ended traditional Medicare by converting the program to a premium support model, this year's version preserves traditional fee for service Medicare as an option within the premium support rubric. Seniors who turn 65 in 2023 would purchase either a private health plan or the traditional fee for service option through a newly created Medicare exchange. Notably, Ryan's plan saves only \$205 billion in Medicare spending over the first 10 years because radical change in the program does not occur until federal fiscal year 2023.

On February 29th and March 1st, Senior Vice President LaRay Brown along with HHC staff from Intergovernmental Relations, participated in the National Association of Public Hospitals' (NAPH) semi-annual legislative conference in Washington. Meetings took place with Congress Members Eliot Engel and Ed Towns and with New York Congressional staff. Some of these meetings also included representatives from several other New York State public hospitals. The focus of the meetings was the impact of the President's proposed budget, which, as I mentioned in February, could result in reduced Medicare and Medicaid payments to HHC of \$1.5 billion over 10 years. In addition, the cut to Disproportionate Share Hospital (DSH) funding was discussed. The New York Congressional staff, with Senator Schumer's staff in the lead, has indicated their strong commitment to fighting any additional proposed Medicaid DSH cuts, as well as supporting efforts to roll back some of the already Affordable Care Act-mandated Medicaid DSH reductions. As noted in past meetings, current law includes a total of \$2.278 billion in Medicaid DSH reductions slated for 2014-2021. These cuts were included in the Accountable Care Act and in the recently enacted HR 3630, the Middle Class Tax Relief and Job Creation Act of 2012.

STATE LEGISLATURE CONSIDERING BUDGET FOR COMING FISCAL YEAR

In Albany, negotiations on the State Budget previously had been proceeding ahead of schedule and it appeared that this would lead to an early budget adoption, but negotiations have slowed down considerably. Both the Assembly and Senate released their respective one-house budget bills and have been discussing the differences between them and the Governor's Executive Budget. As you know, we have a presence in Albany and HHC staff have been reaching out to members and key staff over the past several weeks to discuss our issues. We have also engendered the advocacy of our labor partners, CAB members, consumer advocates and others on issues that impact HHC.

At the moment, we are focused on two key items: The first is maintaining \$75 million in affordable housing funding that was proposed by the Governor. HHC is slated to receive \$7.3 million out of this commitment to develop housing for our patients. The Legislature is seeking to push between \$25 and \$50 million of this funding into the out-years. It is important that the full \$75 million commitment remain as proposed by the Governor for State Fiscal Year 2012-2013. We are also trying to prevent a \$29 million cost shift from the State to the City for the payment of a HCRA tax. Currently, this tax is paid by the State. And, just to remind the Board, last year's state budget agreement reduced our funding by \$174.5 million and over the past 5 years, more than \$500 million in funding has been cut on an annualized basis.

HHC TESTIFIES AT BUDGET HEARINGS BEFORE CITY COUNCIL

Earlier this week, I testified before the Health Committee at the City Council's Preliminary Budget hearing. As I normally do in the testimony, I reviewed our precarious financial state, highlighted several major initiatives and briefed them on the status of our major modernization projects. HHC has been fortunate to receive significant funding from the City and the Council over the past several years. We hope to fare as well or better this year.

The Council holds another round of hearings on the Executive Budget later in the spring at the end May and into early June.

HHC USES MULTIPLE CHANNELS TO SPREAD THE COLON CANCER AWARENESS MESSAGE

As I mentioned in my report last month, HHC is meeting this year's challenge of National Colorectal Cancer Awareness Month with a variety of messages in print, online and over the air throughout March. A key focus of our outreach is to engage staff and patients in understanding that a colonoscopy -- starting at age 50 and repeated every ten years -- not only detects the potential for disease, but treats it as well. Our staff outreach includes many corporate-wide e-mail messages, as well as the placement of brochures and posters printed in English and Spanish in prominent locations in each of our facilities. We also partnered with the American Cancer Society last week to co-host a "twitter-view" -- an interview on the prominent social network Twitter -- featuring a Q&A with Dr. Jennifer Harley at Metropolitan Hospital. To raise awareness of the high incidence of colon cancer in the African American community, we arranged for Dr. Joan Culpepper-Morgan from Harlem Hospital to be interviewed by WBLS radio and featured on their popular "Daily Dose" segment repeatedly throughout the month. We will continue throughout the month to promote colorectal cancer prevention and screening with e-mails, and posts to Facebook, YouTube and Twitter.

HHC PREPARES TO RECEIVE HEALTH HOME ENROLLEES

As I mentioned last month, HHC has been preparing to provide care coordination services for Medicaid patients with chronic medical and/or serious behavioral health conditions, as a Health Home certified by the NYS Department of Health (DOH). The Health Home initiative aims to improve health outcomes for these patients through focused care coordination, and to decrease costs by reducing the emergency visits and avoidable hospital admissions for this group of patients. The State DOH has certified HHC as a Health Home in the Bronx and Brooklyn, and we expect to receive certification for Manhattan and Queens in April. HHC leadership is currently negotiating with New York State to determine the appropriate rate for these services. These rates are directly linked to the acuity of eligible patients assigned to HHC's Health Home. DOH has asked that Health Homes initiate start-up activities by identifying a small group of high acuity need patients for outreach and enrollment. After rates have been negotiated, HHC will begin to provide Health Home services to patients in the Bronx and Brooklyn.

TIER VI PENSION REFORM FOR HHC WORKERS

On March 16, the Governor signed into law pension reform legislation that puts in place a new Tier VI pension plan for workers hired after April 1, 2012. This legislation also affects current employees who have not joined the pension system under the more generous Tier IV. They must join the pension system by March 31 to be a Tier IV member. We are

conducting aggressive outreach to the approximately 5900 HHC employees who are not pension members to make them aware of the March 31 deadline.

Savings to HHC from the Tier VI pension plan will ultimately come from an increase in the retirement age from 62 to 63; increased employee contribution rates, ranging from 3% to 6%, based on salary; a lengthening of the vesting period from 5 to 10 years, and changes to the pension calculation formula. For higher paid employees, the amount earned above the Governor's salary (currently \$179,000) will not be eligible for pension calculation under Tier VI.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

Training Doctors Perform Virtual Colonoscopies To Perfect Their Skills, Katie Walker, Director of IMSAL, Dr. Meade Barlow, Jacobi Hospital, NY1-TV, 3/12/12

Lincoln Hospital's Asthma Grant, News 12 Bronx -TV, 3/2/12

Asthma Grants, Dr. Venkatesh Sabhae, Woodhull Hospital, News 12 Brooklyn - TV, 2/29/12

I Said, "Get Your Hearing Checked!", Dr. Matthew Hanson, Kings County, Brooklyn Independent Television -TV, 3/9/12

Artists Trade Time and Talent for Treatment, Lincoln Hospital, The Brooklyn Ink -TV, 3/3/12

Newest New Yorkers Have Unusual Leap Day Birthdays, Elmhurst, NY1-TV, 2/29/12

Leap Year Babies, Dr. Adeola Atilade, Lincoln Hospital, News 12 Bronx-TV, 2/29/12

Print and Online

Do Electronic Records Cut Health Costs?, Letter to the editor by Alan D. Aviles, HHC President, The New York Times, 3/12/12

Sloan Public Service Awards 2012, Coney Island, Donna Leno Gordon, RN Coney Island, The Huffington Post, 3/19/12

(Also covered in The New York Times, NY Daily News, The Chief)

New York City hospital barter artistic talent for healthcare dollars, Lincoln Hospital, Nursing Spectrum, 3/5/12

Fondos contra el asma en barrios latinos, Funds to fight asthma in Latino neighborhoods, Lincoln, Woodhull, El Diario, 3/7/12

Viewpoint: The United Nations of Medicine, Bellevue Hospital, Dr. Lewis R. Goldfrank, Emergency Medicine News, March 2012

Top ranking for Staten Island's Sea View Hospital Rehabilitation Center, Sea View Hospital, Staten Island Advance, 3/8/12

Why is Colorectal Cancer in the News?, Dr. Margaret Kemeny, Queens Hospital, The Queens Courier, 3/9/12

Who Cares About Colon Cancer?, Dr. Jason Gonsky, Home Reporter and Sunset News, 3/12/12

Balancing Military Service and a Civilian Career Pays Off for These IT Professionals, Corey Cush, HHC, Government Technology, February 28, 2012

An Early Start on a Healthy Smile, Dr. Rawle F. Philbert, Lincoln Hospital, The Bronx Free Press, 3/7/12

NYC health leaders: Get a colonoscopy, HHC, The Staten Island Advance, 3/15/12

Black men last to see doctor but first in the hospital, HHC, Amsterdam News, 3/1/12

Things Adult Medicine Could Learn From Pediatrics, Bellevue Hospital, The New York Times, 3/12/12

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Landlord") to execute a revocable license agreement with Con Edison Company of New York, Inc. (the "Licensor"), for use and occupancy of space for the operation of a radio communication system at Harlem Hospital Center (the "Facility") for five years without further authorization by the Board of Directors of the Corporation.

WHEREAS, in March 2007, the Board of Directors of the Corporation authorized the President to execute a license agreement with the Licensee which by its terms expires April 30, 2012; and

WHEREAS, the Licensee, a public utility, desires to continue operating a radio communication system on the roof of the Martin Luther King Pavilion; and

WHEREAS, the Licensee's continued use of the rooftop space for this installation shall have no impact on patient or staff safety and shall not compromise Facility operations; and

WHEREAS, the Licensee's radio communications system complies with applicable federal statutes governing the emission of radio frequency signals.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with Consolidated Edison Company of New York, Inc. (the "Licensee"), for use and occupancy of space for the operation of a radio communication system at Harlem Hospital Center (the "Facility").

The Licensee shall be granted the continued use and occupancy of approximately fifty (50) square feet of space on the roof of the Martin Luther King Pavilion (the "Licensed Space") for the operation of a Radio Frequency (RF) communications system. The Licensee shall pay an occupancy fee of \$27,007 per annum with an annual increase of 3% on the anniversary of the commencement date for its use and occupancy of the Licensed Space. The Licensee shall be responsible for paying for electrical service.

The Licensee shall be required to indemnify and hold harmless the Corporation and the City of New York from any and all claims arising out of its use of the licensed space, and shall provide appropriate insurance naming the Corporation and the City of New York as additional insureds.

The License agreement shall be revocable by either party on ninety (90) days prior notice. The term of this agreement shall not exceed five (5) years without further authorization by the Board of Directors of the Corporation.

RESOLUTION

Authorizing the Executive Director of MetroPlus Health Plan, Inc. ("MetroPlus") to negotiate and execute a contract with Healthplex, Inc. ("Healthplex") to provide administration of dental services for a term of three (3) years with two (2) options to renew for one (1) year each, solely exercisable by MetroPlus, for an amount not to exceed \$4.9 million per year.

WHEREAS, MetroPlus, a wholly-owned subsidiary corporation of the New York City Health and Hospitals Corporation ("HHC"), is a Managed Care Organization and Prepaid Health Services Plan, certified under Article 44 of the Public Health Law of the State of New York and;

WHEREAS, the Certificate of Incorporation of MetroPlus reserves to HHC the sole power with respect to MetroPlus entering into contract, other than with HHC or a health care service provider, with an annual value in excess of \$1,000,000; and

WHEREAS, MetroPlus provides dental benefits for approximately 60,000 members in its Child Health Plus, Family Health Plus and Medicare Advantage plans, and effective July 1, 2012 MetroPlus will also begin providing dental benefits for approximately 350,000 members enrolled in its Medicaid Managed Care and HIV-SNP plans; and

WHEREAS, MetroPlus seeks to provide a fully integrated dental program to its members working with its selected vendor towards the goal of improving health and reducing health care costs; and

WHEREAS, a Negotiated Acquisition for administration of dental services was issued in compliance with MetroPlus' contracting policies and procedures;

WHEREAS, Healthplex was the vendor selected to provide these services; and

WHEREAS, the Board of Directors of MetroPlus has duly considered and approved the proposed contract between MetroPlus and Healthplex.

NOW THEREFORE, be it

RESOLVED, that the Executive Director of MetroPlus is hereby authorized to negotiate and execute a contract with Healthplex to provide administration of dental services for a term of three (3) years with two (2) options to renew for one (1) year each, solely exercisable by MetroPlus, for an amount not to exceed \$4.9 million per year.

*The **icis** Project*

Update

HHC Board of Directors

April, 2012

1. Project History, Evolution, and Goals
2. Current Status
3. Project Governance
4. Projected Staffing & Timeline
5. Risks and Risk Management

Project Evolution

- The existing Electronic Health Record (EHR) used at HHC is a legacy system
 - Decreasing market share
 - Changes ownership (HDS, Medaphis, Per Se, Misys, and now QuadraMed).
- 2006: HHC reviewed of the current state EHR marketplace.
 - Significant executive turnover including at the CEO level.
 - Minimal new client sales during previous two years.
 - The product has not kept pace with competition. Competitive products have surpassed the incumbents medical record functionality
- 2008: HHC planned and initiated a Negotiated Acquisition for a new Electronic Health Record.
- 2009: The Federal Government announces Meaningful Use incentive funding. HHC estimates total potential incentives at \$120,000,000 for the hospital program.
- 2010: HHC begins preparation for Meaningful Use with incumbent system to avoid potential loss of incentive funding. Anticipates first payment in June, 2012.
- 2011: HHC narrows selection options to three of the leading Electronic Health Record vendors in the marketplace: Allscripts, Cerner, & Epic.
- 2012: Intention to conclude Contract Negotiations and bring a contract to the Board of Directors in late summer.

- One Integrated patient record across HHC
 - The system will be a single centralized data repository
 - Maintained once for the entire corporation (currently do everything 8 times).
- Evidence-based care management tools and decision support
 - Tightly integrated functions to achieve better care management
 - Business process tools for improved care coordination
 - Strong clinical decision support to ensure adherence to best practices
 - Expand EHR into additional areas (Behavioral Health, Operating Room, Long Term Care, Emergency Rooms, Obstetrics)
- Health Information Exchange and Interoperability Capabilities
 - Enhance interaction with the Primary Care Information Project (PCIP) practices
 - Share health information with community partners, care management services, and other healthcare providers
 - Patient portals to provide electronic communication between patients and their care teams.
- Improved Quality & Patient Safety
 - Consistent clinical documentation and information access

- **Support Healthcare Transformation**
 - Accountable Care
 - Patient Centered Medical Homes
 - Health Homes
- **Improved Business Analytics**
 - Increase transparency to the public
 - Real-time management dashboards
 - Drill down capability
 - Demonstrate value of care by calculating quality and cost comparisons
- **Increase Patient Engagement**
 - Drive patient-centered care
 - Helping patients better manage their chronic diseases
 - Enable rapid and sustained change
 - Increase efficiency
 - Responsive to communities
- **Enhance IT Workforce**
 - Reduce the labor needed to maintain redundant systems
 - Increase the expertise of IT workforce so that systems are optimized and have the maximum possible impact of this investment.

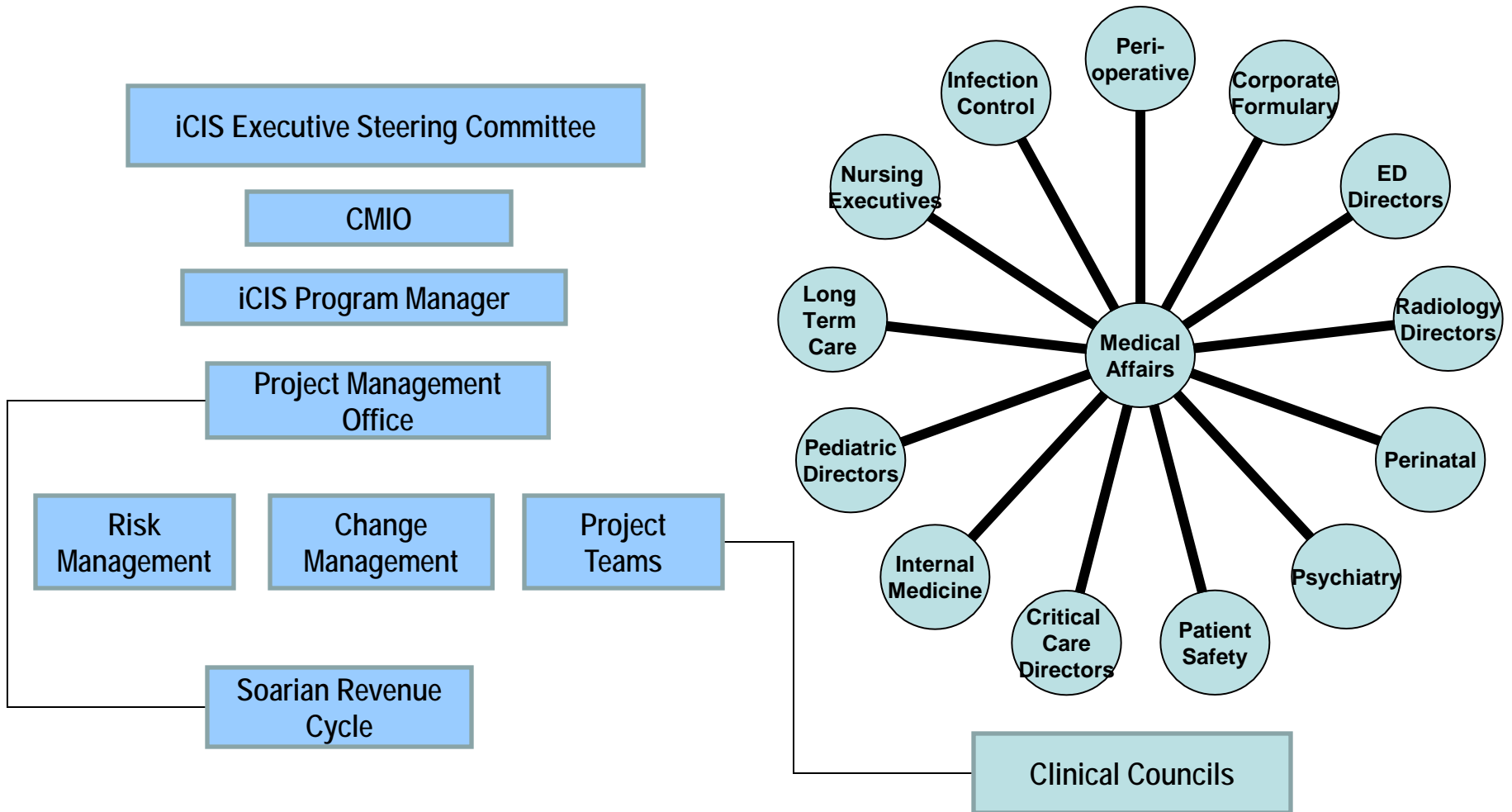
Current Status

milestones

- ✓ RFP review Complete
- ✓ Vendor Demonstrations Complete
- ✓ Client Reference Site Visits Complete
- ✓ Corporate Site Visits Complete
- ✓ Detailed Implementation Plan Complete
- ✓ Technology Scalability Testing Complete
- ❑ Total Cost of Ownership In Progress
- ❑ Soarian Revenue Cycle Integration Ongoing
- ❑ Contract Negotiations April 30
- ❑ HHC Board Contract Review Committee May
- Medical & Professional Affairs/IT June
- Full Board July/Sept.

Vendor	Staff Participation	
	Clinical Sessions	Technical Session
Epic	147	52
Allscripts	98	54
Cerner	125	45
Siemens	111	46
McKesson	116	41
AVERAGE	119	48

Clinical Governance is Key



Vendor Evaluation Framework

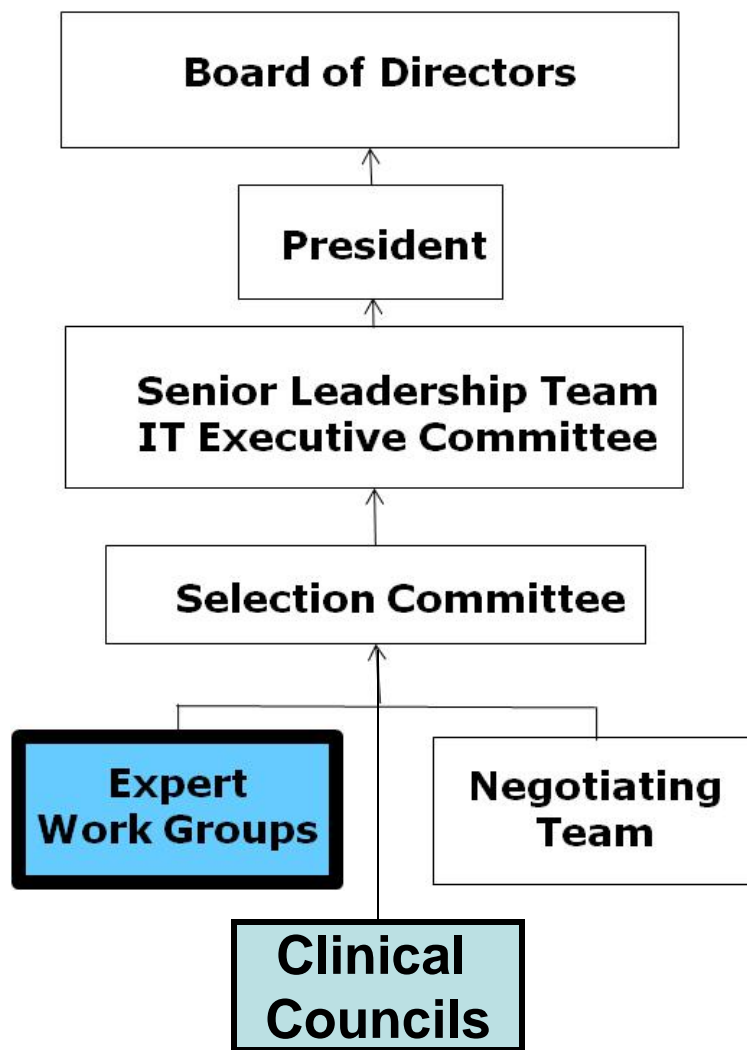
- Integrity and reputation
- Focus on enterprise clinical solutions
- Alignment with HHC vision
- Proven implementation methodology
- Track record in delivering success



- Meets functional requirements
- Is intuitive and easy to use
- Supports patient-focused care
- Provides 24/7 access to data
- Satisfies regulatory requirements
- Safeguards patient data privacy
- Supports health information exchange

- Software licensing & maintenance
- Hardware & technical infrastructure
- Implementation staging & resources
- Total cost of ownership
- Return on investment

System Selection: Engagement and Participation

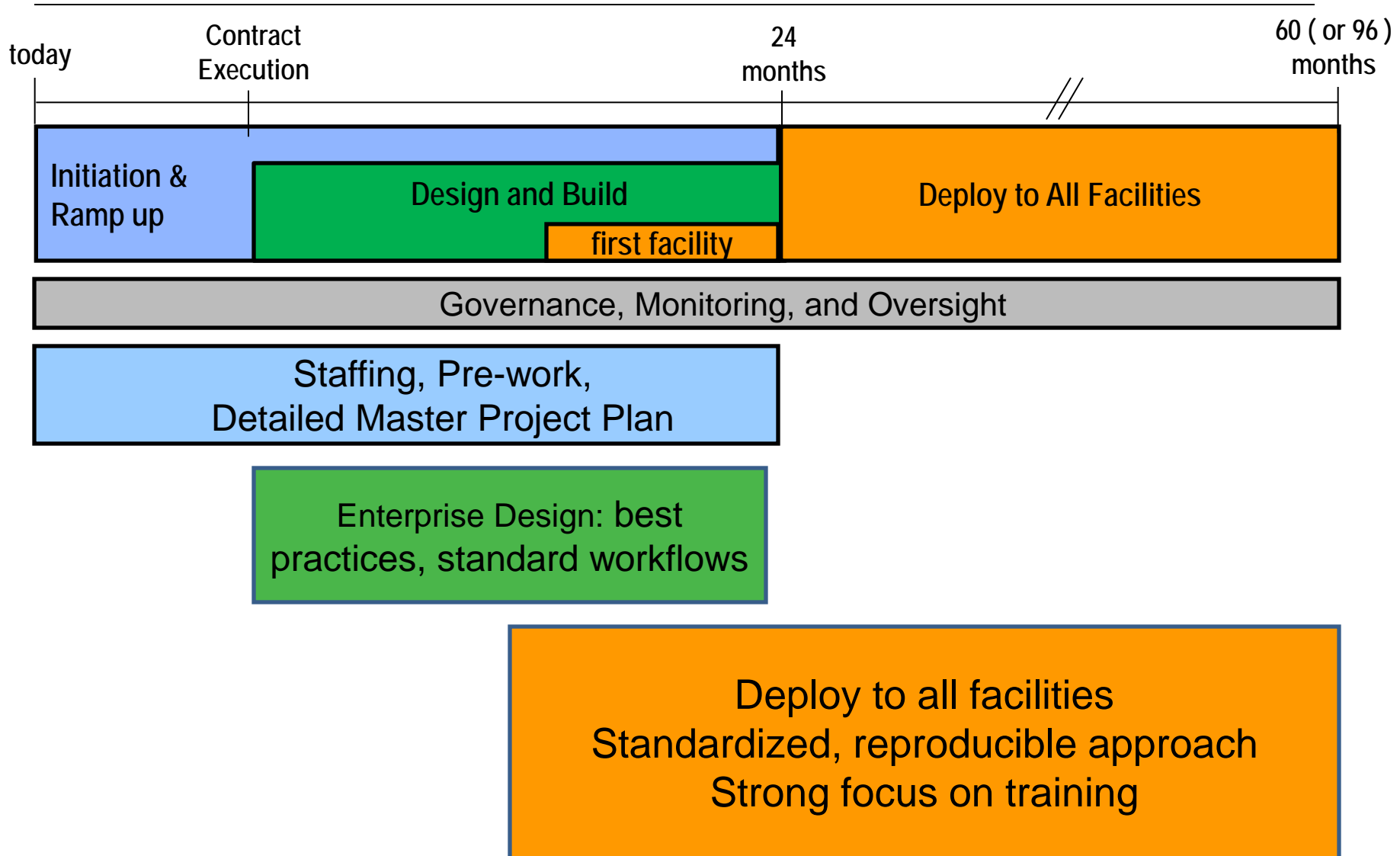


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- System demonstrations were conducted every week in June for five pre-qualified vendors.

- The sessions were well-attended continued high-level of participation.

Overall Project Plan Timeline



Risk Management & Mitigation

- ✓ Each type of risk assigned to specific categories
- ✓ Categories aligned with oversight groups as appropriate
- ✓ Management strategy for each type of risk is standardized

Predictable Risks (examples)

- Other Project Dependencies
- Engagement/Consensus
- Resources
- Technology

Unpredictable Risks (examples)

- Disaster/ Physical
- Financial
- Policy & Regulatory Changes