NYC HEALTH+ HOSPITALS

125 Worth Street ▪ New York, NY ▪ 10013

BOARD OF DIRECTORS MEETING

THURSDAY, SEPTEMBER 20, 2018

A•G•E•N•D•A

CALL TO ORDER - 3:00 PM	**Mr. Campbell**
1. Adoption of Minutes: July 26, 2018	**Mr. Campbell**
Acting Chair's Report	**Dr. Katz**
President's Report	
>> **Action Items**<<	
2. Approving the application of New York City Health and Hospitals Corporation (the "System) for verification by the American College of Surgeons for NYC Health + Hospitals/Bellevue ("Bellevue") as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officer of the System to execute any and all documents necessary to verify Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**
3. Approving the application of New York City Health and Hospitals Corporation (the "System) for verification by the American College of Surgeons for NYC Health + Hospitals/Elmhurst ("Elmhurst") as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officer of the System to execute any and all documents necessary to verify Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**
4. Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Harlem ("Harlem") as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officer of the System to execute any and all documents necessary to verify Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**
5. Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Jacobi ("Jacobi") as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officer of the System to execute any and all documents necessary to verify Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**

6. Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Kings County ("Kings County") as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officer of the System to execute any and all documents necessary to verify Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**
7. Approving the application of New York City Health and Hospitals (the "System") for verification by the American College of Surgeons for NYC Health and Hospitals/Lincoln ("Lincoln") as a trauma center. Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officer of the System to execute any and all documents necessary to verify Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**
8. Approving the application of New York City Health and Hospitals (the "System") for verification by the American College of Surgeons for NYC Health and Hospitals/Jacobi ("Jacobi") as a pediatric trauma center. Committing to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Pediatric Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**
9. Approving the application of New York City Health and Hospitals (the "System") for verification by the American College of Surgeons for NYC Health and Hospitals/Harlem ("Harlem") as a pediatric trauma center. Committing to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Pediatric Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**
10. Approving the application of New York City Health and Hospitals Corporation (the "System) for verification by the American College of Surgeons for NYC Health and Hospitals ("Bellevue") as a pediatric trauma center. Committing to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Pediatric Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma. (Medical and Professional Affairs Committee – 09/13/18)	**Dr. Calamia**
11. Authorizing the New York City Health and Hospitals Corporation (the "NYC Health + Hospitals") to execute an amendment to extend its contract with Harris Computer Corporation ("Harris") to continue operation, maintenance and support of NYC Health + Hospitals' legacy electronic medical record system, Quadramed, for a term of three-years with four (4) one-year renewals in an amount not to exceed $61,316,936.00 (Information Technology Committee – 09/13/18) **EEO: Pending / Vendex: Pending**	**Ms. Youssouf**

12. Authorizing the New York City Health and Hospitals Corporation (the "NYC Health + Hospitals") to execute an amendment to the Participation Agreement (the "Participation Agreement") with Northwell Health, Inc. ("Northwell") to support an amendment to the agreement (the "Cerner Agreement") between Northwell and Cerner Corporation ("Cerner") by which Cerner will provide implementation and support services to complete the installation and roll-out of the Cerner laboratory information system (the "LIS") across all of the NYC Health + Hospitals system with the resulting amendment to the Cerner Agreement increasing the total budgeted cost by $12,955,085 bringing the cost of such implementation and roll-out to a not to exceed total, inclusive of all expenses, of $34,379,677 over the period required for such implementation and roll-out currently estimated to be approximately June, 2020. (Information Technology Committee – 09/13/18) **EEO: Pending / Vendex: Pending**	**Ms. Youssouf**
13. Authorizing New York City Health and Hospitals Corporation (the "System") to execute an agreement with Fusion, a division of Fusion Capital Management, to procure a Correctional Health specific electronic medical record for the System's Correctional Health Services division with primary care, pharmacy, specialty services, mental health and drug treatment in 11 NYC jails, with an initial term of three years with two one-year options to renew solely exercisable by the System and with total amount over the combined five-year term not to exceed $12,999,354 to pay Fusion. (Medical and Professional Affairs and Information Technology Committee – 09/13/18) **EEO: Approved/ Vendex: Approved**	**Dr. Calamia** **Ms. Youssouf**
14. Adopting the attached Mission Statement, Performance Measures and additional information to be submitted on behalf of New York City Health and Hospitals Corporation ("NYC Health + Hospitals") for Fiscal Year 2018 to Office of the State Comptroller's Authorities Budget Office (the "ABO") as required by the Public Authorities Reform Act of 2009 (the "PARA").	**Mr. Campbell**
Committee Reports	
➢ Community Relations Committee ➢ Medical and Professional Affairs ➢ Finance ➢ Information Technology ➢ OneCity Health ➢ Metro Plus	**Ms. Bolus** **Dr. Calamia** **Mr. Rosen** **Ms. Youssouf** **Mr. Israel Rocha** **Mr. Rosen**
Executive Session | Facility Governing Body Report ➢NYC Health + Hospitals | Woodhull	**Mr. Campbell**
Semi-Annual Governing Body Report (Written Submission Only) ➢NYC Health + Hospitals | Lincoln ➢NYC Health + Hospitals | Gouverneur	
2017 Performance Improvement Plan and Evaluation (Written Submission Only) ➢Cumberland Diagnostic & Treatment Center | Gotham Health	**Mr. Campbell**
>>**Old Business**<<	
>>**New Business**<<	
Adjournment	

NYC HEALTH + HOSPITALS

A meeting of the Board of Directors of NYC Health + Hospitals was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 26th day of July 2018 at 3:08 P.M. pursuant to a notice which was sent to all of the Directors of NYC Health + Hospitals and which was provided to the public by the Secretary. The following Directors were present in person:

Mr. Gordon Campbell
Dr. Mitchell Katz
Mr. Scott French
Ms. Hillary Kunins
Mrs. Josephine Bolus, R.N.
Dr. Jo Ivey Boufford
Dr. Vincent Calamia
Ms. Barbara A. Lowe
Mr. Robert Nolan
Mr. Mark Page
Mr. Bernard Rosen
Ms. Emily A. Youssouf
Ms. Deborah Brown

Deborah Brown was in attendance representing Dr. Herminia Palacio in a voting capacity. Hillary Kunins was in attendance representing Dr. Gary Belkin. Scott French was in attendance representing Mr. Steven Banks. Mr. Gordon Campbell chaired the meeting and Ms. Colicia Hercules, Corporate Secretary, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on May 31, 2018 were presented to the Board. Then on motion made and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on May 31, 2018, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

Mr. Campbell reported that the Joint Commission concluded its survey of NYC Health + Hospitals/Kings County on Friday, June 8, 2018 and asked Mrs. Josephine Bolus, who participated in the Leadership Session of the exit conference, to comment. Mrs. Bolus reported that the site visit went beautifully. Mrs. Bolus also reported on the recent Marjorie Matthews Awards Ceremony which took place on July 19, 2018 at Coler. The event was a success with maximum attendance.

Mr. Campbell reported that there were nine new items on today's agenda of which 7 are Vendex approved and two are pending. There are four items from previous board meetings pending Vendex approval. Mr. Campbell said that the Board would be notified as outstanding Vendex approvals are received. .

Mr. Campbell then turned to Dr. Mitchell Katz for his President's report, indicating that he would complete his Chairperson's report upon arrival of Dr. Palacio.

PRESIDENT'S REPORT

Dr. Katz's remarks were in the Board package and made available on the NYC Health + Hospitals website. A copy is attached hereto and incorporated by reference.

Dr. Katz highlighted NYC Health + Hospitals' swift and robust reaction to learning that separated immigrant children were in New York City, and noted it as an example of the role of public hospitals in responding to crises without regard to financial gain. Clinicians at NYC Health + Hospitals/North Central Bronx identified that a number of recently separated immigrant pediatric patients were coming in to the Emergency Department; the System, with many Board members in attendance, and the Mayor held a press conference pledging support to these children; our Chief Medical Officer and Chief Nursing Officer did an immediate site visit to the Cayuga Center to assess the health care needs of the children and how the System could help them; a special outpatient clinic referral line was created; and soon contracts were established with the health plan covering the children's care. Many System employees emailed asking how they could help.

The Vanderbilt Health Center opened on Staten Island to great community support.

Mayor de Blasio nominated Dr. Katz to the Board of Health. He will have a hearing before the City Council on his nomination.

INFORMATIONAL ITEM

Dr. Katz asked Dr. Kim Mendez, Senior Vice President and System Chief Nursing Officer, to provide an update on Nursing in response to the report on the Annual Public Meetings held in each Borough

during 2018. Many of the concerns raised at those hearings related to nurse staffing levels at System facilities. Dr. Mendez described the System's efforts to expedite nurse hiring and to ensure that hiring was sufficient to fill not only current vacancies but to account for predictable turnover and the length of time it takes to onboard and train new nurses. Mr. Nolan asked about turnover rates among newer hires. Mr. Page noted that turnover is always costly and asked about ways to optimize productive time for those already employed. Discussion ensued about ways to encourage retention and optimize productive time. Mr. Campbell asked Dr. Calamia as Chair of the Medical and Professional Affairs Committee to continue to monitor nurse staffing levels and initiatives.

CHAIRPERSON'S REPORT – PART 2

Mr. Campbell then informed the Board that today is Dr. Jo Ivey Boufford's last Board meeting. He noted Dr. Boufford's long-standing commitment to NYC Health + Hospitals, starting in 1982 as Vice President of Medical Operation, moving on to other roles including Vice President of Medical and Professionals Affairs, Executive Vice President, Acting President, then President; Vice Chair of the Board; Chair of the Board; and Board Member.

Deputy Mayor Herminia Palacio arrived at 3:40 and Mr. Campbell recognized her to speak about Dr. Boufford. Dr. Palacio spoke of Dr. Boufford's many years and many roles serving NYC

Health + Hospitals. She noted Dr. Boufford's dedication and talent and innumerable contributions to the System. Dr. Boufford thanked the Deputy Mayor and spoke of the System's importance in New York City.

INFORMATIONAL ITEM

Dr. Ted Long, Vice President for Ambulatory Care, presented on the System's access initiative on ambulatory care scheduling. Discussion ensued related to the practices of other health providers; communication with and education for patients; and other strategies for expanding access within ambulatory care.

ACTION ITEMS

RESOLUTION

2. Authorizing the New York City Health and Hospitals Corporation (the "System") to execute a five-year revocable license agreement with Eyes and Optics (the "Licensee") for its use and occupancy of 308 square feet of space to operate an optical dispensary at Woodhull Medical & Mental Health Center (the "Facility") at an occupancy fee of $16,940 per year or $55 per square foot to be escalated by 3% per year for a five year total of $89,937.

Mr. Gregory Calliste, Chief Executive Officer of NYC Health + Hospitals/Woodhull and Ms. Roslyn Weinstein, Vice President, Operations, presented the proposal.

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

RESOLUTION

3. Authorizing the New York City Health and Hospitals Corporation (the "System") to execute a license agreement with Public Health Solutions ("PHS") to allow PHS to maintain tables in lobby areas at NYC Health + Hospitals/Kings ("KCHC"), New York City Health + Hospitals/Jacobi ("Jacobi"), NYC Health + Hospitals/Lincoln

("Lincoln") and NYC Health + Hospitals/Elmhurst ("Elmhurst") to encourage eligible patients to enroll for the Supplemental Food and Nutrition Program ("SNAP") benefits, to assist them in enrolling in SNAP and provide counseling about, and referrals to, other programs available to address food insecurity for a period of three years with the occupancy fee waived.

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

RESOLUTION

4. Authorizing the New York City Health and Hospitals Corporation (the "System") to execute Job Order Contracts (JOC) with two (2) firms; Jemco Electrical Contractors, Inc.; and Mac Fhionngnaile & Sons Electrical Contractors, Inc.; (the "Contractors"), that were pre-qualified through the System's public bid process, to provide construction services on an as-needed basis at various facilities throughout the System. Each individual contract shall be for a term of two (2) years, for an amount not to exceed $6,000,000. The total authorized value of these contracts is $12 million.

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

RESOLUTION

5. Authorizing the New York City Health and Hospitals Corporation (the "System") to execute Job Order Contracts (JOC) with two (2) firms: AWL Industries, Inc.; and Volmar Construction, Inc., (the "Contractors"), that were pre-qualified through the System's public bid process, to provide construction services on an as-needed basis at various facilities throughout the System. Each individual contract shall be for a term of two (2) years, for an amount not to exceed $6,000,000. The total authorized value of these contracts is $12 Million.

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

RESOLUTION

6. Authorizing New York City Health and Hospitals Corporation

(the “System”) to execute an agreement with Accuity Delivery Systems (“Accuity”) to provide medical coding optimization services for the System’s acute care facilities over a term of approximately two years to expire with the conclusion of FY 2020 with the total amount not to exceed $25,364,000.

John Ulberg, Senior Vice President and Chief Financial Officer, and Robert Melican and Patricia Castro, Revenue Management, presented on the proposal for transitional Coding Optimization services.

In response to questions, Mr. Melican reiterated the expectation that Accuity’s services would be needed on a short-term basis, as training initiatives should help with internal staff coding capacity. Dr. Machelle Allen noted that the vendor had already established an effective feedback loop on coding improvement with facility Chief Medical Officers and physicians in their initial engagement. Mr. Rosen moved the adoption of the resolution which was duly seconded and discussed and unanimously adopted by the Board.

RESOLUTION

7. Authorizing New York City Health and Hospitals Corporation (the “System”) to execute an agreement with Compass Group USA doing business as Canteen (“Canteen”) to provide vending services for the System’s acute care, post-acute care and corporate facilities with an initial term of five years and two five-year options to renew solely exercisable by the System. Canteen will pay the System a signing bonus of $250,000 and a commission of 30.8% on annual sales up to $3,999,999 and commission of 40% on annual sales in excess of $4,000,000.

Paul Albertson, Vice President, Supply Chain Services, presented on the vending services plan.

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

RESOLUTION

7. Authorizing New York City Health and Hospitals Corporation (the "System") to enter into a contract with G-Systems for cabling services as a component of the Network and Unified Communication Infrastructure Upgrade project at NYC Health + Hospitals/Bellevue, NYC Health + Hospitals/Kings County, NYC Health + Hospitals/Woodhull ad NYC Health + Hospitals/Harlem (the "Four Hospitals") in the amount of $24.2 million, of which $21.8 M is funded through the City's Capital budget and $2.4M is funded through the System's operating budget which sum includes a 10% contingency.

Kevin Lynch, Senior Vice President and Chief Information Officer, Jeff Lutz, Assistant Vice President and Barbara Lederman, Assistant Vice President, Enterprise Information Technology Services, presented on the "network refresh" initiative. In response to a question by Dr. Boufford, Mr. Lynch clarified that all hospitals and all of the community clinics are part of the network refresh initiative.

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

BOARD COMMITTEE REPORTS

Attached hereto is a compilation of reports of the NYC Health + Hospitals Board Committees that have been convened since the last meeting of the Board of Directors. The reports were received by Mr. Campbell at the Board meeting.

Mr. Campbell received the Board's approval to convene an Executive

Hospitals Board Committees that have been convened since the last meeting of the Board of Directors. The reports were received by Mr. Campbell at the Board meeting.

Mr. Campbell received the Board's approval to convene an Executive Session to discuss matters of quality assurance, patient privacy, personnel matters and potential litigation.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Mr. Campbell reported that the Board (1) received and approved an oral governing body submission from NYC Health + Hospitals/Queens and NYC Health + Hospitals/Elmhurst; (2) received and approved semiannual governing body (written submission) reports from NYC Health + Hospitals/Bellevue and NYC Health + Hospitals/Kings County and NYC Health + Hospitals/McKinney; and (3) received and approved the (written submission) of the 2017 performance improvement plan and evaluation for NYC Health + Hospitals/Morrisania/Gotham Health and NYC Health + Hospitals/Belvis/Gotham Health.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 5:30 P.M.

Colicia Hercules
Corporate Secretary

COMMITTEE REPORTS

Governance Committee Meeting – May 31, 2018
As Reported by Gordon Campbell
Committee Members – Gordon Campbell; Bernard Rosen; Helen Arteaga Landaverde
Staff – Mitchell Katz; Yvette Villanueva; Colicia Hercules

The meeting was called to order at 2:00 by Gordon Campbell. Mr. Campbell called a motion to accept the minutes of the Governance Committee meeting held on April 26, 2018. The motion was seconded and the minutes were unanimously approved.
Mr. Campbell then requested a motion to convene in executive session to discuss personnel matters. The motion was seconded and approved.
This meeting of the Governance Committee was convened in executive session to deliberate on the following personnel actions.
Action Items

To consider nominee to the following corporate officer level position:

1. *John Ulberg – Senior Vice President, Chief Financial Officer*
   Following a discussion conducted by Dr. Mitchell Katz, , by the candidate, and the subsequent deliberations by the Committee attendees, Mr. Campbell called for a motion to recommend John Ulberg as Senior Vice President, Chief Financial Officer.

The motion was seconded and unanimously approved by the Committee for consideration by the full Board.

There being no further business, the meeting adjourned at 2:43 p.m.

Medical and Professional Affairs Meeting – June 13, 2018
As Reported by Dr. Vincent Calamia
Committee Members Present- Gordon Campbell, Vincent Calamia, Mitchell Katz, Barbara Lowe, Josephine Bolus

Dr. Vincent Calamia, Chair of the Committee, called the meeting to order at 9:10 AM. On motion, the Committee voted to adopt the minutes of the April 12, 2018 of the Medical and Professional Affairs Committee.

CHIEF MEDICAL OFFICER REPORT
Machelle Allen MD, Chief Medical Officer, reported on the following initiatives.

Flu
The official end to the influenza season was declared last month by the New York State Commissioner of Health, Dr. Howard Zucker. This flu season, our system administered a total of 28, 721 vaccinations to staff—up from 26,454 last year. I am happy to report that we've had

steady incremental participation over the last 5 seasons. We will continue to increase awareness and education throughout our system.

Behavioral Health

Integration Efforts:

OBH is implementing primary care integration into behavioral health at 5 sites – Bellevue, Elmhurst, Lincoln, Kings, and Cumberland. OBH is working with Jacobi, Metropolitan and other sites to develop integrated services there. In addition there is continued expansion of collaborative care with the addition of substance use disorder screening and treatment in primary care sites. Maternal health also provides screening and referral for depression, and the addition of pediatric/well-baby sites is on-going.

Opioid Crisis:

OBH is actively working on substance use issues, in particular addressing the current opioid crisis. OBH is a major part of the Mayor's initiative, *Healing NYC* – focused programs that address the current opioid crisis in NYC. Interventions focus on the following: judicious prescribing practices in emergency departments; increasing access to buprenorphine in primary care and emergency departments; increased distribution of naloxone kits to reduce fatal overdose; and establishment of 6 addiction consultation teams (CATCH Teams).

Domestic Violence:

The Family Justice Center sites provide co-located mental health services at the domestic violence centers. All sites are now open: Manhattan, Brooklyn, Queens, Bronx and Staten Island.

Patient/Staff safety:

OBH is working with all facilities to advance safety for patients and staff. A program of debriefing after an incident or aggressive episode has been implemented and focuses on reducing violence and assaults in the acute care areas. Also mock codes/drills related to aggression and violence are being conducted to better train and prepare staff to respond to crisis situations. There is also a major focus on ensuring a safe environment for patients through a comprehensive risk assessment for ligature risk and other environmental safety concerns. We are in the process of developing a system-wide environmental risk assessment.

Homeless mentally ill:

OBH is developing two programs that will better serve the homeless mentally ill. H+H/OBH is developing a mental health and primary care clinic in a homeless shelter, located in the Meyer Building on Ward's Island, specifically for those with mental illness. We will provide a full range of services including screening and assessment, pharmacological treatment, therapy, and support services.

The second program is the development of extended care inpatient units for those who are homeless and need an extended stay to stabilize and be prepared to live in more independent settings such as supportive housing. The unit's goal is to prevent readmissions and engage the patients in ongoing ambulatory treatment for both mental and physical disorders.

Laboratory Services

In general, reducing variation within laboratory operations continues to be a focus including implementation of new equipment as well as, a new laboratory information system. Efforts in progress include the implementation of standard equipment in the areas of chemistry and hematology. We are on schedule to complete both systems by March 2019.

As we prepare Woodhull laboratory for the implementation of the Cerner Laboratory Information System in conjunction with the EPIC EMR, efforts continue to develop using standard build.

In support of Emergency Medicine Services initiatives, a focused body of work is in progress to implement Point of Care (POC) testing where needed is underway with a goal to be completed by September 2018.

Patient Blood Management

As a result of an enterprise workgroup initiative, opportunity has been identified to reduce blood product wastage within our system. Efforts are underway to produce monthly data allowing timely monitoring and actions when appropriate. A 90 day pilot model is in development including several of our hospital blood banks with an aim to relocate platelet products for transfusion within our system, when needed.

Test Utilization

In partnership with our clinical experts and Huron Consulting, an enterprise workgroup has been active for several months to identify strategies to support appropriate test utilization. With support from our EPIC partners, special EMR alerts will trigger when high costs tests, duplicate tests, and once in a lifetime tests have been requested. The aim is to implement the 1st phase alerts by October 2018. This work is on-going. Tools to perform real-time test utilization review are in development which will allow clinical end-users to take action as appropriate.

Clinical Services Planning

Emergency Department Services Initiative - with focus on delivering high quality care to patients that visit our EDs, the development of an urgent care clinic is an important goal. Key partners including, Operations, M&PA, and OneCity Health, have been working in collaboration to develop an enterprise model with the aim to implement Urgent Care Clinics at Elmhurst and Lincoln hospital over the next several months, to be followed by a system-wide implementation.

Additionally, strengthening Observation Beds services throughout the enterprise improves care to patients visiting our Emergency Departments, as some patients who may not meet criteria for admission often still require some level of clinical monitoring while being cared

for. Standard work and EMR build requirements are in development, as are the education and training components required for the new work flows and documentation requirements for proper billing.

Pharmacy Services

1. Collaboration with supply chain to create a conservation plan to manage the injectable opioid shortage.
2. Collaboration with Go Epic Order-sets team to oversee clinical content of order sets.
3. Collaboration with Huron Consulting to develop and design a road map and implementation time line for cost avoiding, revenue generating, transformation of pharmacy services.
4. Antimicrobial Stewardship Initiative continues to ensure optimal antimicrobial therapy prescribing and reduce antimicrobial resistance rates.
5. Collaboration with supply chain and McKesson Patient Assistance Program.
6. Continual progress toward a standardized formulary.
7. Compliance with USP797 standards and preparation of facilities for new USP797 and 800 standards for compounding IV admixtures.
8. Seeking an innovative system-wide inventory management solution for all medications at each of our facilities.

System Chief Nurse Executive Report
Kim Mendez, Chief Nurse Executive, reported to the committee on the following:

System Nurse Practice Council (SNPC)
The System Nurse Practice Council continues to meet monthly. Key agenda focus areas include: Shared Governance, Recruitment, Retention & Recognition, Nurse Practitioner roles, RN driven clinics and supporting a work environment to implement new NYS RN scope of practice changes. Across our system, shared governance councils are being initiated and welcomed by frontline nursing staff. Both Kings and Harlem have kicked off the DAISY Award at their facilities to highlight and recognize excellence of an individual nurse or nursing team. The DAISY Award has been well received and is available for all NYC H + H facilities. A SAVE the Date announcement for the second annual Shared Governance Retreat in November 2018 has been posted.

System New Nurse Hire Orientation

- Following, January 12, 2018, successful launch of phase I of centralizing nurse orientation for Acute Care facilities next steps across the system will focus on standardizing critical care courses for system offerings as well as streamlining the remaining components of new hire nursing orientation. Of note, the May 4th, 2018 nursing orientation on-boarded 150 new RN hires.

- Ongoing collaboration with HR Workforce Development and PeopleSoft teams to align training information into new hire files.
- New agency nursing hires may now take HIPAA training online to facilitate on-boarding process. Additional opportunities for e-learning modules for orientation is actively being evaluated.

New Post-Graduate Nurse Practitioner Fellowship

- In partnership with the VP Primary Care, an interdisciplinary NP fellowship program is being developed for a July/August 2018 one year proof of concept launch. The concept is to embed new post-graduate NPs for one year into a team-based setting alongside internal medicine residents and interdisciplinary care teams to support the new NPs in building their foundational education framework and translate learning into practice. The program will focus on professional development by providing education, role modeling and mentoring, advanced practice and clinical inquiry. Ultimate goal is to attract, train and retain NPs to improve access to care across our ambulatory site clinics.

SART & Domestic Violence Initiatives

- We are continuing to work with the Mayor's Office to Combat Domestic Violence on the integration of identified domestic violence strangulation cases with SAFE exams. The goal is to begin program roll-out at both Kings and Elmhurst hospitals in the fall of 2018 and then learn and spread across the system.

Nursing Quality

- **CAUTI/CLABSI**-system-wide performance improvement programs are well underway to support standardization of care bundles, training, and audit processes. For the CAUTI initiative, a system-wide follow-up indwelling catheter point prevalence study is underway. The results will be available in June 2018.

- **Pressure Injury Prevention (PIP)**
  - The system-wide PI project for Pressure Injury Prevention will be presented by facilities at the upcoming QAC meetings for 4Q17 data. PIP work has focused on standardized training and use of the Braden Risk Assessment Tool as well as use of an audit tool for assessing care bundle compliance.

Staffing

- System wide review of acute care nurse staffing and monthly dashboard updates have been developed and in process.

- Going forward from April 1, 2018, front line nursing positions have an automatic backfill based on NYC H + H staffing guidelines.
- Establishing NYC H + H nursing staff float pools at each acute care facility as an alternative to agency staffing is in final discussions.
- Any critical staffing needs are being addressed one on one with each CNO to develop short and long term mitigation plans.
- FY 2019 Nursing FTE budget for acute care facilities proposal has been completed and is now under finance review.

Nursing Informatics

- Ongoing participation in EPIC build decisions for order sets, workflows, functionality prioritization. Active participation on EPIC Enterprise Executive Committee, ETIS Prioritization Committee, etc.
- Continue to support PeopleSoft (Payroll & timekeeping). Finalizing next steps for new nurse scheduling system (Clairvia) for the enterprise.
- NISA (Nursing **I**nformatics **S**ystem **A**dvisory) On May 18, 2018 NISA held their 6th Annual Nursing Informatics Conference at Bellevue. Keynote speaker was Judy Murphy, CNO, IBM Global Healthcare. The conference was well attended and very informative.

Care Management

- System-wide Care Management Program rolled-out at NYC H+H/Bellevue began on May 1, 2018 and will be completed in June 2018. Standard workflows have been completed for 3 care settings: Ambulatory, ED, and In-patient. A standard curriculum is being completed for training purposes as well as an interim care plan has been established for all three settings plus At Home. Standard work for interdisciplinary rounds is being finalized. Next steps include moving UM and Interdisciplinary Rounds standard work out to all acute care facilities.
- System-wide high risk stratification tool for the ED Care Transition team is in alignment with Population Health predictive model. Hi Utilizer flags are now active in 3 care settings.
- Continue to monitor DSRIP Phase II & III metrics
- Health Home At Risk (HHAR) – workflow transition to PCMH is underway. This includes establishing a referral process for DSRIP 4Qtr goal and updating care plan to meet health home standards. Weekly update meetings are scheduled to maintain momentum.
- Care Management Governance structure introduced and first new meeting was held on May 29, 2018.
- UM Training has kicked-off and the goal is to be completed by the end of June 2018.

- In partnership with OCH Workforce Development Team, Accountable Care Manager standard curriculum for competency & orientation is under development.

Patient & Staff Experience
2018 System approach includes:

- In May 2018, ICARE, a broad customer service training initiative kicked off across our system. As part of the launch of ICARE, facilities will work on implementing proactive purposeful rounding to better anticipate and address the needs of hospitalized patients and focus on both “no pass zone” and quiet at night standard work.

- The “Happy or Not” patient satisfaction assessment tool meters for Ambulatory Care have arrived and are being distributed. Standard work has been developed; Go Live across our ambulatory care sites is scheduled for June 18, 2018. Using this system, patients are encouraged to rate their experience (anonymously) by pressing a button that best depicts their experience during their visit (see diagram below). This information is captured in aggregate and discussed at daily huddles with patient care staff. Engaging staff with direct customer feedback and gaining their insight to barriers and solutions is impactful

MetroPlus Health Plan, Inc.

Total plan enrollment as of March 1, 2018 was 518,407 Breakdown of plan enrollment by line of business is as follows:

Medicaid	371,405
Child Health Plus	17,622
MetroPlus Gold	11,684
Partnership in Care (HIV/SNP)	4,203
Medicare	8,012
MLTC	1,861
QHP	14,568
SHOP	1,324
FIDA	208
HARP	10,754
Essential Plan	74,901
GoldCare I	1,176
GoldCare II	689

Enrollment

Once a year, New York State releases detailed open enrollment numbers for all plans for the Open Enrollment period. The most recent report for the 2017-2018 open enrollment period confirms MetroPlus Health Plan’s strong overall performance. For QHP, membership grew from 8,469 during last year’s open enrollment period to 13,902 at the end of this year’s open enrollment – a 65% increase. In fact, QHP membership now stands at 14,568 members

(see above). Our QHP membership represents 15% of the entire QHP membership in our service area. This is a strong improvement from the 9% market share a year ago. MetroPlus was the only plan throughout the state to have significant growth in its QHP market share compared to a year ago. We were in the top three in QHP enrollments in the Bronx, Brooklyn, and Queens. For EP, MetroPlus was also in the top three in enrollments for all boroughs (except Staten Island). Our EP membership represents 16% of the market in our service area.

Retention

One of the key factors to retaining members is ensuring individuals renew their Medicaid eligibility. To assist members with timely renewals, MetroPlus has a multi-tiered outreach strategy involving mailings, texting, and phone calls. As noted in the chart below, significant improvement has been made in recent months in the overall renewal rate. The increase is due in part to the development and careful monitoring of individual performance metrics in the Retention Department. Retention has also increased its service hours and now contacts people both on weekends and in the evenings until 8 PM to reach people at a time when they are available. Further, MetroPlus has begun to work more closely with facilities to renew individuals who come in to outpatient appointments while they are in the building.

There has been an increasing renewal rate starting in November of last year when the rate was about 78%. In March, the most recent month for which final data is available, the rate had increased to 83%. The top three facilities for renewal rates are Bellevue, Harlem, and Metropolitan each at 86%.

Marketing

MetroPlus has started marketing efforts at the new Vanderbilt site on Staten Island. We are currently active onsite three days a week and will expand our presence as more services are added. During our first week, we were able to enroll around 50 people into health insurance coverage. We plan to do additional outreach to the uninsured population near the facility to let them know about the new facility as well as the opportunity to obtain health insurance.

Special Investigations Unit (SIU)

MetroPlus has a contract with Verscend for our SIU activities. Verscend reviews MetroPlus claims using their algorithms to identify areas of concern in provider billing. A provider may be able to explain certain areas of potential concern when raised. In other cases, he or she may not have been billing fraudulently but may have misunderstood the coding or the rules and further education may be required. Alternatively, Verscend may determine that the provider improperly billed MetroPlus and that a recovery is required. Our SIU staff also reviews all Verscend referrals for an added layer of verification. Verscend has currently initiated over 50 collection efforts with providers. The state has also been focusing more closely on collection efforts made by providers and requiring providers to report the amount collected and the efforts involved.

Soarian

For several months MetroPlus has been working with H+H facility staff to connect with individuals seeking services in the facilities who are potentially insurance eligible. At many facilities, our staff now sit in outpatient areas and in the Managed Care Departments and receive direct referrals of uninsured individuals from facility staff. Additionally, with the implementation of the centralized call center, uninsured individuals are scheduled to see a MetroPlus representative one hour before their scheduled appointment time. To track the referrals as they move from H+H to MetroPlus and to be able to report on outcomes, our staff have been trained on the relevant tools in Soarian. H+H staff and MetroPlus will both use the system; and sharing the platform will allow for tracking the progress of referrals and results. Soarian implementation has started at NCB and will be expanded to other facilities.

INFORMATION ITEM:

Israel Rocha, Vice President, OneCity Health presented to the committee the Strategy to Decrease Avoidable Utilization.

There being no further business, the meeting was adjourned 10:14 AM.

AUDIT COMMITTEE MEETING – June 13, 2018
As Reported by Gordon Campbell
COMMITTEE MEMBERS PRESENT: Mitchell Katz, MD, Josephine Bolus, RN, Gordon Campbell

An Audit Committee meeting was held on Wednesday, June 13, 2018. The meeting was called to order at 10:20 A.M. by Mr. Gordon J. Campbell, Acting Board Chair. He stated that there will be a vote to approve the minutes later, in the meantime he directed the meeting to Mr. Jay Weinman.

Mr. Weinman stated that each year before our audited financial statements, our auditors present to the Audit Committee some required communications. They will go over the auditors' responsibility, the responsibility of management and those responsible for governance. They will talk about the scope and timing of the audit. He asked the auditors of Grant Thornton to approach the table to present their audit plan and introduced themselves.

Mr. Campbell requested that it would be helpful to state what is different from the past since we have a new audit firm.

Grant Thornton introduced themselves as follows: Tami Radinsky, Lead Engagement Partner; Lou Feuerstein, Relationship Partner; Steven Dioguardi, Senior Manager and Ganesh Narayan, Insurance Senior Manager.

Ms. Radinsky began the presentation by reporting on their responsibilities:

- Performing the following audits of financial statements as prepared by management, with your oversight, conducted under US Generally Accepted Auditing Standards (GAAS) and, where applicable, under Government Auditing Standards:
  - NYC Health + Hospitals for the fiscal year ending June 30, 2018

- HHC Accountable Care Organization Inc. annual financial statements for the fiscal year ending June 30, 2018
- MetroPlus Health Plan's annual statutory financial statements for the fiscal year ending December 31, 2018
- HHC Insurance Company's annual statutory financial statements for the fiscal year ending December 31, 2018
- Annual Report of Ambulatory Health Care Facility (AHCF-1)
- Annual Report of Residential Health Care Facility (RHCF-4)
- Communicating fraud risks to you identified during our audit
- Communicating specific matters to you on a timely basis

Those charged with governance are responsible for:

- Overseeing the financial reporting process
- Setting a positive tone at the top and challenging NYC Health + Hospital's activities in the financial arena
- Discussing significant accounting and internal control matters with management
- Informing us about fraud or suspected fraud, including its views about fraud risks
- Informing us about other matters that are relevant to our audit, such as:
  - Objectives and strategies and related business risks that may result in material misstatement
  - Matters warranting particular audit attention
  - Significant communications with regulators
  - Matters related to the effectiveness of internal control and your oversight responsibilities
  - Your views regarding our current communications

Management is responsible for:

- Preparing and fairly presenting the consolidated financial statements including supplementary information in accordance with US GAAP
- Designing, implementing, evaluating, and maintaining effective internal control over financial reporting
- Communicating significant accounting and internal control matters to those charged with governance
- Providing us with unrestricted access to all persons and all information relevant to our audit
- Informing us about fraud, illegal acts, significant deficiencies, and material weaknesses
- Adjusting the financial statements, including disclosures, to correct material misstatements
- Informing us of subsequent events
- Providing us with certain written representations

Audit Timeline

May - June 2018	Client acceptance	• Client acceptance • Issue engagement letter • Conduct internal client service planning meeting, including

		coordination with audit support teams such as IT and tax
May – June 2018	Planning	• Meet with management to confirm expectations and discuss business risk • Discuss scope of work and timetable • Identify current-year audit issues and discuss recently issued accounting pronouncements of relevance • Initial Audit Committee communications
June 2018	Preliminary risk assessment procedures	• Develop audit plan that addresses risk areas • Update understanding of internal control environment • Coordinate planning with management and develop work calendar
June – July 2018	Interim fieldwork	• Perform final phase of audit and year-end fieldwork procedures • Meet with management to discuss results, draft financial statements and other required communications • Review final “draft” reports and other deliverables
October 2018	Deliverables	• Present draft reports and audit results to the Audit Committee and management • Issue final audit reports and other deliverables
December 2018	Deliverables	• Present final management letter to the Audit Committee
December 2018 - January 2019	MetroPlus Health Plan	• Perform walk-throughs of business processes and controls • Perform control testing over significant business processes • Perform selective substantive testing on interim balances
February 2019 – March 2019	MetroPlus Health Plan	• Perform final phase audit and year-end fieldwork procedures • Meet with management to discuss results, draft financial statements and other required communications

		• Issue the final audit report and other deliverables
April 2019 – August 2019	Cost Report Certification and HHC Insurance Company	• Perform applicable audit procedures and issue auditor's reports on cost reports for the skilled nursing facilities (RHCF-4) and diagnostic and treatment centers (AHCF) • Perform HHC Insurance Company audit and issuance of audit report
Timing to be determined	HHC ACO, Inc.	• Perform HHC ACO, Inc. audit and issuance of audit report (2018)

Ms. Radinsky turned the meeting over to Mr. Dioguardi to explain the audit approach.

Planning – In this phase we will update an understanding of and document your operations, control environment, accounts and information technology systems.

Risk Assessment - We use our understanding of your internal control system and operations to identify the inherent audit risks and strengths of your operations and information systems. By performing our risk assessment, we customize our audit approach to focus our efforts on the key areas.

Evaluation & Testing of Controls - We will evaluate the design effectiveness, and when appropriate, the operating effectiveness of the corporate governance and information technology controls, as well as the controls over each significant activity/process. Based on the result of this evaluation, we will determine the extent of our substantive testing.

Substantive Testing - When appropriate, we will use audit software to perform substantive testing. This enables us to retrieve information directly from your data files, if needed, without affecting the integrity of the data.

Concluding & Reporting - We will provide management and the Audit Committee with the results of our audit, including best practices and internal control recommendations.

Significant Risks and other areas of focus

Areas of focus – Accounts receivable, related contractual and uncollectable allowances and net patient service.

Procedures:

- Review account reconciliations including completeness and accuracy testing of the aged patient trial balances
- Perform analytical procedures over key indicators such as days in accounts receivable, account write offs and aging of balances
- Perform detailed account balance testing
- Perform cut-off testing
- Review management's methodology for estimating allowances
- Perform medical record testing for existence (no confirmation procedures) and detail test of subsequent cash receipts

- Perform a hindsight analysis of the prior year accounts receivable balance by reviewing cash collections on prior year balances
- Perform cash to revenue proof to assist in the validation of the revenue balance

Mr. Campbell asked if this will include billing as well? To which, Mr. Gioguardi answered yes, we do billing from a controlled testing aspect over existence of a patient, in terms of when the patient came in and that the service provided was appropriately put into the billing system.

Mr. Campbell asked if this will include going back to the medical records and then back up to see that it is billed appropriately? This is something that the board is looking at very closely, we hope that you give it your just do.
Ms. Radinsky assured Mr. Campbell that they will and added that she is aware that the system is mostly centralized, but we will be doing site visits as well.
Mr. Campbell added that there are lessons to be learned and the more you recommend that better.
Mr. Gioguardi continued on with the presentation.
Areas of focus – Estimate settlements due to third-party payers and net patient service revenue
Procedures:
- Review account reconciliations and roll-forwards and agree significant reconciling items to supporting schedules and documentation.
- Perform detailed account balance testing
- Review management's methodology for estimating amounts
- Review the financial statement presentation and disclosures

Mr. Weinman commented that those third-party include DSH and UPLs, things that are high value and required to be looked at extensively.
Areas of focus – Accrued liabilities reserves and contingencies
Procedures:
- Perform detail testing of management's calculations, including underlying inputs and data provided to specialists used in actuarial calculations for workers compensation, pension, OPEB, and self-insurance health liabilities
- Obtain and review outside actuarial reports used to determine pension and OPEB liabilities
- Assess for reasonableness the assumptions used in developing estimates
- Perform a search for unrecorded liabilities
- Test the completeness and accuracy of accounts payable aged trial balance
- Review payroll accruals for reasonableness

Areas of focus – Accounting Estimates
Planned procedures
The preparation of NYC Health + Hospital's financial statements requires management to make multiple estimates and assumptions that affect the reported amounts of assets and liabilities as well as the

amounts presented in certain required disclosures in the notes to those financial statements. The most significant estimates relate to contractual allowances, the allowance for doubtful accounts, third-party liabilities, malpractice liabilities and actuarial estimates for the pension plan. Our procedures have been designed in part, to review these estimates and evaluate their reasonableness.
Ms. Radinsky commented that during our procedures if there are non-routine transactions, it will be high priority for us to look at.
Areas of focus – Financial Statement Disclosures
Planned procedures
Our procedures will also include an assessment as to the adequacy of NYC Health + Hospital's financial statement disclosures to ensure they are complete, accurate and appropriately describe the significant accounting policies employed in the preparation of the financial statements and provide a detail of all significant commitments, estimates and concentrations of risk, amongst other relevant disclosures required by accounting standards and industry practice.
Other Areas of Audit Focus
Perform substantive testing on key account balances as of June 30, 2018, as follows:

- Confirmation of cash and cash equivalents.
- Test significant fixed asset additions and disposals, as applicable.
- Test deferred revenue, as applicable.
- Obtain debt roll-forward and test payments throughout the year and compliance with debt covenants
- Review and testing the completeness of accounts payable and accrued liabilities.
- Perform an analytical review of revenues and expenses.
- Identify and test non-routine transactions to ensure appropriate accounting treatment.
- Independently confirm with internal and external legal counsel the potential exposure associated with outstanding claims, as applicable. Identify contingent liabilities or assets requiring accounting treatment or footnote disclosure.
- Perform fraud procedures
- Journal entry testing
- Review inter-company accounts
- Vendor testing

Ms. Radinsky stated that during their interim procedures, they will schedule meetings and interviews with Dr. Katz, Ms. Youssouf and Mr. Weinman and others to get a clear understanding on what is on their minds.

Mr. Gioguardi stated that the next item they will look at is Information Systems.
Our approach to testing the Organization's information technology systems is detailed as follows:

Phase 1: Understand and document business processes material to the audit

Our engagement team will:

- Meet with the Organization management to document our understanding of critical business processes and controls, and the technology used to support them.
- Document process flows, controls, and supporting technology relevant to audit objectives.

Phase 2: Assess information technology risks

- Our engagement team will identify information technology related risks and tailor our information technology review procedures to address those risks.

Phase 3: Identify information technology controls that support audit objectives

- General controls review – Review controls applicable to the overall processing environment.
- Applications review – Review specific business systems for application level and related controls.

Phase 4: Test technology related controls

- We will test the identified controls and determine their design and operating effectiveness, within the context of our audit scope and objectives. As a result of our test procedures, we will prepare observations and recommendations to improve existing information technology systems and associated controls and processes.

Mr. Weinman stated that what is going to be different from previous audits is the implementation of a new system for general ledger and accounts payable. This presents a new set audit procedure to make sure that that works properly.

Ms. Radinsky stated that if there were no questions regarding the audit process, she will direct the presentation to Mr. Feuerstein to discuss new standards that are applicable for this year and the future.

Mr. Feuerstein stated that there have been six GASBs issued that will impact the organization over next two to three years. There are only a couple of them that we have to worry about for 2018. One of them is GASB 83: Certain Asset Retirement Obligations. You will note that this not required until 2019, but because your financial statements are included with the City of New York, we have to make sure that our accounting policies are consistent between the two entities. It looks like they are going to adopt this obligation one year earlier.

There are two other June 30 2018 items, they will not have much of an impact.

GASB 85 - This is just question and answer regarding to previous GASB.

GASB 86 – It will only impact you if planning of refunding or irrevocably trust.

Ms. Radinsky asked if there were any questions regarding their presentation. She thanked the committee.

Mr. Campbell asked for a motion to adopt the minutes of the April

12th meeting. Motion was seconded.
Mr. Campbell then directed the meeting to Mr. Telano for Internal Audit update.
Mr. Telano began with the State Comptrollers Audit – Controls over Equipment. This audit began on December 2017 and it is still ongoing. Listed below are the eight sites they have visited, yesterday they indicated that they want to go to Sea View so that will make it nine.

1. NYC Health + Hospitals/Bellevue
2. NYC Health + Hospitals/Elmhurst
3. NYC Health + Hospitals/Jacobi
4. NYC Health + Hospitals/Harlem
5. NYC Health + Hospitals/Gotham Health, East New York
6. NYC Health + Hospitals/Gotham Health, Belvis
7. NYC Health + Hospitals/Gotham Health, Roberto Clemente
8. NYC Health + Hospitals/Gotham Health, South Queens

We had a meeting on June 7th, to discuss preliminary findings. One of the findings that they brought to our attention was that they physical counted ninety items and they were able to locate eighty-two in eight sites which is very impressive. H+H provide documentation on the missing items. The original cost of those eight items was almost $25,000 not including depreciation.
Mr. Campbell asked if there any other external audits going on. To which Mr. Telano responded that that is the only one.
Mr. Telano continued with the next audit – Audit of System-wide Review of Leased & Owned Vehicles. He asked Fred Covino, Paul Albertson and Roslyn Weinstein to approach the table.

This audit was suggested by the audit liaison from the Mayor's Office, George Davis. The audit was conducted at a very high level. We did not do specific testing looking for exceptions, we first evaluated what transpires at Central Office which is very impressive the way vehicles are being monitored. Then we went out to visit ten different sites to compare them to Central Office operations. We also sent questionnaires to every site and was provided with the listing of all the cars and a listing of their motor vehicle operators. The summary of 447 cars at the end of the year, including the facilities having a total 325, Central Office have 87 and the Inspector General (IG) have 35.
Central Office primarily leases vehicles, as Corporate Budget has provided them an analysis that is more fiscally responsible. The facilities purchased the vast majority of their vehicles and the cars for the IG were all purchased, as they required specialized equipment for those vehicles.
Mr. Campbell asked why the IG cars need sirens.
Dr. Katz responded that they said that they are part of law enforcement, and they follow-up with the FBI when money is taken or people are billing for things that they are not supposed to.
Mr. Covino commented that they had extensive discussions with the IGs Office to try to push for leases. H+H also clarified the breakdown of how many cars needed the specialized equipment and of note is that there were some time sensitivity to having the cars in operations in

a timely manner.
Dr. Katz stated that due to this audit, he was made aware of the numbers of cars used by the IG's Office, and they have agreed to give up eight cars. Dr. Katz also stated that, Ms. Weinstein is in the process of reviewing the inventory of vehicles and present a plan to reduce the fleet. This review is only incidental to the audit, not that that was the purpose of the audit, but knowing about the number of cars, given our financial condition, it seems right that we should find ways to get by with fewer cars.
Mr. Telano continued, in conducting this review and visiting the facilities, we came to the conclusion that the control of the vehicles system-wide should be centralized and the policies and procedures be standardized for the following reasons:

a) No Centralized Procurement - Vehicles are purchased from numerous vendors. A review of eight of the facilities revealed that their vehicles were purchased from 46 different car dealers.
b) Excessive number of vehicles at the facilities – 132 are used for maintenance, or by specific departments such as Hospital Police and Behavioral Health. Although there are 193 vehicles used by the facility Transportation Departments, there are only 121 Motor Vehicle Operators (MVO) employed throughout the facilities. The reason for the abundance of vehicles is that the vehicles are purchased, and when they have reached their useful life expectancy, they remain in the fleet.

Mr. Campbell asked if they are purchased and not in use, why not get rid of them?
Ms. Weinstein answered that we are going to review the entire fleet and figure out those that are no longer working or available or does it make sense to use based on the number of MVOs drivers they have. I will also be working with Mr. Foley's office to communicate the process with the CEOs and each of the facilities transportation directors.
Mr. Telano continued, and stated that we noted that Central Office Transportation Department (and Correctional Health) utilizes a Global Fleet Management Service (ARI) to manage the preventive maintenance of their fleet. The facilities are not using ARI for vehicle maintenance to reduce the risk of inflated prices for parts and labor. Instead, the facilities are using outside vendors that do not always have contracted prices. In addition, some facilities are using mechanics that are not in close proximity to their sites. For example, Queens and Harlem use repair shops located in Brooklyn. ARI offers an open network with access to over 600 repair vendors within the five boroughs.
One of the reasons they have some many vehicles is because they are old, 260 of them are age from 1989 to 2012. The maintenance expenses are very high due to the age of the cars.
The disposal of the cars is not always done, the policies and procedures are not that strict so that everyone knows what the rules are. For example, at Kings County Hospital, a 2005 Freight RV has been stationed and not utilized since 2012.

The current Automobile Policy (OP 170-2) was established in 1997. It needs to be updated to reflect the operations currently practiced within Central Office Transportation.
The last item for this audit is the oversight of placards, this item was brought to the City Council in the creation of a special investigation unit and they were going to focus on placards as one of their areas of interest. We decided to include it in our audit and we found that there was a difference between the list maintained by Central Office Transportation and what we can physically locate at the sites. Due to the difference, there will be a periodic review and that should take care of itself.
Mr. Telano continued on to the next audit Volunteer Services at Kings County. He asked for the representatives to approach the table. They introduce themselves as follows: Graham Gulian; COO; Anthony Saul, CFO; Nicole Constantine, HR Director; Juan Checo, Hospital Police; Natalie Jacelon-Lewis, Coordinating Manager.

This audit was requested by Ms. Youssouf during the risk assessment for Fiscal Year 2018. During our review of background checks, we found that they were not done on a timely basis as 12 volunteers began working up to 77 days prior to obtaining results from the State Central Register Child Abuse search. Two volunteers have been active since October 2015 to April 2016 without having a background check at all and there was identification missing within the files.
Systems access was not disabled for inactive volunteers. Two of the inactive volunteers logged into the Active Directory after their end date. One of them logged into QuadraMed, this presented a possible breach which I forwarded to Corporate Compliance. They concluded that although a violation occurred, they could not determine if a breach occurred because the computer is located an area where anyone can use it.
Ms. Patsos commented that in that area, certain individuals are permitted to use someone else’s credentials to get information from QuadraMed.
The Behavioral Health Department uses pre-signed black access forms to access the Network and QuadraMed. The volunteers are given the pre-signed form and they can check off any box they want.
The ID cards for 12 volunteers were still active 112 to 646 days after their separation date. One of the ID cards was used to swipe in 2,106 times during the 6 month period after the volunteer’s separation date. Hospital Police determined that the volunteer’s supervisor had retrieved the card and was using it in error to enter over 30 different areas within the facility.
The personnel information of the volunteers was not properly input to the PeopleSoft Human Resources database.
Mr. Saul thanked Mr. Telano for this audit and stated, one of things we noticed that we were not following the same process for employees as we use for volunteers. The process for employees is to notify IT, HR and Hospital Police to deactivate the account. Now we have implemented the same process for the volunteers.
In terms of the register not being on time, it partly an error in finance and the other one was trying to facilitate students that were

coming into the Behavioral Health Program. In terms of finance, we have this program CABE, the majority of those individuals are vendors and they get paid through GHX. We found out that there were some volunteers included there and we did not steer them to the volunteer department to get assessed correctly, we have now corrected it.

In terms of the students coming into the Behavioral Health, because we were notified late in terms of them starting the program, we allowed them to start while we wait for the verification stage. We have implemented the process of no exceptions, that when they come in, they get processed and until the verification is received they do not start.

In terms of reconciliation to the system within PeopleSoft, every individual that has access to the facility needs to be reported. Previously, the volunteer department kept their active register. They were working with HISS to upload the data and all the data was not uploaded correctly and we did not timely reconciled it. Now we reconcile it on a monthly basis, we run the report and correct any discrepancy.

Ms. Villanueva commented that this is not unique to Kings County, I did conduct an audit of all the volunteers about 46 records across the system and we found similar issues. With the volunteers, we are required to do a preliminary criminal background check, which is the simplest form in H + H, it is not the same as the employees. We do not fingerprint them, it is a quick check. The issue we are having in the volunteers department, when it comes to the processing and background checks is that there are things unique like the Child Registry to Behavioral Health that is a requirement. If you are going to have someone like a volunteer in that service that does take some time to get a response.

Dr. Katz asked who is it required by?

Ms. Villanueva answered that it is required by the State, the Office of Mental Health (OMH), if anyone is in that service whether is a student or a volunteer, or an employee, and they must go through certain checks. Some facilities want Child Registry checks on all of their employees, some want it on Pediatrics, some on other services like the emergency room and that is kind of unique to the facilities. This is something we are discussing with them and challenging them with support from the legal department and from Dr. Charles Barron at Elmhurst just to determine if we need to have it done in all of the areas that is currently being required. It is creating an issue of over processing, while reducing H+H exposure to risk, we need to be conscious of over processing of our volunteers and employees.

Dr. Katz added that we want a sensible balance, we want to make sure that people are not going to harm our patients. On the other hand a check is no proof of anything other than what happened before they come into the facilities. I would rather we spend our efforts and money on training and supervising when they are with us. That seems to matter quite a lot more, than to be spending time and money on the past. Of course, we have to uphold whatever is required by law.

Ms. Villanueva stated that I do foresee that there will be standardization across the system. We are working with the CEOs and

the Risk Management department, we want to make sure we are addressing their concerns. But it is very clear that we are over processing. Now that the Volunteer Department is under the Human Resources, we are trying to standardize including the background investigation standards making clear for them as to what they should do and should not do because they need guidance.
Dr. Katz asked if we know what other the facilities require, i.e. NYU, Columbia, what is considered the community standard?
Ms. Villanueva responded that we looked into that and we are quite extensive with what we require.
Mr. Campbell stated that he agrees with Dr. Katz in regards to standardization and he asked what is the timeline? To which Ms. Villanueva answered that they are looking at September.
Mr. Campbell requested that Ms. Villanueva comes back to the committee when the standardization is final.
Mr. Telano stated that that concludes his presentation.
Mr. Campbell directed the meeting to Catherine Patsos for the Corporate Compliance report.
Ms. Patsos started off with monitoring of Excluded Providers – Part of the Federal and State requirements, we have to make sure that we check and screen for excluded providers. During the period of April 1, 2018 and May 31, 2018, we identified one provider who is a Physician Affiliate Group of New York (PAGNY) affiliate physician at Harlem who had limitations placed on his license restricting him from being able to prescribe certain controlled substances and also requiring him to be monitored by a licensed board-certified physician during his period of probation. We have informed PAGNY and are in consult with Legal Affairs and Dr. Wright, Chief Medical Officer at Harlem.
Privacy Incidents and Related Report – Between April 1, 2018 and May 31, 2018, there were 20 privacy complaints, 6 were found to be violations, 5 were not substantiated, 5 were not in violation, 3 are still under investigation and 1 was a request for guidance.
The 3 that were found to be breaches are at Coney Island, Lincoln and Bellevue. In Coney Island, laboratory specimens for 5 patients went missing. They have added new procedures to transport and log specimens to and from the laboratory to better track the movement of specimens so that does not happen again. At Lincoln, one patient was given the incorrect discharge papers, which were returned to Lincoln. At Bellevue, one patient was mistakenly given documentation of another patient, unfortunately we are not able to contact that patient. Notifications were sent out in all cases to the affected individuals.
OCR Inquiries Regarding Potential and/or Determined Privacy Incidents – There was one inquiry from the Office of Civil Rights (OCR) regarding the incident which occurred at Harlem which was reported at the last Audit Committee meeting involving the stolen laptop from the Audiology Department. The OCR requested additional information about the breach, including short-term and long-term remediation efforts and our policies and procedures and other internal controls documentation which were sent on May 29th.
Also, at the last meeting involving the stolen laptop from the Audiology Department, the OCC reported that it would be working with Enterprise Information Technology Systems (EITS) to develop a policy

and procedure for documenting and securing biomedical devices that enter the Systems and connect to the System's network, as well as devices that do not connect to the System's network. The OCC and EITS are currently working on such a policy, and expect to have it completed before the next Audit Committee meeting.

Compliance Reports – For the period April 1, 2018 through May 31, 2018, there were 51 compliance reports, none of which were classified as Priority A, 13 were classified as Priority B and 38 were classified as Priority C reports.

Review and Updating of Compliance Policies and Procedures – We are still working on the Operating Procedures regarding the Federal and State False Claims Acts and Federal and State Laws Related to the Commission of Health Care Fraud. However, I am pleased to inform you that the Emergency Treatment and Active Labor Act has been signed by Dr. Katz and is currently in effect.

Status Update – DSHRIP Compliance Activities –

As reported to the Audit Committee in April 2018, NYC Health + Hospitals/OneCity Health ("OneCity Health"), as a Performing Provider System ("PPS") Lead in the DSRIP Program, is responsible for taking "reasonable steps to ensure that Medicaid funds distributed as part of the DSRIP program are not connected with fraud, waste, and abuse. OneCity Health Partners must certify annually to OneCity Health that they have met their DSRIP compliance training obligations and certain other compliance-related obligations.

OneCity Health Partners were asked to confirm they have completed the compliance training requirements and specify the method by which the training was conducted.

The Attestation requires Partners who confirmed that they completed the SSL certification to include proof of such completion (e.g., a copy of the electronic confirmation receipt that OMIG provides to each Partner upon their SSL § 363-d certification submission) along with their completed Attestation.

The Attestation requires Partners who confirmed that they completed the DRA certification to include proof of the same (e.g., a copy of the electronic confirmation receipt that OMIG provides to each Partner upon their DRA certification submission) along with their completed Attestation.

To date, of the one hundred sixty-eight that were sent out, we received 77.

Audit of OneCity Health DSRIP Program by Outside Auditor - The committee voted in favor of the vendor Bonadio, which has extensive experience in this area. Bonadio has begun its audit of OneCity Health, and has provided a list of documents for OneCity Health to submit for the audit. Last Friday, June 8, 2018, Bonadio conducted a full-day walkthrough of OneCity Health, which covered OneCity Health's internal processes, including Partner selection and contracting, quarterly reporting, funds flow, and the Partner portal. The audit is expected to be completed in October 2018.

With regard to ACO, there is no update.

HHC ACO Application for New York State ACO Certification of Authority – That application is still pending.

Aetna Desk Review Update - On April 16, 2018, the OCC received a draft of Aetna's review of the OCC's document submissions and its conclusions based thereon. According to the draft review, Aetna concluded that NYC Health + Hospitals passed three of the compliance requirements, and failed nine of the requirements. During a conference call with Aetna auditors, however, the OCC presented verification for five of the requirements that Aetna had concluded were failed, prompting Aetna to conclude that NYC Health + Hospitals passed those requirements.

On April 30, 2018, the OCC received Aetna's Notice of Compliance Program Audit (the "Audit Report"), which included Aetna's final conclusions regarding NYC Health + Hospitals' compliance with its audit. According to the Audit Report, NYC Health + Hospitals satisfied eight of the compliance requirements, but failed to satisfy four compliance requirements. The Audit Report also required NYC Health + Hospitals to submit to Aetna corrective action plans for the failed compliance requirements, which the OCC did on May 25, 2018. NYC Health + Hospitals has ninety (90) days to implement these corrective actions plans, most of which involve changes to Operating Procedures.

We are in the process of developing the FY 2018 Risk Assessment. On June 8th, we met with the Executive Compliance Work Group which reviewed the draft compliance assessment, this work is ongoing. As a follow-up we will be meeting with the facilities' compliance committees to address their concerns. The final product will be a final risk assessment that will be used to develop next fiscal year's work plan to address the risk that are identified. Ultimately the risks that are identified will be presented to the Audit Committee for risk tolerance and determination of the final fiscal year work plan.

Ms. Bolus asked if we are going to have the same problem with other insurance companies we bring in.

Ms. Patsos replied that this is the first time we had this review and nothing else has come through.

Mr. Campbell call for a motion to conduct an executive session to discuss matters of quality assurance, patient privacy; and potential litigation.

There being no other business, the meeting was adjourned at 11:34 AM.

Capital Committee Meeting – July 19, 2018
As Reported by Mark Page
Committee Members Present: Mark Page, Josephine Bolus, Emily Youssouf, Gordon Campbell and Mitchell Katz

The meeting was called to order by Mark Page, Committee Chair, at 9:07 A.M.

On motion, the Committee voted to adopt the minutes of the May 10, 2018, Capital Committee meeting.

VICE PRESIDENT'S REPORT

Roslyn Weinstein, Vice President, advised that there were four action items on the agenda; a license agreement for an optical dispensary at Woodhull Medical and Mental Health Center; a license agreement allowing Public Health Solutions to occupy space at various facilities; and, requests for approval to enter into contracts for Electrical and Heating,

Ventilation and Air Conditioning (HVAC) services.
Ms. Weinstein explained that she would be providing a series of updates on construction projects at upcoming Capital Committee meetings, under the following categories; 1) Regulatory and Infrastructure; 2) Energy Program; 3) Federal Emergency Management Administration; and, 4) Capital Restructuring Financing Program (CRFP). She said she would begin with the CRFP update, to be provided at the days meeting.
Ms. Weinstein explained that New York State provided capital dollars, through the Capital Restructuring Financing Program (CRFP), as a means of support to meet the goals of the Delivery System Reform Incentive Payment Program (DSRIP). An effort with the goal of decreasing emergency visits in favor of primary care visits. In 2016 Health + Hospitals awarded capital grants totaling $273.9 million for various projects; $19.5 million for ED Reconfiguration for Improved Access and Coordination; $44.6 million for Integration of Behavioral Health and Primary Care Services; $109 million for Digital Healthcare Network; $19.5 for OneCity Health Patient Engagement and Contact Center; and, $81.3 million towards Population Health Information Technology needs.
Gordon Campbell, Vice Chair/Acting Chairman, asked if the call center would be the same as the one being developed at present, or if this would be a new call center. Ms. Weinstein said it would be the same call center but more robust. There would only be one call center, with one phone number.
Ms. Youssouf asked if all the awards in 2016 were now in process. Ms. Weinstein said yes, the first year or two was spent getting necessary approvals by filing Certificates of Need (CON), and answering related contingency questions.
Ms. Weinstein summarized progress at Gotham Health, related to integration of behavioral health and primary care. She explained that each site had a different plan, based on their unique needs at the site.
Mr. Page asked for a description of the integration. Ms. Weinstein said that behavioral health services were often separate from other services and so if a patient required behavioral health as well as regular medical services they would need to visit multiple locations. The integration is expected to incorporate those services into the same area and should allow for providers to enhance patient care and for patients to navigate more easily.
At East New York they are using an existing, vacant, outdoor space, to add necessary square footage for the expansion, and to hold group visits.
Mr. Page asked what a “group visit” was. Ms. Weinstein explained that some sites were offering group visits, where several patients seeing the same counselor could have a group session, which would allow for more patients to be seen at a time.
Ms. Youssouf asked if all sites were experiencing high utilization, to ensure that dollars were not being invested in sites that are not successful. Ms. Weinstein said yes.
Mr. Page asked if work had begun at any of the sites. Ms. Weinstein said no, to date, all the preliminary paperwork was filed and designs were being finalized. She noted that the CON process could take six to nine months.
Ms. Youssouf asked if a Construction Manager would be engaged to oversee these projects. Ms. Weinstein said yes, there are dollars in the budget

for construction management. The next step will be to bid projects, with the hopes that construction will begin by December 2018.
Ms. Youssouf asked if projects would be formally bid or if we would be using our contracted consultant and construction firms. Ms. Weinstein said yes, we will be using our contract vendors, as long as they are also on the State list. She noted that was not a difficult process. Were one of our vendors not on the State list that should be a relatively easy process, and had not been an issue as of yet.
Mrs. Bolus asked if there were a deadline for completion. Brenda Schutlz, Senior Assistant Vice President, Finance, said the program required completion by March 2021.
Ms. Weinstein explained that the site at Kings County, being built in an in-fill space, was the most complicated and the one she would be keeping a close watch on with regards to time and budget.
Mr. Page asked what a phone consultation would be like and how one would arrange one. Ms. Weinstein said a patient would call the general call center number and be routed to an appropriate provider. Mr. Katz noted that an individual could call 311 and be directed to mental health services or a provider.
Mr. Page asked about home health services, noted as part of a project for Queens Hospital. Ms. Weinstein said it would be an enhancement for nurses that make home visits. It would be for patients that already have a relationship with their providers.
Ms. Weinstein explained that in addition to the integrations, reconfiguration of emergency services was being done at certain sites. This was planned to decrease emergency visits and shift some of those towards primary care. Express visits would also be available at some sites. Those visits would be similar to ambulatory care, and would be initiated by a hospital employee (likely at the time of triage) and would help shift patients towards the correct services and providers, and away emergency services when not necessary.
Ms. Youssouf asked about Coney Island, since there was a new building being constructed on their campus. Ms. Weinstein explained that the State understood that a new site was being built and approved that their dollars be invested in an infusion center. It was determined that was likely to help meet efforts to decrease emergency visits.
Ms. Weinstein stated that at present, CON applications hac been submitted and reviewed by the State, and contingency questions had been answered and approved. Facilities were now submitting proposals for construction. Monthly meetings would be held, with finance, to assure budgets were being met, and monthly meetings between the Office of Facilities Development (OFD) and project/construction managers would also be scheduled.
Ms. Youssouf asked if contingencies were built into the budgets. Ms. Weinstein said yes but bids are coming in a little higher than expected so projects definitely require monitoring.
Ms. Youssouf asked if there were any projects that could be eliminated in order to use that money elsewhere. Mr. Katz, President, explained that each project was funded individually, so if one was cancelled then those dollars would be lost and not shifted to another project.
Ms. Weinstein thanked Tracey Bowes for her leadership in these efforts, and advised that her next report would be on FEMA projects.
Ms. Weinstein added that there was ongoing follow-up regarding Mr. Page’s

concerns about an excess of generator power. There are efforts to eliminate the use of fuel and those are being considered at each site as projects are initiated. Louis Iglhaut, Assistant Vice President, Facilities Development, noted that it was a big change but they were working on it. That concluded her report.

ACTION ITEMS

- **Authorizing the New York City Health and Hospitals Corporation (the "System") to execute a five year revocable license agreement with Eyes and Optics (the "Licensee") for its use and occupancy of 308 square feet of space to operate an optical dispensary at Woodhull Medical & Mental Health Center (the "Facility") at an occupancy fee of $16,940 per year or $55 per square foot to be escalated by 3% per year for a five year total of $89,937.**

Lisa Scott-McKenzie, Deputy Executive Director, NYC Health + Hospital / Woodhull, read the resolution into the record on behalf of Gregory Calliste, Executive Director, NYC Health + Hospital / Woodhull.
Mr. Page noted that this enterprise had similar agreements in place at other Health + Hospitals facilities, and those terms were to be repeated in this agreement. He asked if there was a plan for comprehensive services of this type or if they would continue to be incremental, one agreement at a time. Mr. Berman explained that there was one more facility that had expressed an interest in the services and if an agreement was made for that location then it was possible that the multiple agreements would be consolidated into one agreement. Mr. Berman added that rates varied at the different sites because occupancy fees were based on fair market value analysis, but the essence of the arrangement(s) would be the same.
There being no further questions or comments, the Committee Chair offered the matter for a Committee vote.
On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

- **Authorizing the New York City Health and Hospitals Corporation (the "System") to execute a revocable license agreement with Public Health Solutions ("PHS") to allow PHS to maintain tables in lobby areas at NYC Health + Hospitals/Kings ("KCHC"), NYC Health + Hospitals/Jacobi ("Jacobi"), NYC Health + Hospitals/Lincoln ("Lincoln") and NYC Health + Hospitals/Elmhurst ("Elmhurst") to encourage eligible patients to enroll for the Supplemental Food and Nutrition Program ("SNAP") benefits, to assist them in enrolling in SNAP and provide counseling about, and referrals to, other programs available to address food insecurity for a period of three years with the occupancy fee waived.**

Marian Krauskopf, Senior Director, Population Health Solutions, read the resolution into the record.
Mr. Page asked if there were a more all-encompassing way of communicating this information to our patients. Josephine Bolus explained that historically the facilities would provide food directly to patients, and then there were farmers markets introduced, and neither of those ways had met the needs of the community. She said that she felt that this new option was a good one.
Mr. Page asked if there would be notice, when Public Health Solutions was

not on site, for the information to still be available. Ms. Krauskopf said yes, and this is just one piece of the puzzle. The Human Resources Administration (HRA) has an aggressive enrolling initiative with community based initiatives and within its own agency, and Health + Hospitals care managers and social workers also routinely refer patients to SNAP. The advantage of this effort was determined in studies that showed, patients referred to enrollment centers off-site were not nearly as likely to get registered as those that had the ability to register on site at the facility. Therefore, being located right in the facility would likely lead to greater enrollment.

Emily Youssouf, asked if materials would be available when the staff was not on site. Ms. Krauskopf explained that each location would have a specific flier and those fliers would be provided to areas within the facility that are identified as the most common to make referrals for SNAP services, so they are working with pediatric and adult ambulatory care, Women Infant and Children (WIC) programs, and financial counselors, because they asses eligibility. She said they were working closely with the entire facility, and planned to have fliers available in all the noted locations, adding that the possibility of increasing the SNAP presence to five days a week, from two and a half days a week, would increase likelihood that PHS staff would be available and on site when needed.

Gordon Campbell asked if there were a way to consolidate all the supportive services/resources into one area. Ms. Krauskopf said it had been discussed and will continue to be discussed but nothing had been determined yet.

Mr. Berman noted that training was being provided to financial counselors so that they were more informed and confident in referring for enrollment. Ms. Krauskopf added that HRA was operating a system online that trains organizations and individuals on enrollment.

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

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

- **Authorizing the New York City Health and Hospitals Corporation (the "System") to execute Job Order Contracts (JOC) with two (2) firms; Jemco Electrical Contractors, Inc.; and, Mac Fhionnghaile & Sons Electrical Contractors, Inc.; (the Contractors"), that were pre-qualified through the System's public bid process, to provide construction services on an as-needed basis at various facilities throughout the System. Each individual contract shall be for a term of two (2) years, for an amount not to exceed $6,000,000. The total authorized value of these contracts is $12 Million.**

Leithland Rickie Tulloch, Senior Director, Office of Facilities Development, read the resolution into the record.

Mr. Tulloch explained that these contracts were to provide electrical services.

Mr. Page asked how the two firms were selected. Mr. Tulloch said, through the bid process. The Office of Facilities Development (OFD) partnered with eGordian to come up with factors and criteria to select, and followed operating procedures including the Manual for the Acquisition of Contractors and Maintenance Services. We followed Corporation guidelines, he said.

There being no further questions or comments, the Committee Chair offered the matter for a Committee vote.
On motion by the Chair, the Committee approved the resolution for the full Board's consideration.

- **Authorizing the New York City Health and Hospitals Corporation (the "System") to execute Job Order Contracts (JOC) with two (2) firms: AWL Industries, Inc.; and, Volmar Construction, Inc., (the Contractors"), that were pre-qualified through the System's public bid process, to provide construction services on an as-needed basis at various facilities throughout the System. Each individual contract shall be for a term of two (2) years, for an amount not to exceed $6,000,000. The total authorized value of these contracts is $12 Million.**

Leithland Rickie Tulloch, Senior Director, Office of Facilities Development, read the resolution into the record.
Mr. Page asked if this contract was for installation or repair of HVAC equipment. Mr. Iglhaut said the contracts could be used for both.
Mrs. Bolus asked if the contracts were heavily used in prior years. Ms. Weinstein 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 amended resolution for the full Board's consideration.
There being no further business, the meeting was adjourned at 9:47 A.M.

Finance Committee Meeting – July 19, 2018
As Reported by Bernard Rosen
Committee Members Present: Bernard Rosen, Gordon Campbell, Dr. Mitchell Katz, Josephine Bolus, Mark Page, Emily Youssouf

Mr. Bernard Rosen called the meeting to order at 10:01 am. The minutes of the May 22, 2018 meeting were approved as submitted.

SENIOR VICE PRESIDENT'S REPORT

Mr. Ulberg began his report noting that at the end of June, the cash balance was about $725 million which includes a City payment of $200 million and supplemental payments of $300 million. Mr. Ulberg noted that he, Linda DeHart, and other Finance staff have Friday calls with the State and OMB about streamlining the flow of funds. Mr. Gordon Campbell asked about the monies owed to the City, in terms of the amounts and for what years. Mr. Fred Covino noted that, in prior years, with the delay in receipt of supplemental payments, there were delays in City payments. There is approximately $290 million for FY15 due to the City, there are also some outstanding health insurance payments for prior years. Mr. Campbell asked if there were no outstanding payments for FY 16 through FY 18, and Mr. Covino confirmed none other than the health insurance payments. Ms. Josephine Bolus asked if there were any impacts from the

settlement for nurses reported in the news last night. Mr. Covino noted that the physically taxing settlement will be paid by the City as it is related to collective bargaining. Ms. Bolus asked if there was an amount available, and Mr. Covino noted that follow-up would occur to determine that number. Utilization trends have not changed and continue to show declines, and headcount is holding steady at about 44,450 full time employees (FTEs). Ms. Emily Youssouf asked if the headcount figure included part-time employees and consultants. Mr. Covino noted that it includes part-time staff, temp staff, and IT consultants, but not consultants like those who are working on the year-end audit. Mr. Campbell asked if there was still a vacancy control board process in place, and Mr. Covino confirmed there was, with physicians, nursing, and nursing support positions being automatically approved. Mr. Campbell noted that at the Board meeting next week that there would be an update on nurse staffing.

Mr. Ulberg continued his reporting on looking at next year and finalizing budgets with the facilities. He noted that the execution of the budget is critical, with a disciplined implementation of approved business plans. A work plan process is being implemented that requires details on operationalization to achieve the $1.6 billion gap closing plan. Mr. Ulberg reported that Health + Hospitals is participating, through Dr. Katz, in the State's indigent care workgroup. The workgroup was initiated by the Governor's Office and the Legislature, with the first meeting focused on defining the scope of work, and there are three more meetings expected to take place in the fall. Ms. Youssouf asked about the participation in the workgroup, and whether each hospital system was included. Mr. Ulberg confirmed that hospital systems, advocacy groups, health plans, hospital associations, and the State Department of Health were included. Ms. Youssouf asked if the DSH funds would be distributed more favorably to hospitals that are public. Dr. Katz noted that he stated at the workgroup that disproportionate meant systems that treated a disproportionate share of Medicaid and uninsured patients; in California, disproportionate meant disproportionate. Dr. Katz continued that the State is concerned that any system is seen as losing something. In California, a hospital may go to the governor and state that they are closing, and the governor may not see that as an issue; in New York, there is a different consideration, particularly for a list of distressed hospitals that may not be serving a disproportionate share of Medicaid and uninsured patients. At the workgroup, Dr. Katz raised the issue of a hospital that may be in financial trouble, but not due to treating uninsured and Medicaid patients, but because it is not run well. The purpose of disproportionate hospital payments should be for those systems that are serving a disproportionate number of uninsured and Medicaid patients. Mr. Mark Page asked about the proportionate funds Health + Hospitals receives, what was the structural connection of the workgroup to what Health + Hospitals will receive. Dr. Katz noted that he raised this issue at the workgroup in terms of what success would look like in terms of outcomes, and that the State responded that they were not prepared to

answer the question and that more information will come later. Dr. Katz asked the State if this was a consensus process, a voting process, what the rules of engagement for the workgroup were; Mr. Katz noted that the State did not provide an answer at the meeting. Mr. Page noted that these types of forums can steer off into the wilderness without concrete outcomes. Mr. Ulberg noted that one strategy could be to memorialize the recommendations and draft legislation for adoption. With no further questions, the report was concluded.

KEY INDICATORS REPORT

Ms. Krista Olson began the utilization report reporting through May 2018. Starting with acute care hospitals, ambulatory care visits are down by 1.1% against last year, compared to 1.5% from the May meeting. Utilization is trending up against earlier in the fiscal year. Dr. Katz noted the impact of adding doctors in ambulatory care in hospitals and Gotham clinics. Ms. Youssouf asked about Woodhull decreases, and Ms. Olson noted that the number of vacancies had an impact. Dr. Katz noted that a physician was hired as the new ambulatory care director; she is a Bellevue trainee who currently works at Gouverneur. Acute Inpatient discharges are down by 2.8% with the largest decline at Metropolitan. However, Metropolitan has seen a large increase in observation stays which are counted as outpatient that offsets a significant portion of the decline from a workload perspective. Mr. Campbell requested clarification on where acute and ambulatory visits were captured, and Ms. Olson noted that visits included emergency department and ambulatory care, and inpatient numbers were captured in discharges. Mr. Campbell requested headers in the report moving forward.

Ms. Olson continued her report on the average length of stay which is a half-day greater at Health + Hospitals overall, compared to the city-wide average, when adjusting for case mix. Mr. Rosen asked if the expected average length of stay was adjusted. Ms. Olson noted that the average length of stay was calculated by dividing the number of days by discharges, and excludes psych and rehab. The reasons for the higher length of stay are likely a combination of differences, in the patients served, documentation and coding differences, and discharge planning processes. Ms. Bolus asked about the clients who were staying in the system and not being discharged and how they were affecting the length of stay numbers. Ms. Olson noted that the metric only counted patients who were discharged. If there are patients who were discharged and who had a long length of stay, it is generally noted as a driver in a report. Mr. Campbell asked if there were “expected” targets for visits and discharges like there is for average length of stay. Ms. Olson noted that the Strategic Planning Committee did have different metrics around targets. Dr. Katz noted that when Health + Hospitals implements cost accounting, that there may be more available data that facilitates capturing that. He added that the case mix index (CMI) is not reflective of the Health + Hospitals population, as the CMI suggests the system is serving a healthy population. Coding is an example of a driver of how data looks, such as mortality rates and how much Health + Hospitals gets

paid. For example, a patient may have pneumonia, but it is pneumonia with other conditions, and the other conditions and severity may not be captured. Ms. Youssouf asked if this was being addressed. Dr. Katz confirmed it was, and the system is not currently coding how sick patients are. There is a new Coder Academy being implemented, available to approximately 160 coders. As agreed to with the unions, staff will be training on their own time, but Health + Hospitals is paying for the training. Approximately 120 staff signed up for it, and about 97 attended the kick-off event. It is on-line CUNY learning targeted for working staff. If a certificate is earned, better pay may be an outcome. Mr. Rosen noted that the average length of stay did not look terrible, and Dr. Katz agreed, and that as more observation is used, that will push up the average length of stay, and noted that the industry wide average was closer to four. Mr. Rosen noted that his Finance Committee predecessor claimed that the length of stay was huge. Mr. Covino noted that the metric had been calculated differently in prior years. Mr. Page also noted that the length of stay has been decreasing across the industry.

Ms. Youssouf asked if visits should have been increasing as discharges are decreasing, and Ms. Olson noted that the due to the relative small number of discharges when compared to the volume of visits, that it may not be fully visible in that metric. Dr. Katz noted that discharge volume has a bigger effect on length of stay compared to number of outpatient visits. Ms. Olson continued her reporting with the case mix index increasing by 3.4%, and Mr. Covino noted that was an increase of 12% over prior years. Diagnostic and Treatment Center visits continue to decline, down by 5.4% compared to this time last year. Dr. Katz noted that the numbers are reflective of the number of providers. For example, East New York has 1.5 providers versus 4.5 providers, and Dr. Ted Long’s hiring will make a difference. Long-term care days are down by 2.3% compared with last year, primarily at Coler and Henry J. Carter. For Carter, the decline is in LTAC services. Gouverneur Skilled Nursing Facility days increased by 10.1%. With no further questions, the report was concluded.

CASHRECEIPTS & DISBURSEMENTS REPORT

Ms. Michline Farag began her reporting on global full-time equivalents (GFTEs). For Global FTEs, Health + Hospitals is down 1,040 GFTEs since the start of FY18 through May. Mr. Campbell asked about the changes in headcount numbers in facilities compared to those noted in Central Office, and Mr. Covino noted that with the centralization and shared services initiatives such as accounts payable and payroll functions, that there are a shift in numbers as to where staff are allocated.

For FY18 through May budget numbers, receipts came in $113.3 million better than budgeted, and disbursements are $28.7 million better than projected. Ms. Youssouf asked if better meant that the system was spending less, and Ms. Farag confirmed that it was. Ms. Farag continued her report discussing the comparison of FY18 actuals to FY17 actuals through May. For direct patient care receipts, Health + Hospitals is

doing better through May compared to last fiscal year. Inpatient receipts are up $118.2 million, and outpatient receipts are $49.2 million higher. Overall receipts in FY18 through May are $28 million higher than last year. This is due to increased patient care revenue and Disproportionate Share Hospital/Upper Payment Limit (DSH/UPL) payment which is $122 million higher than last fiscal year, offset by the Value Based Payment/Quality Improvement Program (VBP/QIP) payment in FY17 in the Grants line. There will be a VBP/QIP FY18 payment in FY19.

In terms of total cash disbursements, Health + Hospitals is $340.8 million higher than last fiscal year partly due to a payment made to the City in the first quarter of FY18 for FY17 obligations as well as $331.7 million higher in fringe retiree health and pension payments made in FY18. This was offset by PS underspending of $162.7 million. Mr. Rosen asked if there was an additional pension payment, and Mr. Covino answered that Health + Hospitals caught up on payments this year compared to this time last year. Ms. Farag continued her report for FY18 through May actual receipts and disbursements against budget. Receipts are $113 million better than budgeted, the majority of which is in patient care receipts - $83.7 million better in patient care receipts. For cash disbursements, Health + Hospitals is $28.7 million less than budgeted due to PS and associated fringe. With no further questions, the report was concluded.

CANTEEN RESOLUTION

Mr. Paul Albertson presented a resolution to authorize the New York City Health and Hospitals Corporation (the “System”) to execute an agreement with Compass Group USA doing business as Canteen (“Canteen”) to provide vending services for the System’s acute care, post-acute care and corporate facilities with an initial term of five years and two five-year options to renew solely exercisable by the System. Canteen will pay the System a signing bonus of $250,000 and a commission of 30.8% on annual sales up to $3,999,999 and commission of 40% on annual sales in excess of $4,000,000. Mr. Albertson provided an overview of the current vending arrangement within Health + Hospitals. There are 485 snack and beverage vending machines throughout facilities, stocked with items that meet the NYC Healthy Food and Beverage Standards. The current vending arrangement was implemented in 2005, and is constrained by several issues, including the commission structure. The machines only accept cash. There is not a wide variety of items. The machines do not have Health + Hospitals branding, and do not have the capacity for online reporting for sales, maintenance, and other issues. Vending services went through a Request for Proposal (RFP) process, including posting in the City Record and disseminated to thirty-two known vending companies of which nine were certified as Minority and Women-Owned Business Enterprises (MWBE). A pre-proposers conference was held, and site visits were conducted at six facilities.

Five proposals were received, and three vendors were invited to present to the selection committee. The financial impact of the proposals varied from net revenue of $1 million to $3.4 million. Canteen scored the

highest for proposal and presentation, and is the sole vendor to meet our MWBE goals through the Gilly subcontractor. Canteen's proposal is highlighted by its financial proposal, exceptional references including CUNY and NYU, and the service level agreements for preventative maintenance and on-call service. The evaluation committee had broad representation, chaired by Mercedes Redwood who is a registered dietician. Committee members were included from Finance and facilities. Canteen was the highest rated proposer following vendor presentations and a second round scoring. An application to enter contract was presented and approved by the Contract Review Committee at its June 2018 meeting.

Approval is being sought to enter into contract with Canteen for the Health + Hospitals vending machine program. The contract would be five years with two five-year renewal options. It includes installation of all new NYC Health + Hospitals branded vending machines, stocked with items in compliance with NYC Healthy Food and Beverage Standards. The vendor would work with facilities to optimize machine locations. The vending machines will include integrated technology for transparency, reporting, and auditing. The arrangement includes a $250,000 signing bonus for Health + Hospitals with a 30.8% commission on annual sales up to $3,999,999 and 40% over $4 million. The total projected revenue for the first five years and the two renewal periods are estimated at approximately $11.4 million. Ms. Youssouf asked about the estimates, if the prior vendor lacked the capacity for robust accounting in terms of the volume of products sold. Mr. Albertson noted that the projections were modeled on prior vendor dollars, as well as walk-through assessments and projections of foot traffic. Ms. Bolus asked if Health + Hospitals would do its own assessment of the machines, and Mr. Albertson confirmed there was a review. Mr. Campbell asked if the revenue projections were Health + Hospitals; and if the other proposing vendors had less or more projected revenue. 10.47 Mr. Albertson noted that these were Health + Hospital projections, based on projected volume and the commission structure, and that the other vendors had less projected revenue. Mr. Campbell asked if there would be additional machines throughout the facilities, and Mr. Albertson answered that the number would be determined with facility staff. Mr. Rosen asked who owns the actual machines, and Mr. Albertson confirmed the vendor did. Mr. Page asked if the current vendor bid, and Mr. Albertson confirmed the vendor had. Mr. Page asked about if the service was not optimal, if the renewal term had to be pursued, and Mr. Albertson confirmed that the renewal did not have to be implemented. Ms. Bolus noted that it would be an incentive for healthier choices to have water be the least expensive drink available, and to work with nutritionists to ensure that healthier snacks were the least expensive option. Mr. Albertson noted that Ms. Redwood is a registered dietitian and lead the selection committee, and that all the snacks and beverages in the machines would meet the NYC Healthy Food and Beverage Standards. Ms. Youssouf requested an update after a year of implementation on revenue projections from the machines.

The resolution was brought for motion, seconded, and the motion carried.

ACCUITY RESOLUTION

Mr. Bob Melican presented a resolution to authorize the New York City Health and Hospitals Corporation (the "System") to execute an agreement with Accuity Delivery Systems ("Accuity") to provide medical coding optimization services for the System's acute care facilities over a term of approximately two years to expire with the conclusion of FY 2020 with total amount not to exceed $25,364,000. Mr. Melican provided an overview of the coding work within Health + Hospitals. The coding and documentation work is in transition throughout the system. There are three key initiatives currently in place. Epic implementation throughout the system and 3M computer assisted coding are changing the process of capturing codes. The Huron engagement is providing ongoing physician education to improve the quality of clinical documentation. A Coder Academy is starting August 6, focused on improving coder skills. The Accuity contract will be a short-term bridge for a unified Health + Hospitals coding and documentation environment. Health + Hospitals will achieve self-sufficiency from Accuity by June 2020.

A RFP for Coding Optimization services was issued in April 2017 with four proposals received. Accuity was selected in June 2017 as part of the corporate-wide transformation initiative process. Accuity's model of cases reviews by a physician coder and a Clinical Documentation Improvement Specialist (CDIS) was key to the selection. A pilot began in September 2017 at Queens and Elmhurst, with an expansion in March 2018 to Bellevue, Lincoln, and Jacobi. The pilot phase for the five facilities will end August 2018. There is a projected cost of $5 million, and a projected net revenue of $15 million. The request is to roll-out this work to the remaining six acute facilities in September 2018 with a projected 8,505 cases per month at full operation with FY19 and FY20 projections of $75 million in net revenue.

Accuity's model includes a team comprised of a physician, coder, and CDIS who review Health + Hospital's coding and documentation in the EMR before final billing. Accuity is only reviewing cases with a revenue opportunity. Ms. Youssouf asked who is deciding which cases. Mr. Melican noted that the excluded cases are those with low opportunity due to reimbursement methodology such as psychiatry, rehab, and simple newborn cases, as well as severity of illness of four as those are already at the highest level. Mr. Melican noted that MetroPlus cases were under consideration for inclusion, and Committee members concurred that was a great idea. The Accuity work focused on a coding change or a query change, such as diabetes. Accuity sends a note to the physician inquiring if diabetes was present throughout the case, and askes the attending physician to review the case and document accordingly if diabetes was present so that Accuity could document diabetes as a secondary condition. Ms. Bolus asked how long a review took. Mr. Melican noted that coding changes happen within 24 hours, and documentation changes with the query option allow attending physicians up to ten days to respond back. Dr. Katz shared a story that a doctor flagged for him

after a town hall meeting. The doctor had been with Health + Hospitals for twelve years, and came from a private hospital. At that private hospital, the doctor had weekly sit downs about coding improvements and coding charts. The doctor noted that, in the twelve years, no one at Health + Hospitals had done this with her. Dr. Katz noted that multiple strategies around coding should be pursued. Mr. Campbell noted that there are teachable moments throughout the work, and what would the feedback loop be. Mr. Melican noted that the Accuity work includes meeting with each facility Chief Medical Officer and department heads, and that two months after the launch of the work, Accuity comes back to meet with leads about observations and lessons learned. Dr. Katz noted that Epic implementation will facilitate better coding as well because it's easier in that environment than in Quadramed as it takes time to populate each diagnosis Mr. Ulberg noted that as he has been doing his site visits, he has observed that revenue cycle work is a team sport, and the Accuity model supports that approach. Ms. Youssouf asked where Accuity had worked before. Mr. Melican noted that the vendor has worked with Montefiore, Mt. Sinai, and New York Presbyterian. Ms. Youssouf noted that as a public corporation, Health + Hospitals sometimes gets assigned a C or D team from vendors, and requested that the project have an A-team from Accuity assigned. Mr. Page noted that this initiative was important and a cost-effective measure. He asked if there was a need for incremental staff resources, what will this work mean for a doctor, in terms of what incremental time the doctor will need to focus on this work. Dr. Katz agreed, and noted that the doctor time issue has not been fully figured out; hiring doctors is being pursued. Mr. Rosen asked if the current coding system would stay in place, and that the Accuity team supplements that work. Mr. Melican confirmed the time frame was 24 hours for coding changes, and up to ten days for query changes. Mr. Page asked if the doctor will still need to look at records. Dr. Katz noted that the work will be real time efforts. Mr. Campbell noted that there may be a series of pilots to look at efficiencies and to identify different initiatives to implement. Dr. Katz confirmed there would be a variety of efforts. Ms. Youssouf asked if there was an overlap with Huron work. Mr. Melican relayed that the coding and documentation work was a three-pronged approach – the Huron CDI work, the Epic and 3M software work, and the Accuity work. Dr. Katz raised the analogy of a toolbox with different tools – the coding and documentation work was being addressed through different initiatives. Ms. Youssouf asked about how the work would be judged for effectiveness. Mr. Covino noted that results would be monitored against projections. Mr. Rosen asked where the firm was located, and Mr. Melican noted New York City. Mr. Campbell requested more information about achieving self-sufficiency by 2020, and Mr. Melican answered that a work pan could be shared. The resolution was brought for motion, seconded, and the motion carried.

ADJOURNMENT

There being no further business to discuss, Mr. Rosen adjourned the meeting at 11:09 am.

Information Technology Committee Meeting – July 19, 2018
As Reported by Emily Youssouf
Committee members present: Emily Youssouf, Josephine Bolus, Gordon Campbell, Dr. Mitchell Katz

Emily Youssouf called the meeting to order at 11:15 AM. The minutes of the April 12, 2018 meeting were adopted.

CHIEF INFORMATION OFFICER REPORT
David Starr thanked the Committee for allowing him to be there. He said Kevin Lynch could not be at the meeting due to a family reunion. He and others would give the CIO Report on his behalf.

EMR GO Program Update
Mr. Starr reported that the GO team continues its work to get the Epic system into all facilities. The next go-lives are scheduled for 92 days from now in October 2018. It includes Clinical and Revenue Cycle Epic applications at Woodhull/Cumberland and the retrofit of Revenue Cycle at Queens, Elmhurst, and Coney Island. The latter sites are already live with Epic Clinical applications.

Enterprise Radiology Integration Update
Dr. Alfred Garofalo said the system is live at Coney Island and Woodhull. He said it is on track for go-live at Metropolitan in July, and Kings County in August. The remaining sites including Lincoln, Harlem, Bellevue, North Central Bronx, Jacobi, Queens and Elmhurst are scheduled for fall and winter of 2018/19.

Enterprise Resource Planning (Project *Evolve*) Update
Janet Karageozian said Waves 1-5 of PeopleSoft Finance and Supply Chain are now live across NYC Health + Hospitals. We worked with Finance and Supply Chain to do this. She said Cost Accounting is on track for go-live in September 2018. This will conclude Phase 1 of Finance and Supply Chain deployment. We are now in Phase 2 which includes PeopleSoft Payroll/Time & Labor/Absence Management/Electronic Time Capture. Payroll go-Live is on track for January 2019 and Time and Labor/Absence Management is on track for May 2019. She said the program is on time and on budget.

ACTION ITEM 1:

RESOLUTION ON INFRASTRUCTURE UPGRADE SPENDING AUTHORITY

Jeff Lutz read the resolution:

Authorizing the New York City Health and Hospitals Corporation (the "System") to enter into a contract with G-Systems for cabling services as a component of the Network and Unified Communication Infrastructure Upgrade project at NYC Health + Hospitals/Bellevue, NYC Health + Hospitals/Kings County, NYC Health + Hospitals/Woodhull and NYC Health + Hospitals/Harlem (the "Four Hospitals") in the amount of $24.2 million, of which $21.8M is funded through the City's Capital Budget and $2.4M is funded through the System's operating budget which sum includes a 10% contingency.

Mr. Lutz spoke to the presentation Enterprise Information Technology Services Network Refresh Cabling; Application to Award Contract. He addressed the Network Refresh Project and The Request to Award Contract to G-Systems to provide cabling services. He spoke to G-Systems' Vendor Experience & Services. He concluded with the Procurement Process, which included the Solicitation, Evaluation, and Selection of G-Systems.

In answer to questions, Mr. Lutz said this money ($26.5 million) is part of the $32 million previously approved by the board. He said G-Systems has an excellent reputation and has done a lot of wiring work across NYC Health + Hospitals. They are very professional and work with our staff to minimize disruptions.

Mr. Starr added that every computer and device is tested to make sure it works and interfaces with Epic.

The resolution was adopted.

There being no further business, the meeting was adjourned at 11:50 AM.

Strategic Planning Committee – July 19, 2018
As Reported by Gordon Campbell
Committee members present: Robert Nolan, Josephine Bolus, Gordon Campbell, Dr. Mitchell Katz

Gordon Campbell called the meeting to order at 12:05 PM. The minutes of the April 12, 2018 meeting were adopted.

LEGISLATIVE UPDATE

Mr. Campbell informed the Committee that going forward the Strategic Planning Committee meeting will include a Legislative Update and invited Mr. Siegler to present the update.
Mr. Siegler greeted and informed the Committee that he would provide city and state updates as well as updates on some ongoing federal issues.

Local Update

Mr. Siegler reported that, in the FY19 Adopted Budget, H+H facilities received over $14 million in capital funds from the City Council and Borough Presidents to purchase new equipment, upgrade existing ones, and renovate patient care areas. In addition, Mr. Siegler reported that, as part of H+H's strategic effort, that H+H had received $435,000 in expense funding from the City Council to support immigrant health initiatives, including $300,000 for the New York Legal Assistance Group (NYLAG), which provides legal assistance to our immigrant patients. Lastly, Mr. Siegler reported that H+H participated in City Council Hearings on FY19 Budget on May 24th; Behavioral Health on June 20th and migrant children separated from their families on July 14th.

State

Mr. Siegler reported that they were 641 bills passed at the end of the session with 125 of them going to the Governor's desk. Mr. Siegler reported that the major state update is that the New York State Indigent

Care Workgroup, which was required by a side letter agreement between the Executive and the Legislature in the enacted State Fiscal Year (SFY) 2018 budget convened on July 11, 2018. Dr. Katz is a member of the workgroup.

Federal

Mr. Siegler reported that the days of direct legislative efforts to repeal the Affordable Care Act (ACA) and the Medicaid expansion appear to be behind us for the moment. He added that federal efforts to undermine or directly sabotage enrollment through the marketplaces are ongoing.

Mr. Siegler reported that the Government Continuing Resolution expires at the end of September. H+H will monitor potential Opioid legislation and discussions around 340B policy changes.

Lastly, Mr. Siegler discussed H+H's response to the Trump Administration zero tolerance immigration policy which has resulted in hundreds of children separated from their families and brought to New York City. Mr. Siegler reported that in a matter of days H+H developed clinical pathways to help address these children's health needs. Mr. Campbell recommended that Matt report on the aforementioned H+H's contribution to the City response to the Trump Administration family separation policy at the upcoming Board meeting next week.

INFORMATION ITEM

Update and System Dashboard

Dr. Eric Wei, Chief Quality Officer, greeted members of the Committee. He reported that a strategic initiatives diagram for communication, alignment, and cascading of dashboards was created and is represented by a pyramid centered around Patient, Family & Community (see attached).

Cascading of Dashboards

Dr. Wei reported on the different types of dashboards:

- System dashboard accompanies the diagram-system level metrics.
- Facility dashboard: facilities identify 3-5 metrics within each pillar that will be the facility dashboard
- Unit level dashboard
- Provider level dashboard

Next Steps

Dr. Wei announced the System Dashboard's next steps. They are:

- Communication/rollout plan
- Supporting documentation
- Harmonization of high level dashboards and metrics

Updated System Dashboard – FY 2018, July

Mr. Siegler reported on the first goal, which is to increase primary care visits. He explained that the goal is to stabilize and reduce the decrease in visits and build back from there. Theodore Long, Vice President, Office of the President, had already recruited 22 new clinicians on board and aims to recruit another 55 this year. Mr. Siegler noted that the Vanderbilt clinic in Staten Island is opened and is expected to see as many as 40,000 visits a year.

Mr. Siegler reported on the progress of E-consults completed during this quarter. He stated that there were approximately 9,700 e-consults, an increase of 1,225 from the last period.

As for the financial sustainability metrics, which include patient Care Revenue/ Expenses, the number of insurance applications submitted per month, the percentage of MetroPlus medical spend at H+H and the total AR days per month (excluding in-house). Mr. Siegler informed the Committee that modest improvements were made on patient care revenue/expenses, as well as for the number of insurance applications submitted per month. The percentage of MetroPlus medical spend at H+H is at 39% for Q1 of 2018 from 37% last quarter and 36% a year ago. He noted that the total account receivable days per month dropped down to 45 from 47.6.

Janet Karageozian, Assistant Vice President, Business Applications, reported that both EPIC implementation and ERP milestones are on target. She outlined the ERP Implementation milestones as follows:

1. Phase I of the ERP has been completed. The 1-5 phases includes: PeopleSoft's Finance (Accounts Payable/General Ledger), & Supply Chain modules across all NYC H+H locations.
2. Cost Accounting is on track for go-live in September 2018.
3. Phase 2 – PeopleSoft Payroll/Time & Labor/Absence Management/Electronic Time Capture:
    a. Payroll Go-Live on track for January 2019
    b. Time and Labor/Absence Management on track for May 2019
    c. Electronic Time Capture on track for June 2019
4. Clairvia Clinical Scheduling in progress and expected to go live in Spring 2019

Under the Quality and Outcomes metric, Dr. Wei reported that Sepsis 3 hour bundle compliance increased from 61.8% in Q4 2017 to 67.7%. Follow-up appointment kept within 30 days after behavioral health discharge is at 64.4 % in Q1. HGbA1c control is at 63.9%, a slight decrease from 64.4%. The percentage of people left without being seen in EDs rose from 6% to 7%.

CARE EXPERIENCE

Chief Nursing Officer Kim Mendez reported on the Care Experience Metric:

- Inpatient Rate the Hospital 0-10, the average is 61.5; the target 65.4 and the stretch 70.1.
- Post-Acute Care, Likelihood of Recommending, the Average is 84.1, the target 84.3 and the stretch 85.9
- Medical Practice – Recommend this Provider Office, the average is 82.2, the target 83.6 and the stretch 85.9

Dr. Mendez reported that the HAPPY or NOT Meters consist of four smileys with different face expressions and the Happy Index is a summed up score calculated as the weighted average of the four smileys. Happy or Not Kiosks are being used at our facilities to help track their performance in different areas at certain period of the day.

Dr. Mendez reported on the 11 patient experience initiatives followed by a timeline of events from August/September 2017 to date and outlined the next steps for the upcoming months as follows:

- October 2018 – Conduct Assessment/Design of IHI Joy in Work Rollout
- November 2018 – Development of Standardized Purposeful Rounding
- December 2018 – All Facilities Have a PFAC
- March 2019 – Patient Experience Day

Dr. Mendez stated that Press Ganey provides healthcare performance improvement products such as:

- Value Based Purchasing Calculator
- Key Driver Report – Priority Index
- InfoEdge
- Comment Report
- Webinars
- Advisory Days
- Point of Care
- Improvement Portal

Dr. Mendez concluded her presentation by sharing the Care Experience next steps with the Committee. They are:

- Integration of ICARE values
- Continue to leverage Press Ganey data analysis & resources
- Joy in Work
- Standardize Purposeful Rounding
- System-wide Patient and Family Advisory Councils – December 2018
- Patient Experience Day – March 2019

ADJOURNMENT

There being no further business, the meeting was adjourned at 1:23 PM.

SUBSIDUARY REPORTS

HHC Capital Corporation Meeting: May 31, 2018
As Reported by Gordon Campbell
Members present: Gordon Campbell, Bernard Rosen, Dr. Mitchell Katz

Gordon Campbell called the meeting to order at 2:37 P.M. The minutes of the November 30, 2017 meeting were adopted.

Background on HHC Capital Corporation:

Ms. DeHart briefly explained that the HHC Capital Corporation was established in 1993 as a wholly owned subsidiary to receive H+H's Health Care Reimbursement Revenues, as part of the security structure for H+H revenue bonds. And stated that the By-Laws of the HHC Capital Corporation required a minimum of two public board meetings annually.

Ms. DeHart then referred to the HHC Capital Corporation Semi-Annual

Meeting Presentation and began her update to the Board.

HHC Outstanding Bond Portfolio:

Ms. DeHart stated that this is the semi-annual meeting of the HHC Capital Corporation where the status of the System's bond financing program and other debt is presented. Page 1 shows H+H's current outstanding bonds of approximately $680 million, where a majority of bonds are fixed rate bonds, 79% ($535 million) and the remaining 21% ($145 million) are variable rate bonds, supported by letters of credit provided by JP Morgan Chase Bank and TD Bank.

HHC Bonds - Issuance History:

Ms. DeHart pointed to page 2 which shows a history of bonds issued. The outstanding bonds are the 2008 Series A-E, the 2010 Series A and the 2013 Series A bonds, with a total outstanding par amount of is $680 million.
Mr. Gordon asked if H+H foresees issuing any H+H's bonds in the near future. Ms. DeHart answered no, and further explained that H+H capital plan has shifted to near complete reliance on NYC financing. Ms. DeHart also informed the Board that there are two boiler projects to be financed by New York Power Authority ("NYPA"), which are expected to close in the coming months.

Construction Fund Balance on the 2010 Bonds:

Ms. DeHart described page 3 which shows that the unspent balance for the HHC Series 2010 construction fund is approximately $1.2 million. The remaining balance will be spent once OFD completed their reconciliation efforts on the projects financed by 2010 Bonds.

Health System Bonds-Arbitrage Rebate:

Ms. DeHart explained that arbitrage rebate liability is required to rebate to the IRS when interest earnings on bond proceeds exceeded the tax-exempt bond yield (i.e. issuers are not allow to make any profit when borrowing in tax-exempt debt).
Ms. DeHart informed the Board that H+H's 2013 Series A Bonds interest earning exceeded bond yield by $581,458.02, as indicated in page 4, and that H+H had sent the rebate check to the IRS on May 25, 2018, as required.
Ms. Cohen inquired if H+H had made similar payment back to the IRS in the past? Ms. Lok answered yes, a rebate check on H+H's 1997 Series Variable Rate Bonds was sent to the IRS in the past. And further explained that an arbitrage rebate liability typically will be incurred with a variable rate debt, since the bond yield of a variable rate debt is likely lower than the interest earnings on the bond proceeds.

Short Term Financing Program:

Ms. DeHart provided an overview of the organization's short term financing program on page 5. Through multiple resolutions approved by the Board in 2013 and 2015, Health + Hospitals authorized the Chief Financial Officer (CFO) to borrow up to $120 million on an "as-needed" basis. As of now, H+H has entered into two loans with JP Morgan Chase and Citibank.

2015 JP Morgan Chase Loan:

Ms. DeHart presented page 6 which describes the JPM Chase loan negotiated in July 2015 for up to $60 million to finance the purchase of medical

equipment and related renovation projects. The $60 million loan was borrowed at 2.088% fixed rate interest with a final maturity of July 1, 2022. As of the end of April 2018, the outstanding loan amount is $51.3 million.

Ms. DeHart further explained to the Board why H+H uses short-term financing to finance shorter life projects. By borrowing "as needed", it prevented H+H from borrowing a large amount of capital funds, where the interest earnings is much lower than the interest cost on the borrowed proceeds, which is typically the case if issuing bonds.

2017 Citibank Loan:

Ms. DeHart explained to the Board that the 2017 Citibank Loan on page 7 was entered into in November 2017, of which $30 million was borrowed as a fixed rate loan at the interest rate of 2.17% with final maturity of November 1, 2022; and the remaining $30 million is available to be borrowed as 5-year variable rate loan, if necessary.

Mr. Gordon asked under what conditions H+H would borrow the remaining $30 million. Ms. DeHart answered H+H would evaluate our capital project needs and available funding from various funding sources, as well as the interest rate of the loan, to determine if it is advantageous for us to borrow the remaining $30 million loan from Citibank. As of now, we encumbered $46.6 million and expended $42.1 million of project costs eligible for this financing. Therefore, we would consider borrowing at least $12 to $17 million to cover those unreimbursed capital expenses.

Adjournment:

There being no further business before the Board, Mr. Campbell adjourned the meeting at 1:50 p.m.

HHC Assistance Corporation/OneCity Health Services Board of Directors
As Reported by Israel Rocha
May 22, 2018

The meeting of the HHC Assistance Corporation Board of Directors, d/b/a OneCity Health Services, was held on May 22, 2018 in Room 532 located at 125 Worth Street.

The Board discussed the following matters:

- A motion was made, duly seconded, and unanimously accepted to adopt a resolution electing Israel Rocha as Chairman of the Board, and recognizing the Directors designated by the Sole Member and electing Directors of the Corporation: Mitchell Katz, Plachikkat V. Anantharam, Jeremy Berman, William T. Foley, Israel Rocha, Matthew Siegler, and Michael Stocker.

- Mr. Rocha, Chief Executive Officer of OneCity Health Services provided an update on the status of the external audit for which the Bonadio Group had been selected to conduct a review of funds flow pertaining to DSRIP from New York State Department of Health to NYC Health + Hospitals and the appropriateness of funds

distribution to all partners. The board discussed other strategies to engage partners, with focus on community-based providers, to collectively addressing social determinants.

- Mr. Rocha provided the CEO update, highlighting OneCity Health goals over the next 14 months of performance including: Maximizing DSRIP revenue as part of duty to the fiduciary; making change permanent by leaving tangible products of change through reports created by new workgroups; and developing a transition plan to align DSRIP work with ongoing managed care contracting for value-based purchasing

- Mr. Rocha presented a new view of OneCity Health's approach to ongoing work, which will borrow strategies/approaches from various industries and move the organization to a project management structure which will allow for greater flexibility and agility.

- Dr. Katz stressed the importance of engaging front-line providers as a successful strategy to allay misconceptions that all DSRIP funding will be directed to NYC Health + Hospitals. Mr. Rocha reiterated the support that Dr. Katz and other Central Office leadership have shown in regard to creating partnerships and avenues to flow funds to community partners.

HHC Assistance Corporation/OneCity Health Services Board of Directors
As Reported by Israel Rocha
June 11, 2018

The meeting of the HHC Assistance Corporation Board of Directors, d/b/a OneCity Health Services, was held on June 11, 2018 in Room 405 located at 125 Worth Street.

The Board discussed the following matters:

- A motion was made, duly seconded, and unanimously accepted to adopt a resolution recognizing the Directors designated by the Sole Member and electing Directors of the Corporation: Mitchell Katz, Jeremy Berman, William T. Foley, Israel Rocha, Matthew Siegler, Michael Stocker, John E. Ulberg.

- Tatyana Seta, Chief Financial Officer for OneCity Health, reviewed the Fiscal Year 2019 (FY19) starting cash balance, highlighting project and administrative expenses and Performing Provider System (PPS) partner payments made. Operating expenses budgeted for FY19 were substantially lower ($14.5M) than the budgeted amount in FY18 ($42.5M), which were originally intended for start-up investments in a Management Services Organization and related consulting fees. Notably, the $12M allocated to other than personnel services in FY19 includes PPS-wide investments, including project implementation and IT and analytics infrastructure. The FY19

budget includes $160M for partner payments, an increase from the $152M allocated in FY18. Partner payments are subject to the approval by the PPS Executive Committee.

- Among other items, Board members discussed OneCity Health's network strategy to focus on DSRIP performance outcomes and facilitate partnerships at the local hospital and community-based provider level.

- A motion was made, duly seconded, and unanimously accepted to adopting the fiscal year 2019 HHC Assistance Corporation's (d/b/a) OneCity Health Services) budget of $184,466,073 in total expenses $160,000,000 Performing Provider System (PPS) partner payments subject to PPS governance approval] for the period July 1, 2018 to June 30, 2019.

MetroPlus Health Plan, Inc. – July 18, 2018
As reported by Mr. Bernard Rosen

CHAIRPERSON'S REMARKS

In Mr. Bernard Rosen's absence, Dr. Saperstein, MetroPlus' President and Chief Executive Officer chaired the meeting and Kathleen Nolan, Secretary to the Board, kept the minutes, thereof.

Dr. Saperstein stated that due to not having a quorum, the minutes from the last Board meeting would not be presented for approval until September's meeting.

EXECUTIVE DIRECTOR'S REPORT

Dr. Saperstein presented his report. Dr. Saperstein's remarks were in the Board of Directors packet and a copy is attached hereto and incorporated by reference.

Dr. Saperstein stated that disenrollments have decreased significantly in comparison to April and May 2017. The decrease in disenrollment may be attributed to the Finity rewards program and the members being more engaged. Dr. Saperstein informed the Board that in place of Seth Diamond, former MetroPlus Chief Operating Officer, Dr. Schwartz, MetroPlus' Chief Medical Officer, will now oversee the Finity rewards program to ensure that Finity stays on track. Mr. Still stated that the decrease in disenrollments has been a huge turn around for the Plan. Dr. Saperstein stated that a reduction in disenrollment is a nice improvement. A decrease in disenrollment is also a product of an increasing retention rate. Dr. Saperstein stated that the increase in the retention of members is due to better cooperation with onsite facility staff, increased

emphasis on productivity metrics, and the implementation of a new payment system that will give the member more flexibility in paying their premiums.

Dr. Saperstein informed the Board on some industry updates that would affect the Plan. Dr. Saperstein stated the CMS “Mega Rule” that requires members on Medicaid to be approved by New York State Medicaid has been postponed. Dr. Saperstein stated that the Governor announced a program to ensure that health plans don’t have any policies or procedures that will discriminate against the transgender population. Dr. Saperstein stated that the Plan is looking into the regulatory and written policies to ensure that the transgender population is protected.

MEDICAL DIRECTOR’S REPORT

Dr. Schwartz reported that NCQA has added 4 new measures to HEDIS 2019. These measures will be captured in this calendar year and reported in 2019. In HEDIS 2018, NCQA added two opioid measures focused on high dosage and multiple providers. This year NCQA continues to expand this effort and has introduced the Risk of Continued Opioid Use. The measure looks at the percent of members who have a new episode of opioid use that puts them at risk for continued opioid use. Continuing to build on measures that focus on effective transitions, Hospitalization Following Discharge from a Skilled Nursing Facility has been added to the measure set. The measure applies to Medicare only and measures the percent of members who had skilled nursing facility discharges to the community that were followed by an unplanned acute hospitalization. Adult Immunization Status will measure the percent of adult members who are up-to-date on recommended routine vaccines for flu, tetanus, diphtheria, pertussis, zoster, and pneumococcal. And continuing its focus on immunization, Prenatal Immunization Status measures the percent of deliveries whereby women received influenza and tetanus, diphtheria and pertussis vaccinations.

NCQA has also made several Crosscutting Changes. The ones that apply to MetroPlus Health Plan are 1) added telehealth as an acceptable visit for 14 additional measures, 2) exclusion of members 66 and older with advanced illness and frailty, or members 81 and older with frailty in certain measures, and 3) added socioeconomic stratifications for a select number of measures.

Dr. Schwartz stated that Consumer Assessment of Healthcare Providers and Systems (CAHPS) results dated October 2018-January 2018 for the adult Medicaid Managed Care, SNP and HARP populations are outlined in the graph attached to her report. Of the nine key

measures considered in the survey, MetroPlus scored 2 above State average and 7 below State average. The two measures scoring above State average are Customer Service and Rating of Health Plan. Two measures decreased significantly – Getting Needed Care and Getting Care Quickly.

Dr. Schwartz informed the Board that the Plan is working with the non-for-profit organization, Comunilife, to place homeless Plan members in available housing. Given priority for Plan members who are attributed to Health + Hospitals. Medical Management is currently working on two housing projects: Brooklyn for members with behavioral health issues and Bronx members living with HIV/AIDS. The Plan has already identified close to 100 members who may be eligible for placement into these units.

Dr. Schwartz reported that the Plan has contracted with God's Love We Deliver to deliver meals to members without the necessary ability and support system to buy and prepare food. This is focused on members immediately following hospitalization discharge.

Given the success of the End the Epidemic Art workshop, MetroPlus is launching a summer camp for Medicare members who were identified as not fully engaged in their care. These members were invited to participate in a camp held at Health + Hospitals facilities: Elmhurst, Bellevue, Cumberland and Morrisania. Camp includes art projects, exercise, as well as health screenings and education.

MetroPlus is collaborating with Health + Hospitals Behavioral Health Central Office and Health + Hospitals Health Home to create a partnership to utilize the infrastructure dollars to fully develop Health + Hospitals' delivery of Health Home and Community Based (HCBS) Services and Recovery Coordination assessments. Health + Hospitals is designated to deliver the following BH HCBS services: Family Support and Training, Psychosocial Rehabilitation (PSR) and Community Psychiatric Supports and Treatment (CPST) in its hospitals.

Dr. Schwartz stated that new opioid criteria were drafted and implemented in February of 2018. These criteria were based on the CDC guidelines for chronic opioid prescribing and focused on ensuring patients are assessed for appropriateness, monitored for substance abuse disorder and prescribed an appropriate dose. Due to this criteria MetroPlus saw a 25% reduction in utilizers, high dosing and claims for Medicaid, and a 20% reduction for the same measures for the commercial lines of business. MetroPlus also began to target prescribers who were potentially inappropriately prescribing opioids to Plan members. Three prescribers were

initially identified by their rate of prescriptions for a 30-day supply, their panel's medical claims for substance abuse codes, and their volume of opioid prescriptions were higher than average. The strategy to assess appropriateness of use is to ensure that every prescription from these prescribers goes through the new Opioid Criteria monitoring. MetroPlus continues to collaborate with Housing Works and is now training Home Health Aides who attend to members in their homes on Narcan use, which is an Opioid overdose treatment.

After three years of successful End the Epidemic grant implementation, the grant was extended indefinitely at 60% of its current funding. This will allow the Partnership in Care Department to continue to invest resources in members who are not virally suppressed or were lost to follow up.

MetroPlus assumed the role of NY State designated HIV peer certification program subsequent to Jacobi's withdrawal. The Plan will oversee the training and preparedness of peers to work effectively with members afflicted by HIV.

Dr. Schwartz reported that, since last quarter of 2017, Utilization Management (UM) adopted a more stringent process for reviewing out of network (OON) services. Through first quarter of 2018 the Plan saw a 5% rise in OON denials for non-emergent services available in-network. In the first quarter of 2018, UM further revised the OON workflow process to include outreach to members, providers, and Health + Hospitals sites to confirm availability and to assist with appointment scheduling. UM staff and management are working collaboratively with Health + Hospitals staff and management with established points of contacts and escalation at each location. With the launch of the new process the Plan has experienced better collaboration with Health + Hospitals sites for appointment scheduling of redirected services.

Executive Director's Report MetroPlus Health Plan, Inc. Board of Directors

July 18, 2018

Total plan enrollment as of June 1, 2018 was 518,696. Breakdown of plan enrollment by line of business is as follows:

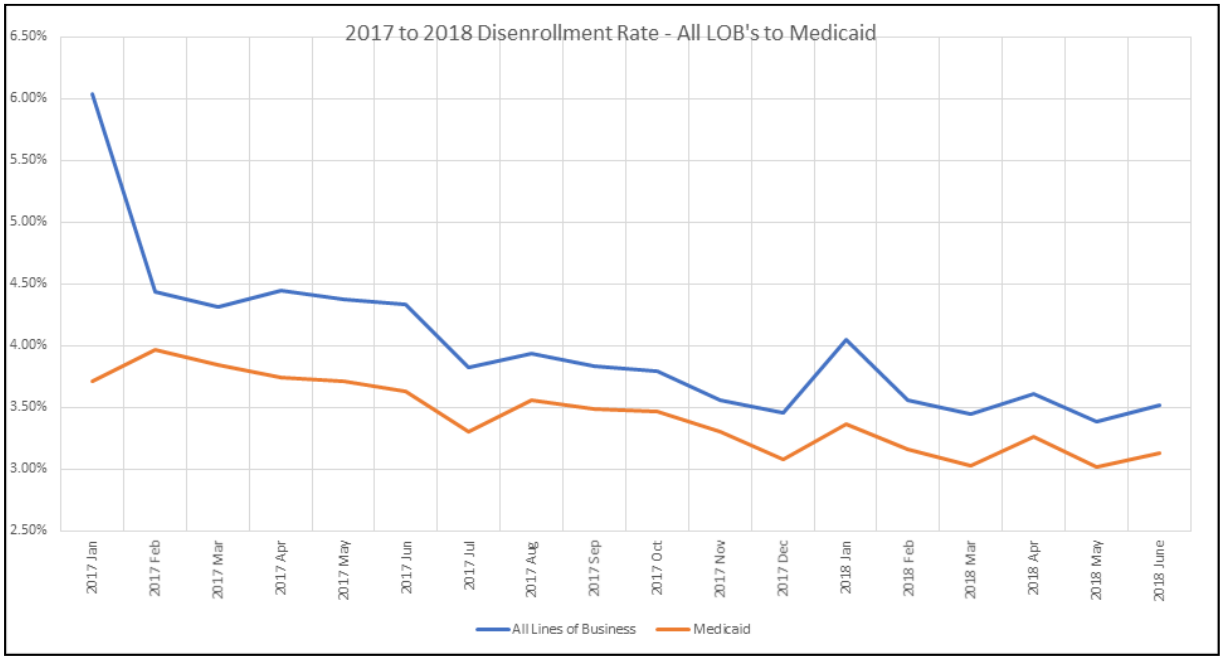
Medicaid	371,097
Child Health Plus	17,619
MetroPlus Gold	12,023
Partnership in Care (HIV/SNP)	4,169
Medicare	8,019
MLTC	1,896
QHP	14,685
SHOP	1,310
FIDA	210
HARP	10,993
Essential Plan	74,822
GoldCare I	1,174
GoldCare II	679

Operations

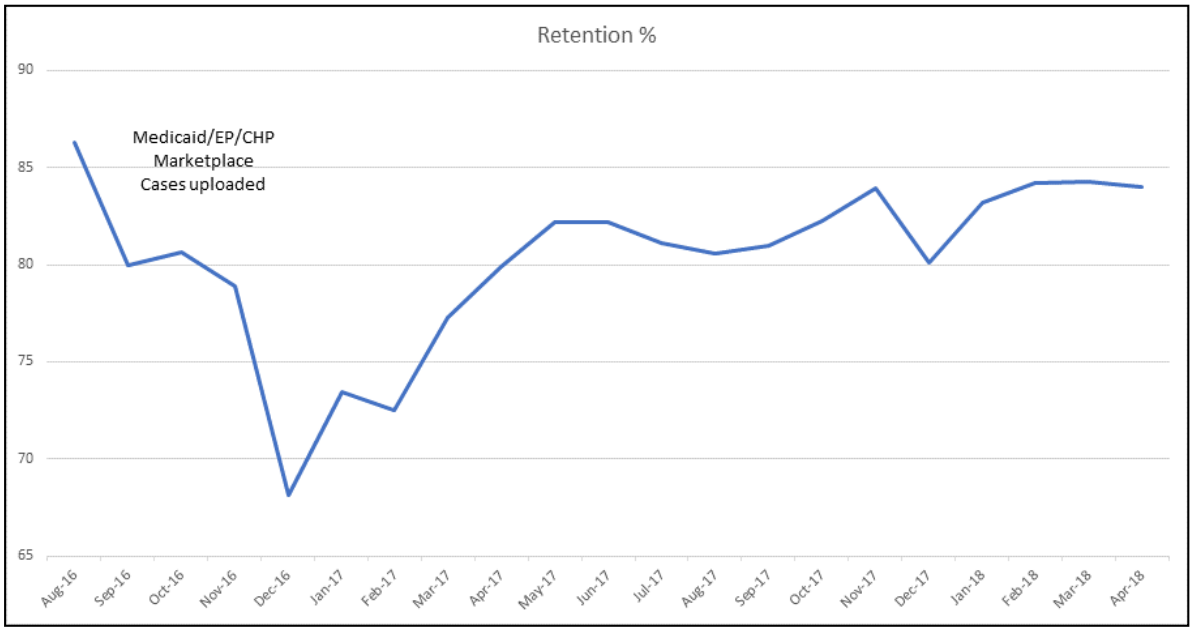
Overall membership was largely flat between April and May, totaling approximately 522,000. As of June 1, our membership decreased to 518,696. One notable trend in overall membership is our continued growth in the QHP product, which now stands at approximately 14,500 – a near doubling from 8,300 just one year ago. While last year we added between 2 and 300 QHP members each month at this time of year, currently we are adding over 800 each month. MetroPlus is also more aggressively contacting members through text messages and outreach phone calls to remind members to pay their premium.

We have seen fewer disenrollments this year than last as well. In April, even with a larger membership, we saw over 3,000 fewer involuntary disenrolled members than one year ago. In May, we had 4,500 fewer disenrolled members when compared with last May. These significant declines reflect our greater emphasis on providing high quality service to our members. It is also an outcome of our rewards program, which has now registered nearly 35,000 members and has provided rewards to over 9,000.

The chart below shows the continuing decline in our disenrollment rate both for Medicaid and for all lines of business.



Decreasing disenrollment is also a product of an increasing retention rate. Because of greater cooperation with onsite facility staff, expanded hours of outreach, and more emphasis on productivity metrics, the retention rate has climbed steadily since the beginning of last year. In January of 2017, the rate was approximately 70% and in April of this year it approached 85%. We are currently working with several facilities on a plan to refer individuals who come to the facility for outpatient appointments to MetroPlus if they are within their renewal period. This method once implemented has been proven successful at various facilities thus far.



We also recently implemented a new payment system for lines of business where members must pay monthly premiums. The new system gives our customers much greater flexibility in paying their premiums. They can now schedule payments ahead of time, set up recurring payments, and have access to more detailed information about their account. Payments can also be made 24 hours a day, 7 days a week. Information about the new system is on the MetroPlus website and we are conducting a mailing to all members as well.

Industry Updates

We would like to share some key industry updates that are of interest to MetroPlus:

- As a follow-up to the CMS “Mega Rule” that requires providers to enroll in the State’s FFS program before enrolling in Medicaid Managed Care, the July 1 deadline has been postponed, which gives MCOs more time to prepare and work with providers to be ready for the change
- DOH plans on working with MCOs to establish a reliable process for Plans to access the federally mandated sanctions database for Medicaid
- As part of the Cuomo Administration’s comprehensive initiative to target maternal mortality and reduce racial disparities in health outcomes, a Medicaid pilot program covering doulas will be launched soon
- The Administration also recently announced health care protections for transgender New Yorkers in response to an anticipated rollback of similar protections in the Affordable Care Act

MetroPlus Health Plan
Membership Summary by LOB Last 7 Months
June-2018

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Total Members	Prior Month	506,478	509,245	517,007	517,703	524,323	522,743	522,004
	New Member	22,741	32,400	21,879	27,314	19,922	19,380	17,561
	Voluntary Disenroll	1,596	1,841	1,571	1,686	1,724	1,637	1,648
	Involuntary Disenroll	18,378	22,797	19,612	19,008	19,778	18,482	19,221
	Adjusted	52	68	127	179	446	2,931	0
	Net Change	2,767	7,762	696	6,620	-1,580	-739	-3,308
	Current Month	509,245	517,007	517,703	524,323	522,743	522,004	518,696
Medicaid	Prior Month	373,011	374,007	373,766	372,599	375,556	373,745	372,849
	New Member	13,838	14,006	12,311	15,801	11,835	11,636	11,338
	Voluntary Disenroll	583	619	570	749	706	634	633
	Involuntary Disenroll	12,259	13,628	12,908	12,095	12,940	11,898	12,457
	Adjusted	58	68	119	170	398	1,424	0
	Net Change	996	-241	-1,167	2,957	-1,811	-896	-1,752
	Current Month	374,007	373,766	372,599	375,556	373,745	372,849	371,097
Essential Plan	Prior Month	71,807	73,256	75,305	75,905	77,117	76,992	76,777
	New Member	5,941	7,798	5,450	6,502	4,957	4,978	3,480
	Voluntary Disenroll	2	3	2	2	0	1	1
	Involuntary Disenroll	4,490	5,746	4,848	5,288	5,082	5,192	5,434
	Adjusted	0	-2	-4	-7	-8	1,314	0
	Net Change	1,449	2,049	600	1,212	-125	-215	-1,955
	Current Month	73,256	75,305	75,905	77,117	76,992	76,777	74,822
Child Health Plus	Prior Month	16,780	16,980	17,145	17,186	17,675	17,710	17,726
	New Member	1,327	1,400	1,094	1,558	1,092	1,075	963
	Voluntary Disenroll	738	865	718	681	712	723	702
	Involuntary Disenroll	389	370	335	388	345	336	368
	Adjusted	6	9	14	14	29	104	0
	Net Change	200	165	41	489	35	16	-107
	Current Month	16,980	17,145	17,186	17,675	17,710	17,726	17,619

MetroPlus Health Plan
Membership Summary by LOB Last 7 Months
June-2018

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
HHC	Prior Month	10,100	10,312	12,046	11,612	11,769	12,009	12,067
	New Member	281	1,808	180	235	344	160	46
	Voluntary Disenroll	0	0	3	0	0	0	0
	Involuntary Disenroll	69	74	611	78	104	102	90
	Adjusted	-2	5	8	9	46	132	0
	Net Change	212	1,734	-434	157	240	58	-44
	Current Month	10,312	12,046	11,612	11,769	12,009	12,067	12,023
SNP	Prior Month	4,161	4,147	4,189	4,222	4,256	4,257	4,215
	New Member	71	138	157	158	141	122	103
	Voluntary Disenroll	17	18	23	22	25	36	19
	Involuntary Disenroll	68	78	101	102	115	128	130
	Adjusted	-1	-2	1	5	8	10	0
	Net Change	-14	42	33	34	1	-42	-46
	Current Month	4,147	4,189	4,222	4,256	4,257	4,215	4,169
Medicare	Prior Month	8,186	8,173	8,062	8,019	7,991	8,008	8,005
	New Member	264	242	264	224	293	255	283
	Voluntary Disenroll	181	261	195	154	184	174	203
	Involuntary Disenroll	96	92	112	98	92	84	66
	Adjusted	0	0	0	0	0	-6	0
	Net Change	-13	-111	-43	-28	17	-3	14
	Current Month	8,173	8,062	8,019	7,991	8,008	8,005	8,019
Managed Long Term Care	Prior Month	1,724	1,738	1,762	1,775	1,811	1,845	1,836
	New Member	73	72	70	90	80	49	97
	Voluntary Disenroll	22	17	12	4	15	4	17
	Involuntary Disenroll	37	31	45	50	31	54	20
	Adjusted	-1	-2	-2	-3	-8	-19	0
	Net Change	14	24	13	36	34	-9	60
	Current Month	1,738	1,762	1,775	1,811	1,845	1,836	1,896

MetroPlus Health Plan
Membership Summary by LOB Last 7 Months
June-2018

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
QHP	Prior Month	7,302	6,983	10,880	12,213	13,909	14,005	14,379
	New Member	116	6,379	1,721	2,380	839	862	668
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	435	2,482	388	684	743	488	362
	Adjusted	0	0	-1	0	-11	-15	0
	Net Change	-319	3,897	1,333	1,696	96	374	306
	Current Month	6,983	10,880	12,213	13,909	14,005	14,379	14,685
SHOP	Prior Month	855	965	1,145	1,251	1,329	1,323	1,336
	New Member	172	271	149	113	69	47	16
	Voluntary Disenroll	9	4	1	0	4	2	5
	Involuntary Disenroll	53	87	42	35	71	32	37
	Adjusted	0	0	0	0	0	0	0
	Net Change	110	180	106	78	-6	13	-26
	Current Month	965	1,145	1,251	1,329	1,323	1,336	1,310
FIDA	Prior Month	185	185	206	211	210	204	208
	New Member	7	27	12	3	3	9	4
	Voluntary Disenroll	1	0	1	0	0	0	0
	Involuntary Disenroll	6	6	6	4	9	5	2
	Adjusted	0	0	0	0	0	0	0
	Net Change	0	21	5	-1	-6	4	2
	Current Month	185	206	211	210	204	208	210
HARP	Prior Month	10,456	10,595	10,628	10,834	10,829	10,793	10,754
	New Member	376	247	444	223	251	166	535
	Voluntary Disenroll	43	54	46	74	78	63	68
	Involuntary Disenroll	194	160	192	154	209	142	228
	Adjusted	0	0	0	0	0	0	0
	Net Change	139	33	206	-5	-36	-39	239
	Current Month	10,595	10,628	10,834	10,829	10,793	10,754	10,993

MetroPlus Health Plan
Membership Summary by LOB Last 7 Months
June-2018

		Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
GOLDCARE I	Prior Month	1,095	1,178	1,167	1,171	1,173	1,163	1,168
	New Member	228	11	21	20	16	16	25
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	145	22	17	18	26	11	19
	Adjusted	-5	-5	-5	-5	-4	-8	0
	Net Change	83	-11	4	2	-10	5	6
	Current Month	1,178	1,167	1,171	1,173	1,163	1,168	1,174
GOLDCARE II	Prior Month	816	726	706	705	698	689	684
	New Member	47	1	6	7	2	5	3
	Voluntary Disenroll	0	0	0	0	0	0	0
	Involuntary Disenroll	137	21	7	14	11	10	8
	Adjusted	-3	-3	-3	-4	-4	-5	0
	Net Change	-90	-20	-1	-7	-9	-5	-5
	Current Month	726	706	705	698	689	684	679

Management Indicator Report # 1

For Enrollment Month 201806

Indicator #1A for Enrollment Month: June 2018

Disenrollments To Other Plans

		Enrollment Mont			Twelve Months Period		
		FHP	MCAD	Total	FHP	MCAD	Total
	INVOLUNTARY		60	60		1368	1368
	VOLUNTARY		28	28		466	466
Affinity Health Plan	**TOTAL**		**88**	**88**		**1834**	**1834**
	INVOLUNTARY		95	95		2060	2060
	VOLUNTARY		24	24		708	708
Amerigroup/Health Plus/CarePlus	**TOTAL**		**119**	**119**		**2768**	**2768**
	INVOLUNTARY		364	364		7482	7482
	VOLUNTARY		86	86		2708	2708
Fidelis Care	**TOTAL**		**450**	**450**		**10190**	**10190**
	INVOLUNTARY		588	588		13941	13941
	VOLUNTARY		281	281		6354	6354
Health First	**TOTAL**		**869**	**869**		**20295**	**20295**
	INVOLUNTARY		12	12		713	713
	VOLUNTARY		5	5		241	241
HIP/NYC	**TOTAL**		**17**	**17**		**954**	**954**
	INVOLUNTARY		171	171		3317	3317
	VOLUNTARY		31	31		611	611
United Healthcare of NY	**TOTAL**		**202**	**202**		**3928**	**3928**
	INVOLUNTARY		103	103		2060	2060
	VOLUNTARY		3	3		182	182
Wellcare of NY	**TOTAL**		**106**	**106**		**2242**	**2242**
	INVOLUNTARY		1677	1677		35145	35145
	VOLUNTARY		462	462		11324	11324
Disenrolled Plan Transfers	**TOTAL**		**2139**	**2139**		**46469**	**46469**
	INVOLUNTARY		165	165		3007	3007
	UNKNOWN		1	1		16	16
	VOLUNTARY		157	157		2294	2294
Disenrolled Unknown Plan Transfers:	**TOTAL**		**323**	**323**		**5317**	**5317**
	INVOLUNTARY		10069	10069		227273	227273
	UNKNOWN		41	41		1341	1341
	VOLUNTARY		13	13		606	606
Non-Transfer Disenroll Total:	**TOTAL**		**10123**	**10123**		**229220**	**229220**
	INVOLUNTARY		11911	11911		265425	265425
	UNKNOWN		42	42		1395	1395
	VOLUNTARY		632	632		14224	14224
Total MetroPlus Disenrollment:	**TOTAL**		**12585**	**12585**		**281044**	**281044**

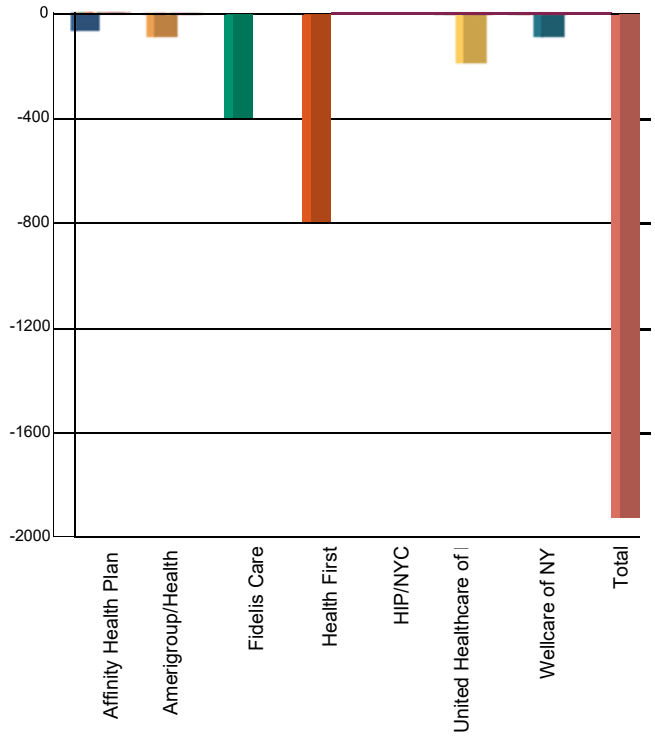
New MetroPlus Members Disenrolled From Other Plans

	FHP	MCAD	Total	Y FHP	Y MCAD	Y Total
Affinity Health Plan		27	27		653	653
Amerigroup/Health Plus/CarePlus		39	39		1,110	1,110
Fidelis Care		30	30		1,040	1,040
Health First		55	55		1,552	1,552
HIP/NYC		14	14		449	449
United Healthcare of NY		22	22		728	728
Wellcare of NY		25	25		500	500
Total		212	212		6,032	6,032
Unknown/Other (not in total)		2,264	2,264		50,877	50,877

Net Difference

	Enrollment Month			Twelve Months Period		
	FHP	MCAD	Total	FHP	MCAD	Total
Affinity Health Plan		-61	-61		-1,181	-1,181
Amerigroup/Health Plus/CarePlus		-80	-80		-1,658	-1,658
Fidelis Care		-420	-420		-9,150	-9,150
Health First		-814	-814		-18,743	-18,743
HIP/NYC		-3	-3		-505	-505
United Healthcare of NY		-180	-180		-3,200	-3,200
Wellcare of NY		-81	-81		-1,742	-1,742
Total		-1,927	-1,927		-40,437	-40,437

Enroll Month Net Transfers (Known)



Plans	Getting Needed Care (Usually or Always)	Getting Care Quickly (Usually or Always)	How Well Doctors Communicate (Usually or Always)	Customer Service (Usually or Always)	Shared Decision Making (Yes)	Rating of all health care	Rating of personal doctor	Rating of specialist seen most often	Rating of health plan
MMC Statewide	79	78	91	86	80	77	81	80	76
NYC	74	73	90	83	80	73	80	75	75
Rest of State	81	82	92	86	80	78	81	82	75
Affinity Health Plan	74	73	94	85	83	75	83	77	74
CDPHP	86 ▲	85 ▲	93	91 ▲	82	83 ▲	85 ▲	84	87 ▲
Empire	76	75	89	86	81	71	78	74	76
Excellus BlueCross BlueShield	82	79	92	83	79	84 ▲	83	79	80
Fidelis Care New York	80	80	93	86	82	78	81	80	77
Healthfirst PHSP	73 ▼	75	90	84	76	75	79	78	79
HealthNow New York	79	85 ▲	89	83	81	70 ▼	75 ▼	81	66 ▼
HIP (EmblemHealth)	75	76	90	89	82	72	78	76	67 ▼
Independent Health	82	82	94 ▲	86	82	79	86 ▲	88 ▲	81 ▲
MetroPlus Health Plan	71 ▼	71 ▼	90	88	74 ▼	74	78	77	79
Molina Healthcare	83	78	88	82	83	78	85	86	72
MVP Health Care	83 ▲	77	93	92 ▲	80	81	85 ▲	81	85 ▲
UnitedHealthcare Community Plan	76	80	90	81	79	74	78	79	70 ▼
WellCare of New York	78	75	91	84	81	76	82	76	72
YourCare Health Plan	83	85 ▲	90	87	77	77	76 ▼	80	74

▲▼ **Statistically significantly better/worse than MMC Statewide 2017.**

Mitchell Katz, M.D.
NYC Health + Hospitals President and CEO
Report to the Board of Directors - July 26, 2018 Meeting

HELPING KIDS BROUGHT TO THE CITY AFTER BEING SEPARATED FROM PARENTS AT THE BORDER

I'd like to start my report by again thanking the members of this Board of Directors for their support and participation in last month's press conference with the City's First Lady Chirlane McCray to highlight the situation facing immigrant children who were separated from their families. Our clinicians promptly flagged what they were beginning to see when about 12 of these children began showing up at our Emergency Rooms showing signs of stress and trauma. I'm really proud of the swift and comprehensive response this health system put in place to not only speak out about the serious health impact facing these children, but also to ensure these kids had access to the health care services they needed.

Our Chief Medical Officer Dr. Machelle Allen and our Chief Nursing Executive Kim Mendez visited the day care center to see first-hand what was happening there and establish connections with the staff. Our renowned child and adolescent mental health expert Dr. Jennifer Havens set up on-site child and adolescent psychiatric consultation services to Cayuga Centers, Lutheran Social Services, and Catholic Guardian, which are federally contracted by the Office of Refugee Resettlement to provide care to the separated children. Our VP of Primary Care Dr. Ted Long put in place a process for expedited referrals and a 24-hour hotline. And our SVP of Managed Care Matt Siegler cleared some hurdles for insurance contracts and reimbursement for the services provided.

Our essential public health care system and the entire city government pulled together to ensure the children were being properly cared for while they were here and offered other support, including legal assistance, trauma training for the foster parents, recreational activities and more. Dr. Allen and Dr. Havens joined City agency officials at a second press briefing to outline all the services in place, and also participated at a City Council hearing on the impact of the Trump Administration family separation policy in New York City.

I was so proud of our response and so grateful for the dedicated and compassionate health care professionals of NYC Health + Hospitals who care so deeply for the health and wellness of every child.

CORRECTIONAL HEALTH SERVICES SAVING LIVES AT RIKERS

I also want to give a special shout out to the NYC Health + Hospitals clinicians and staff who provide health services in city

jails. Their work was well documented in a powerful human interest story publish this week in the Daily News that highlighted the life-saving results of our opioid treatment services to individuals incarcerated. The headline said it all: ***A Bronx woman battling heroin addiction got locked up at Rikers Island – and is convinced it saved her life.*** Dr. Jonathan Giftos, director of NYC Health + Hospitals/Correctional Health Services' opioid treatment program discussed their important work and noted the sad reality that still, for too many opioid users, their only access to the proper treatment is in jail. For those of you getting this report electronically, here's the link to the story: http://www.nydailynews.com/new-york/ny-metro-bronx-woman-heroin-rikers-20180722-story.html

MAYOR MARKS OPENING OF NEW NYC HEALTH + HOSPITALS COMMUNITY HEALTH CENTER ON STATEN ISLAND

Mayor Bill de Blasio today marked the opening of the new $28 million NYC Health + Hospitals/Gotham Health, Vanderbilt community health center on Staten Island that will expand access to primary care for children and adults, offer mental health counseling and referrals, and opioid treatment. The health center is expected to serve more than 4,500 patients this year—growing to 15,000 patients and 40,000 annual visits by 2020—and help reduce the reliance on overcrowded emergency rooms and prevent avoidable hospitalizations. The center has same- and next-day primary care appointments available for children and adults.

Expanding ambulatory care, especially primary care, is the right way to address community health needs, and it is also a central element of our transformation into a financially stable health care system. We are pleased to offer the residents of Staten Island high-quality care in a beautiful, modern facility. This represents an important extension of our presence on Staten Island, which includes our health plan, MetroPlus, our top-ranked skilled nursing facility, NYC Health + Hospitals/Sea View, and our home care services. Thanks to all the staff who have worked so hard to get the Vanderbilt center on Staten Island up and running.

NYC HEALTH + HOSPITALS/QUEENS MARKS COMPLETION OF PHASE 1 EMERGENCY DEPARTMENT EXPANSION

NYC Health + Hospitals/Queens this week marked the completion of Phase 1 of its Emergency Room Expansion Project to help meet the community's growing demand for health care services. We are grateful to the support from Queens Borough President Melinda Katz, who allocated $2.5 million for the project. The expansion adds 6,500 square feet to the existing Emergency Department, and will now include three nurse stations, three triage rooms, a resuscitation room, three isolation rooms, seven exam rooms, and

19 cubicles. The long-awaited project, staged in four phases, is essential as more people rely on NYC Health + Hospitals/Queens following the closures in recent years of other hospitals in the borough. The other phases of expansion are expected to be completed next year and will help the ED capacity to nearly double from its current 50,000 visits per year to 97,000 visits per year.

While as a health system we aim to reduce the need for emergency room care by keeping people healthy and managing their chronic conditions through regular visits to a primary care clinician, people will always need emergency care. This expansion will help us better serve those who entrust us with their care at some of life's most difficult moments, and we are privileged to help them at such times.

REVITILIZED COMMUNITY HEALTH CENTER REOPENS ON THE LOWER EAST SIDE

I was pleased to join patients, staff, and local elected officials at a community celebration to mark the reopening of the newly renovated NYC Health + Hospitals/Gotham Health, Roberto Clemente Center, on Manhattan's Lower East Side. The $1 million renovation, funded by the Manhattan Borough President and the NYC Council, reflects our commitment to community-based ambulatory care. We are proud to continue expanding access to essential primary care and behavioral health services in New York City's underserved neighborhoods. For more than three decades, this community health center has provided care to the Lower East Side community and this renovation provides a strong foundation to continue that mission for generations to come.

CITY LAUNCHES PLAN TO REDUCE MATERNAL DEATHS AND LIFE-THREATENING COMPLICATIONS FROM CHILDBIRTH AMONG WOMEN OF COLOR

First Lady McCray and Deputy Mayor Palacio last week announced New York City's first comprehensive plan to reduce maternal deaths and life-threatening complications of childbirth among women of color. The five-year plan aims to eliminate disparities in maternal mortality between black and white women – where the widest disparity exists – and reduce by half the number of severe maternal morbidity events in the five boroughs. The City will invest $12.8 million over the next three years to address implicit bias, increase surveillance, enhance maternity care and expand public education. The plan includes support to enhance maternal care at NYC Health + Hospitals facilities by focusing on four specific strategies:

- Simulation training to help obstetrics staff master skills to identify and respond to the two top causes of pregnancy-related deaths for women of color— postpartum hemorrhage and blood clots

- New maternal care coordinators who will assist an estimated 2,000 high-risk women in the prenatal and postpartum periods to keep appointments, procure prescriptions, and connect women to eligible benefits.
- Co-location of newborn and postpartum appointments to increase the number of women receiving postpartum care from 60 percent to 90 percent. Postpartum care will include contraceptive counselling, breastfeeding support and screening for maternal depression.
- New practices in primary care to identify women who are planning to have a child within six to 12 months. Providers will assess hemorrhage risks and establish a care plan for women seeking to give birth within that timeline.

Every incidence of maternal mortality is a tragedy, and we believe many such tragedies can and must be prevented. We are excited to play an active role in this life-saving program.

CITY AND NYSNA REACH TENTATIVE AGREEMENT TO GRANT NURSES PHYSICALLY TAXING STATUS

The City reached a tentative agreement with the Department of Justice and the New York State Nurses Association (NYSNA) this month to settle a longstanding action involving the physically taxing status of certain NYSNA represented nurses employed by the City and NYC Health + Hospitals. The parties have been in negotiations for several years and I am happy to hear that an equitable and mutually agreeable tentative settlement has been reached. I understand that the settlement will provide payments to approximately 1,700 active and retired nurses, which will be based on their age and years of service. I would like to thank Mayor DiBlasio for resolving this longstanding matter and for acknowledging the difficult and physically demanding work that our nurses and midwives perform day in and day out.

FEDERAL, STATE,CITY UPDATE

State -- The State Department of Health convened a temporary workgroup on indigent care funding in which NYC Health + Hospitals is one of the participating members. The first meeting was held on July 11th and meetings will occur throughout the fall with policy recommendations on disproportionate share hospital funding and indigent care funding due December 1st. Health + Hospital will be working closely with labor and community advocates to ensure that we are treated appropriately as the largest safety net provider.

Federal -- ACA repeal and/or major cuts to hospital reimbursement is unlikely in the near term. However, we will continue to monitor the federal Centers for Medicare and Medicaid Services efforts to cut the ACA risk- adjustment payments to providers, which was created to help stabilize premiums and spread financial risk across insurers, as well as its cut to the ACA’s navigator funding, which helps organizations assist consumers wade through

health insurance options. We are also monitoring Congressional hearings on the 340B program, and opioid-related legislation moving through Congress.

ONECITY HEALTH UPDATE

- To help patients schedule and complete an annual visit with a primary care physician, OneCity Health, in collaboration with a vendor and the NYC Health + Hospitals call center, developed a program to conduct proactive, automated outreach phone calls to patients overdue for an annual primary care visit. OneCity Health has helped schedule over 1,250 primary care appointments since April 2017.
- At the conclusion of the 2017-2018 school year, the 100 Schools Project is now in 95 schools across the Bronx, Queens, Brooklyn and Manhattan, an increase of 52 schools since September 2017.
  - ✓ Through the program, Behavioral Health Coaches promote wellness and prevent distress in the classroom, meeting the needs of students with emotional, behavioral and substance-abuse issues that can often be a challenge for schools.
  - ✓ To scale the benefits of the program, over the summer the 100 Schools Project will expand to colleges. Four community colleges in the CUNY System – Bronx Community College, Guttman Community College, Hostos Community College and LaGuardia Community College – will begin to host workshops for staff, student leaders and families, conduct crisis trainings and mentor students interested in behavioral health careers.

NYC HEALTH + HOSPITALS/BELLEVUE SERENITY ROOM PROVIDES COMFORTING NEW SPACE FOR FAMILIES

NYC Health + Hospitals/Bellevue unveiled its new Palliative Care Family Meeting Room, also known as the Serenity Room, a project that was a collaboration of hospital staff and graduating medical students who transformed a conference room into a tranquil space for the families of gravely ill patients. The space is designed to provide a tranquil environment for providers to meet with family members of patients to deliver serious news, discuss end-of-life issues, and explore goals of care in gravely ill patients. During a difficult time, the room fosters a feeling of serenity and calm.

SAFE SLEEP TOOLKIT WILL BE PROVIDED TO THOUSANDS OF PARENTS AT ALL NYC PUBLIC HOSPITALS

The city’s first-ever Safe Sleep Toolkit will be provided to the parents of new babies in all our public hospitals before discharge in an effort to reduce sleep-related injury deaths. The kit, a collaboration between ACS and DOHMH, is part of a larger, citywide

public awareness campaign as a way to promote safe sleep practices and prevent future tragedies. The toolkit contains a wearable blanket to keep the baby warm, infant onesie, netting and educational materials about breastfeeding and best practices for infant safe sleep. With our longstanding commitment to promoting safe sleep practices—in both training our staff and educating new parents—we are pleased to play a key role in making available this important new resource. We'll all sleep easier knowing our newborns are sleeping more safely.

AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION RECOGNIZES ALL PUBLIC HOSPITALS FOR IMPROVING QUALITY OF CARE AND PATIENT OUTCOMES

I'm proud to report that, for the first time, all 11 hospitals in our public health care system received national recognition awards for implementing specific quality improvement measures related to the treatment of patients suffering from heart failure, cardiac arrest, and stroke. The awards from the American Heart Association and the American Stroke Association recognize the consistent application of best-practice, research-based standards of care, which reduce recovery time, disability, and mortality rates for stroke patients, and reduce hospital readmissions for heart failure patients. This is a well-deserved recognition of the hard work among our front line providers and further evidence of our ongoing commitment to improving care for our patients.

NYC HEALTH + HOSPITALS/HARLEM LAUNCHES SOCIAL MEDIA CAMPAIGN TO PROMOTE USE OF PRE-EXPOSURE PROPHYLAXIX

NYC Health + Hospitals/Harlem launched a month-long social media campaign on Grindr, Instagram, and Facebook to raise awareness among the Harlem community about Pre-Exposure Prophylaxis (PrEP) and direct more New Yorkers to take advantage of the comprehensive HIV/AIDS prevention and treatment programs available at the hospital. PrEP is an HIV prevention method in which people who do not have HIV take a daily pill to reduce their risk of becoming infected. The $20,000 social media campaign uses the tag line "Love Without Fear" and targets Blacks and Latinos who self-identify as men who have sex with men or women who may have an HIV-positive partner, as well as other New Yorkers at risk for contracting HIV. The campaign is part of a larger program funded by the New York State Department of Health's AIDS Institute to support the operation and administration of the hospital's PrEP Program. The grant funding is part the State's commitment to end AIDS as an epidemic by 2020.

# # #

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Bellevue ("Bellevue") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officer of the System to execute any and all documents necessary to verify Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of trauma services at Bellevue; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Bellevue as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Bellevue, as a Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Bellevue, as a Trauma Center
And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Elmhurst ("Elmhurst") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Trauma Center designation for Elmhurst through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of trauma services at Elmhurst; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Elmhurst as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Elmhurst, as a Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Elmhurst, as a Trauma Center
And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Harlem ("Harlem") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Trauma Center designation for Harlem through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of trauma services at Harlem; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Harlem as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Harlem, as a Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Harlem, as a Trauma Center
And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Jacobi ("Jacobi") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Trauma Center designation for Jacobi through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of trauma services at Jacobi; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Jacobi as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Jacobi, as a Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Jacobi, as a Trauma Center
And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Kings County ("Kings County") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Trauma Center designation for Kings County through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of trauma services at Kings County; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Kings County as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Kings County, as a Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Kings, as a Trauma Center
And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Lincoln ("Lincoln") as a trauma center.

Committing to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Trauma Center designation for Lincoln through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of trauma services at Lincoln; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Lincoln as a trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Lincoln, as a Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Lincoln, as a Trauma Center
And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Jacobi ("Jacobi") as a pediatric trauma center.

Committing to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary pediatric trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Pediatric Trauma Center designation for Jacobi through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of pediatric trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of pediatric trauma services at Jacobi; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Jacobi as a pediatric trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary pediatric trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Jacobi, as a Pediatric Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Jacobi, as a Pediatric Trauma Center And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Harlem ("Harlem") as a pediatric trauma center.

Committing to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary pediatric trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Pediatric Trauma Center designation for Harlem through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of pediatric trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of pediatric trauma services at Harlem; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Harlem as a pediatric trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary pediatric trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Harlem, as a Pediatric Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Harlem, as a Pediatric Trauma Center And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Approving the application of New York City Health and Hospitals Corporation (the "System") for verification by the American College of Surgeons for NYC Health + Hospitals/Bellevue ("Bellevue") as a pediatric trauma center.

Committing to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

Authorizing the appropriate officers of the System to execute any and all documents necessary to verify Pediatric Trauma Center designation for Bellevue through the American College of Surgeons, Committee on Trauma.

WHEREAS, the System has played a significant and needed role in the provision of pediatric trauma services in New York City; and

WHEREAS, in 2018 the American College of Surgeons is the verifying authority for trauma centers; and

WHEREAS, the System's Board of Directors fully supports the continued provision of pediatric trauma services at Bellevue; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors (the "Board") of the New York City Health and Hospitals Corporation (the "System") hereby approves the application for verification of NYC Health + Hospitals/Bellevue as a pediatric trauma center; and

FURTHER RESOLVED, that the Board commits to maintain the high standards needed to provide optimal care of all pediatric trauma patients, and that the multidisciplinary trauma performance improvement program has the authority to evaluate care across disciplines, identify opportunities for improvement, and implement corrective actions; and

FURTHER RESOLVED, that the Board authorizes the appropriate System officer to execute any and all documents necessary to verify NYC Health + Hospitals/Bellevue, as a Pediatric Trauma Center, by the American College of Surgeons.

EXECUTIVE SUMMARY
Designation of NYC Health + Hospitals/Bellevue, as a Pediatric Trauma Center And Verification by the American College of Surgeons

Background: The American College of Surgeons ("ACS") has a long history of activities improving trauma care. Its Verification, Review & Consultation Program validates the resources needed for high-quality care at trauma centers. The designation of trauma facilities is a regulatory and bureaucratic process performed by authorized governmental or other agencies. ACS does not designate trauma centers; instead, it verifies the presence of the resources, structures, and processes listed in *Resources for Optimal Care of the Injured Patient,* a guide for the development of trauma centers. The ACS Verification, Review, & Consultation Program is designed to assist hospitals in evaluating and improving trauma care and to provide objective, external review of institutional capabilities and performance. This process is accomplished by an on-site review of the hospital by a peer review team experienced in trauma care. The team assesses commitment, readiness, resources, policies, patient care, performance improvement, and other relevant features of the program as outlined in *Resources for Optimal Care of the Injured Patient.* State and Federal regulators look to ACS. In this way, ACS functions much as Joint Commission does.

Program: Central to an ideal trauma system are large, resource-rich trauma centers (Levels I and II**).** Optimal resources include immediate availability of board-certified emergency physicians, general surgeons, anesthesiologists, neurosurgeons, and orthopedic surgeons, as well as other board-certified specialists when their expertise is required. The elements of a trauma program include: (1) hospital organization; (2) medical staff support; (3) the trauma medical director; (4) the trauma resuscitation team; (5) the trauma service; (6) the trauma program manager; (7) the trauma registrars; (8) the performance improvement support personnel; and (9) the multidisciplinary trauma peer review committee of the performance improvement and patient safety program. Trauma centers must have an integrated, concurrent performance improvement and patient safety program to ensure optimal care and continuous improvement in care. The trauma program must involve multiple disciplines and transcend normal departmental hierarchies. Because optimal care extends from the scene of an injury through the acute care setting to discharge from a rehabilitation center, the trauma program should have appropriate specialty representation from all phases of care. Representatives of all disciplines provide the appropriate skills as team members' work in concert to implement treatment based on a plan of care. A trauma service represents the primary structure for providing care for injured patients. The service includes personnel and other resources necessary to ensure appropriate and efficient provision of care. In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers. Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification. A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff. The commitment and collaboration of these two bodies are necessary to facilitate the allocation of resources and the development of programs designed to improve the care of injured patients. According to ACS rules, this commitment must be reaffirmed by the System's Board of directors every three years.

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "NYC Health + Hospitals") to execute an amendment to extend its contract with Harris Computer Corporation ("Harris"), successor in interest of Quadramed, to continue operation, maintenance and support of NYC Health + Hospitals' legacy electronic medical record system, Quadramed, for a term of three-years with four (4) one-year renewals in an amount not to exceed $61,316,936.00

WHEREAS, New York City Health + Hospitals is undergoing a major upgrade to a new Epic electronic medical record ("EMR") system which is expected to be completed by the end of 2019; and

WHEREAS, it is critical to continue to operate, maintain and support the legacy EMR, Quadramed, throughout the Epic deployment for facilities that have not transitioned to Epic and remain on the legacy EMR;

WHEREAS, it is in the best interest of NYC Health + Hospitals to renew the contract with Quadramed for a minimum of three years (with four one-year renewal options); to maintain its current legacy EMR operations and allow the ability to meet any changing guidelines or regulations by Federal, NYS State and the City requirements while facilities are still live on Quadramed; and

WHEREAS, as each NYC Health + Hospitals facility becomes live on the EPIC EMR, the Quadramed EMR will revert to a read-only model, which will allow continued access to patient records as a reference assuring as close to continuity of care, as possible; and

WHEREAS, access to over twenty years of patient data is critical as NYC Health + Hospitals migrates from its legacy system, Quadramed to Epic, this extension will assure that all caregivers will continue to have access to the patient data throughout the extended contract term;

WHEREAS, NYC Health + Hospitals has contracted with a succession of parties that have owned Quadramed, the current owner is Harris; and

WHEREAS, the Senior Vice President of EITS will be responsible for the administration of this contract.

NOW, THEREFORE, BE IT

RESOLVED, the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") is hereby authorized to execute an amendment to extend its contract with Harris Computer Corporation ("Harris"), successor in interest of Quadramed, to continue maintenance and support of NYC Health + Hospitals' legacy electronic medical record system, Quadramed, for a term of three-years with four (4) one-year renewal options, in an amount not to exceed $61,316,936.00.

EXECUTIVE SUMMARY
AMENDMENT TO EXTEND THE AGREEMENT WITH HARRIS TO CONTINUE OPERATION AND SUPPORT OF THE QUADRAMED ELECTRONIC MEDICAL RECORD

Background

The New York City Health + Hospitals (H+H) currently uses proprietary software to support its legacy Electronic Medical Record (EMR). The firm selected to develop an automated system for HHC was solicited through an RFP issued in June 1989. The contract was awarded to Health Data Sciences (HDS) in 1991 to provide for the purchase of a perpetual software license, development, installation, training and maintenance of an automated EMR for H+H. In January 1999, the contract with HDS Corporation/d/b/a Per-Se Technologies for software maintenance, support, training and consultation services was extended through December 31, 2006. In July 2003, Misys Hospital Systems, Inc. (Misys) purchased Per-Se Technologies' Patient 1 product, the software and code that currently support HHC's EHR and renamed the product "Misys CPR". At that time, H+H agreed to accept the assignment of its contract and all related service agreements from Per-Se Technologies to Misys Hospital Systems, Inc. In July 2007 Quadramed Corporation announced it would be acquiring Misys Computerized Patient Record (now referred to as qCPR) and then in March 2010, Francisco Partners completed a private acquisition of Quadramed Corporation and again in 2013, it was acquired by Harris Computer Corporation. Currently, H+H is undergoing a major upgrade to a new EMR by Epic Systems (EPIC) which is expected to be completed by the end of 2019. It is in the best interest of the H+H to renew the contract with Quadramed for a minimum of three years (with two one-year renewal options). Currently, Quadramed is the only vendor with the staffing and expertise to support this Clinical Information System application. Execution of this contract will allow H+H the ability to maintain its current legacy EMR (qCPR) operations and continue to meet any changing guidelines/regulations for both Federal, State and City while facilities are still live on qCPR. As each H+H facility becomes live on the EPIC EMR the Quadramed EMR will revert to a read-only model. This read-only version will allow continued access to patient records as a reference assuring as close to continuity of care, as possible.

Costs

The total contract cost for three years including two one-year renewals is projected to be $50,882,209.00. As with the current contract, there is a baseline and included annual increases in the current rates for staffing, which are low by market standards, and annual increases in costs for support and maintenance. The cost savings associated with the 4th Amendment compared to the 3rd Amendment is considerable less than the prior contract by almost 50% based on a five-year comparison. This reduction is due primarily by leveraging a wind-down fee scale with an associated 60% savings when qCPR is converted to a read-only state as Epic goes live. In addition to this savings, Quadramed will offer identical maintenance support that it currently offers to all full production sites that are still using qCPR as the core EMR.

Benefits

As one of the early adopters of computerized patient records, the corporation has been among the leaders in the use of this technology to enhance patient safety, improve the quality and continuity of patient care and support improvements to the corporation's financial management. Access to over twenty years of patient data is critical as the Corporation migrates from its legacy system, Quadramed to Epic. This contract will assure all caregivers will continue to have access to the patient data throughout the next three to five years as H+H completes the installation of Epic at all facilities. This will also allow H+H the time necessary to continue utilizing qCPR for Long Term and Sub Acute care facilities as it concludes a decision regarding an electronic medical record for those care areas. An appreciated cost savings which is immediate upon contract signing for three Quadramed sites in 2018 with the remainder appreciating this cost savings in 2019 on Annual Support and Maintenance by a cost reduction over about 60% in comparison to the third amendment while maintaining 24/7 full support coverage by Quadramed.

NYC HEALTH+ HOSPITALS

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160 Water Street, 13th Fl, New York, NY 10038 Tel: (646) 458-2034

32216

Keith Tallbe
Associate Counsel, Director of Procurement
Legal Affairs, Supply Chain Services

TO: Mitchell Jacobs, Director
Procurement Systems/Operations
Division of Materials Management

FROM: Keith Tallbe KT

DATE: September 17, 2018

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Harris/Quadramed,** has submitted to the Supply Chain Services Diversity Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: _____ Project: Legacy EMR Services

Submitted by: Division of Materials Management

EEO STATUS:

1. [X] Approval Pending

2. [ ] Approved with follow-up review and monitoring

3. [ ] Not approved

4. [ ] Approved Conditionally - Subject to EEO Committee Review

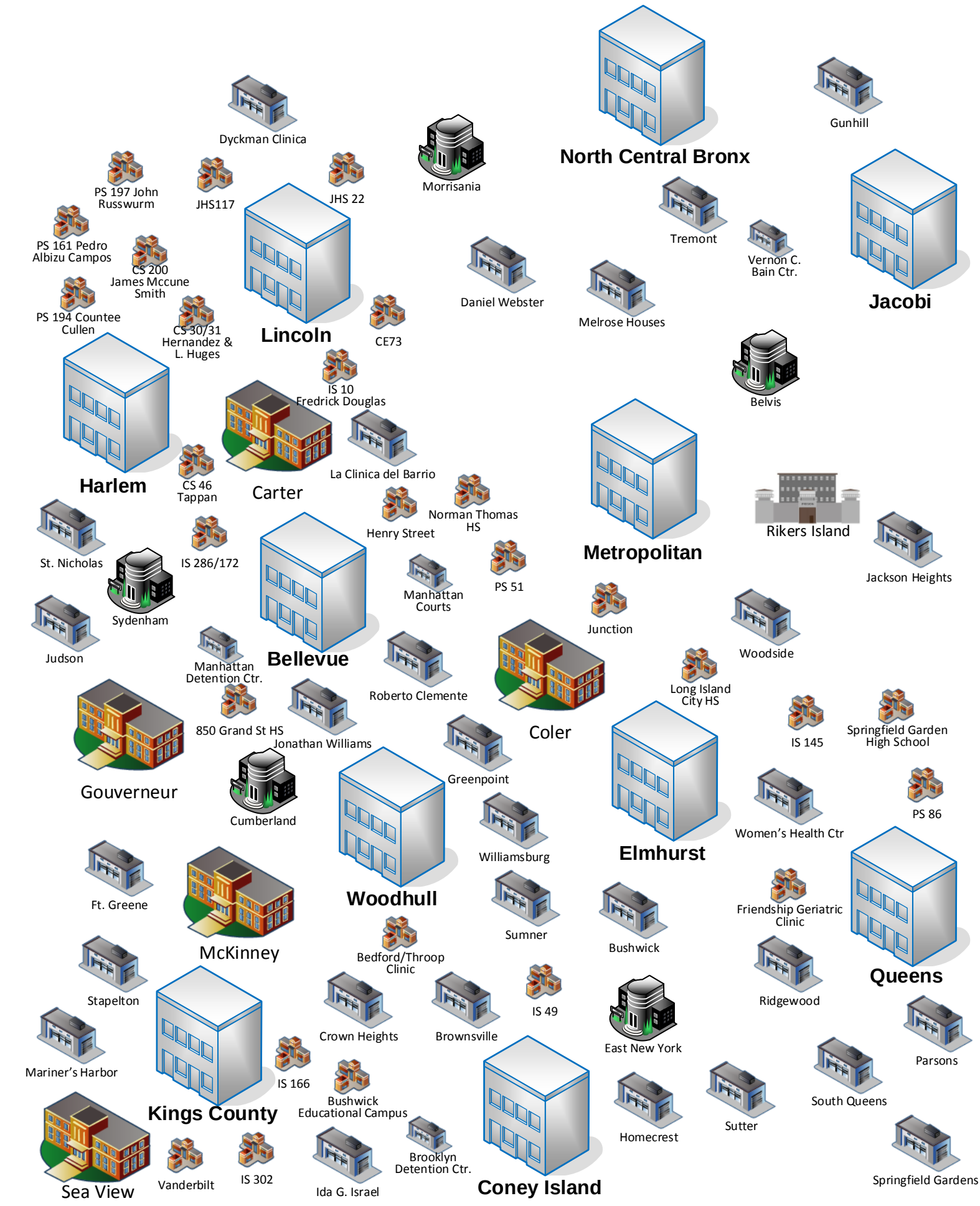
COMMENTS:

KT/srp

Cc: Jeremy Berman
Keith Tallbe
Mitchell Jacobs

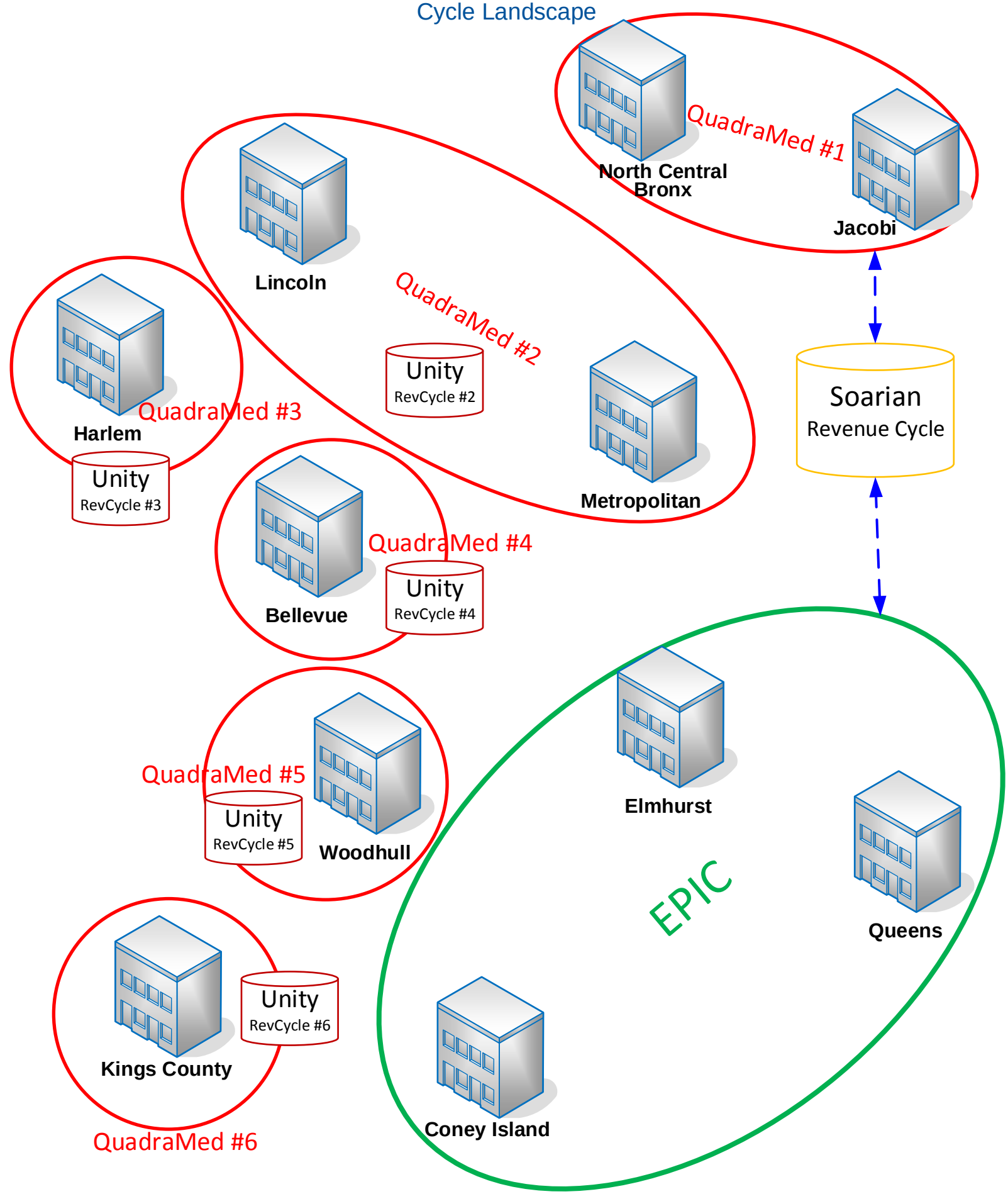
NYC H+H

Acute Facilities + Post Acute Care + Correctional Health Services+ Gotham Health Facilities



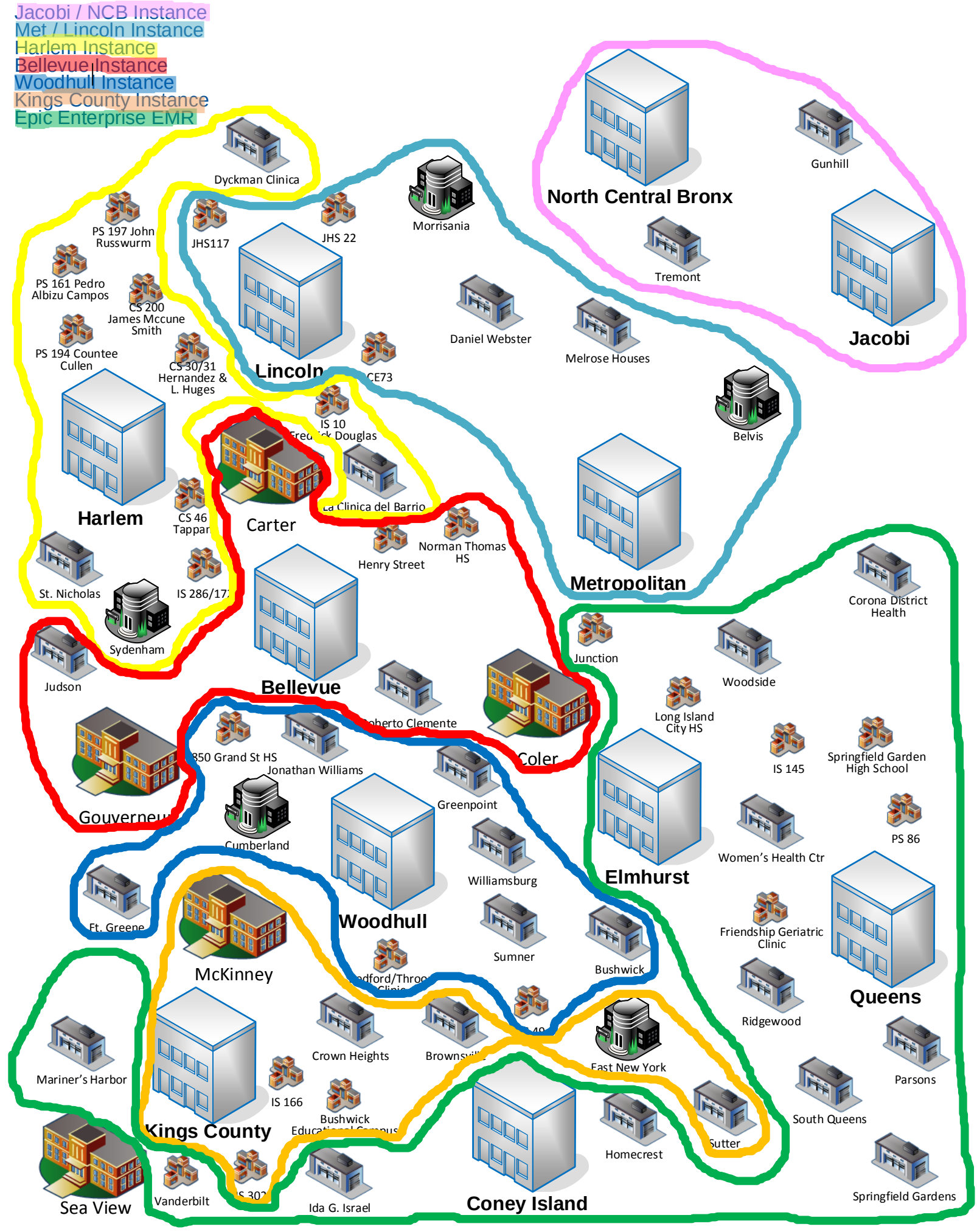
NYC H+H

Current Electronic Medical Record + Revenue Cycle Landscape



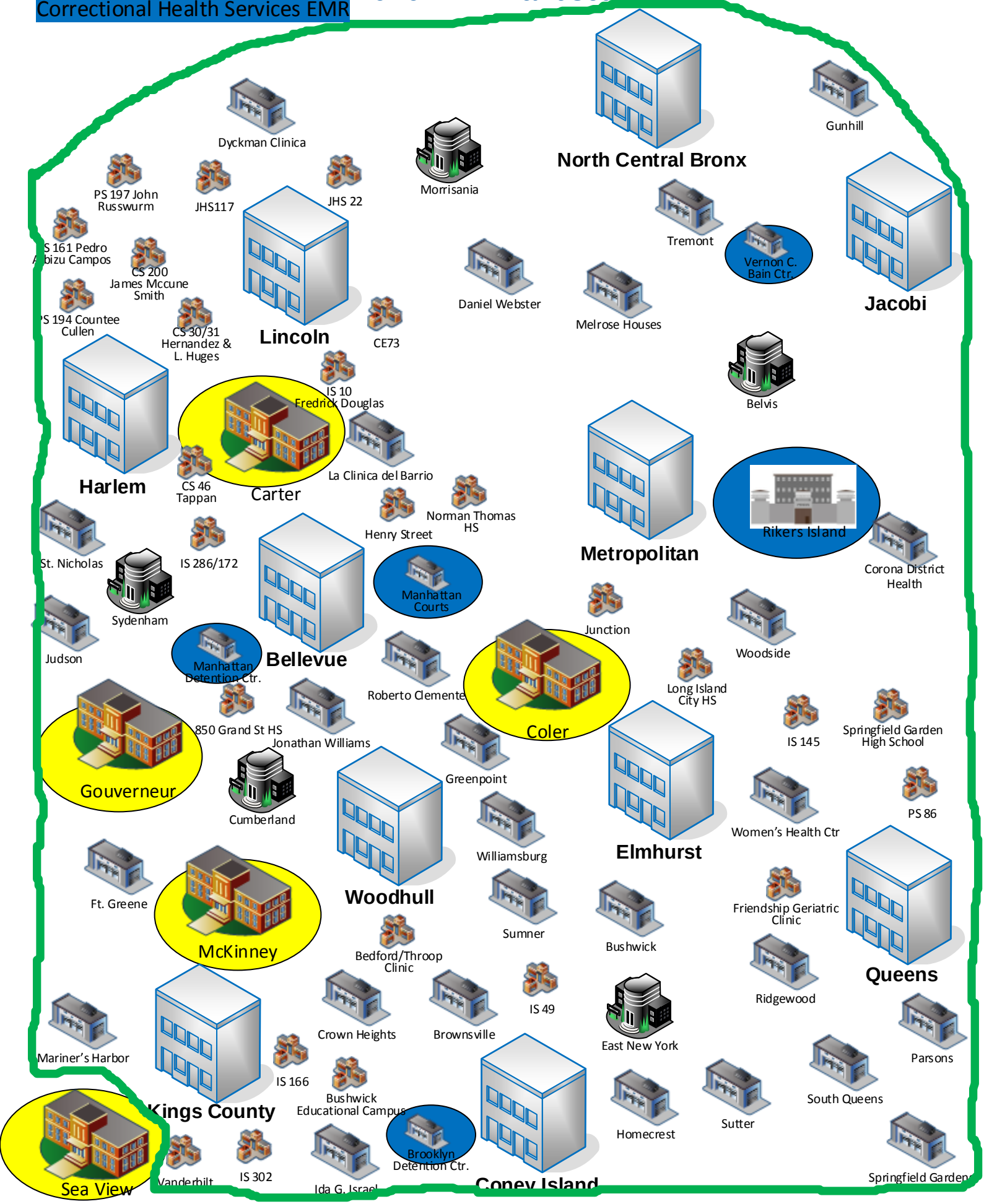
NYC H+H Epic and QuadraMed Instances

Jacobi / NCB Instance
Met / Lincoln Instance
Harlem Instance
Bellevue Instance
Woodhull Instance
Kings County Instance
Epic Enterprise EMR

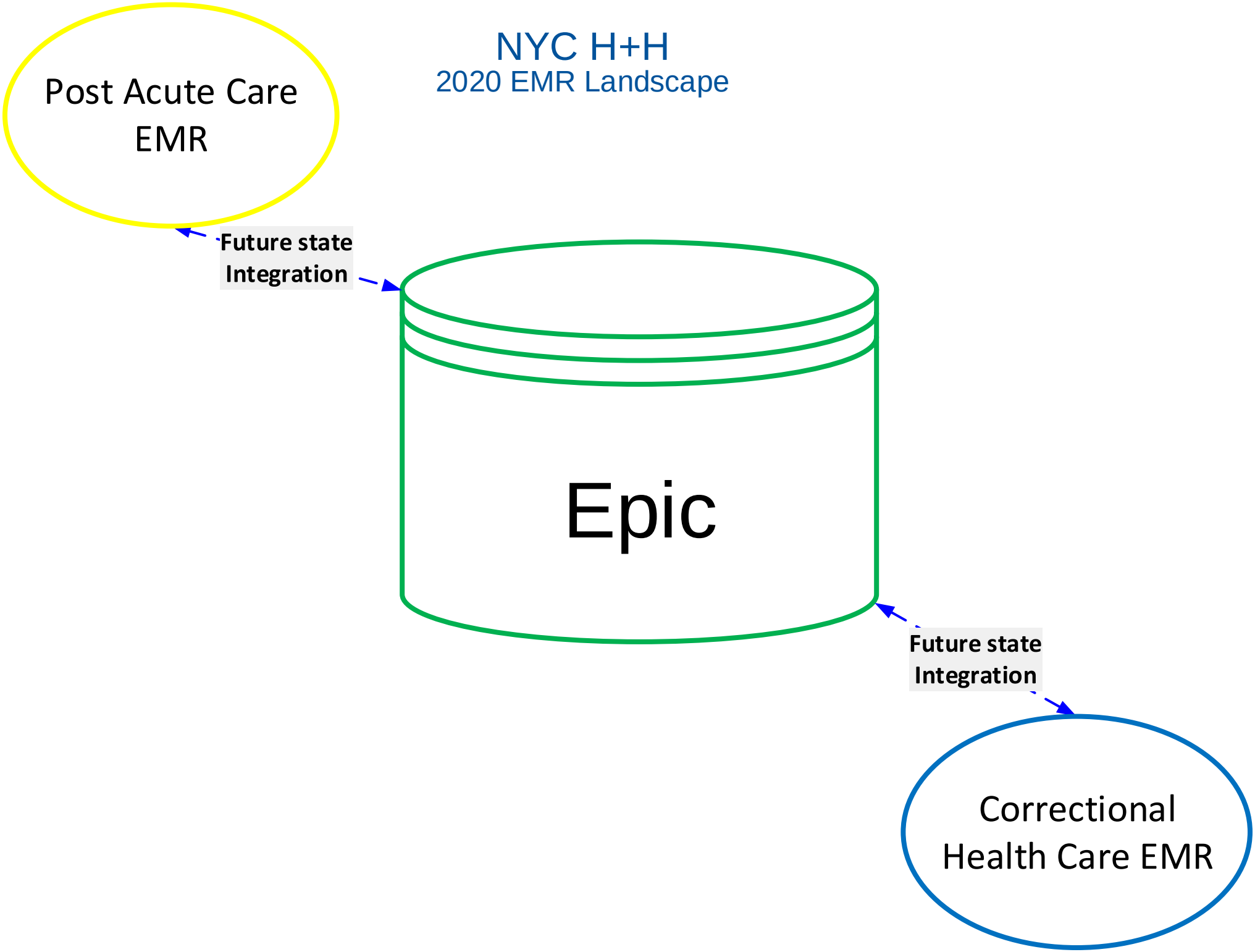


Epic Enterprise EMR
Post Acute Care EMR
Correctional Health Services EMR

NYC H+H
2020 EMR Landscape



NYC H+H
2020 EMR Landscape



Harris Healthcare/Quadramed

4th Amendment Contract
Board of Directors Meeting

September 20, 2018

Kevin Lynch
Senior Vice President
Chief Information Officer

Al Garofalo, DPM
Senior Assistant Vice President
Clinical Information Systems

Contract History

Date Executed	Agreement	Vendor
Sep 30, 1993	Master Contract	Health Data Science
Sep 28, 1999	1st Amendment	Per Se Technologies
July 01, 2006	2nd Amendment	MISYS Corporation
July 01, 2011	3rd Amendment	Quadramed
July 1, 2018	4th Amendment	*Harris Healthcare

* Harris HealthCare is a division of Harris Associates which includes Quadramed within their portfolio

Benefits & Risks

Benefits

- Assures all H + H providers will continue to have access to the Quadramed (qCPR) while the implementation of Epic at all facilities is completed.
- Assures all H + H providers post Epic Go-Live will have Read access to the patient record within qCPR.
- Appreciated savings upon contract signing for three qCPR sites (Queens, Elmhurst and Coney Island) using the Read-Only-Access pricing model. The remainder of the site will be appreciating this cost savings in 2019 as they go live with Epic.
- Permits the necessary time to review potential cost savings for a permanent archival solution to qCPR.

Risks

- The anticipated savings are directly aligned with each Epic Go-Live. A change in the EPIC timeline will result in a significant increase per quarter (60%) and a delay in the appreciation of these savings.
- The Read-Only rate includes a 60% discount based on timely payment of invoices. Failure to meet those requirements will result in only a 50% discount rate.

Additional Potential Savings

Our legacy EMR (qCPR) has been the source of truth for the patient medical record for over 25+years and the challenge ahead is to assure our care-teams continue to have access to this information post Epic. Our recent data indicates that over 7-10% of the users at our former Quadramed sites (Queens, Elmhurst and Coney Island) are still accessing Quadramed for patient information look-up. High utilizers include Medicine, Surgery, Nursing, Mental Health, Emergency, Obstetrics, Laboratory and Radiology,

Action Plan

Assembling a clinical workgroup consisting of CMIO's, CMO's and to review and recommend to;

- ✓ Continue currently with Quadramed post Epic Go-Live, in a Read-Only state with the assumption to Sun-Set the product in the future years as dependency on referencing the legacy medical record is no longer a factor.
- ✓ Continue with our current archival solution (Compass) making recommendations for enhancements which will allow for an earlier migration from qCPR or;
- ✓ Review alternate 3rd party Archival Vendors to determine if their product can meet the needs of H+H for a long term archival system.

Cost Breakdown

	Q3-18 Q2-19	Q3-19 Q2-20	Q2-20 Q3-21	Q3-21 Q2-22	Q3-22 Q2-23	Q3-23 Q2-24	Q2-24- Q3-25	Total
Maintenance Support Licenses	$11,889,305	$7,113,844	$5,881,312	4,723,560	4,809,092	$4,952,727	$5,101,962	**$44,471,805**
eRX Licenses	$2,700,000	2,085,750	$347,625	-	-	-	-	**$5,133,375**
Professional Services	$750,000	$772,500	$795,675	$819,545	$844,131	$869,455	$895,539	**$5,746,864**
LTC / Subacute Care Maintenance Support	$8,166	$53,527	$61,985	$63,817	$65,732	$67,704	$69,735	**$390,642**
Total with Contingency	$16,882,219	11,028,184	$7,795,228	$6,167,616	$6,290,853	$6,478,875	$6,673,961	**$61,316,936**

Contract Cost Comparison

Date Executed	Agreement	Vendor	Amount
Sep 30, 1993	Master Contract	Health Data Science	$40,923,393
Sep 28, 1999	1st Amendment	Per Se Technologies	$57,988,999
July 01, 2006	2nd Amendment	MISYS Corporation	$90,000,000
July 01, 2011	3rd Amendment	Quadramed	$137,589,936
July 1, 2018	4th Amendment	*Harris	$61,316,936

* Harris HealthCare is a division of Harris Associates which includes Quadramed within their portfolio

CRC Approval Request

- We are seeking approval to enter into contract with Harris for;
  - qCPR – Electronic Medical Record

  - Terms: Three Years with Four (1) year renewals
    July 1, 2018 through June 30, 2025

RESOLUTION

Authorizing the New York City Health and Hospitals Corporation (the "NYC Health + Hospitals") to execute an amendment to the Participation Agreement (the "Participation Agreement") with Northwell Health, Inc. ("Northwell") to support an amendment to the agreement (the "Cerner Agreement") between Northwell and Cerner Corporation ("Cerner") by which Cerner will provide implementation and support services to complete the installation and roll-out of the Cerner laboratory information system (the "LIS") across all of the NYC Health + Hospitals system with the resulting amendment to the Cerner Agreement increasing the total budgeted cost by $12,955,085 bringing the cost of such implementation and roll-out to a not to exceed total, inclusive of all expenses, of $34,379,677 over the period required for such implementation and roll-out currently estimated to be approximately June, 2020.

WHEREAS, pursuant to a resolution of the NYC Health + Hospitals' Board of Directors adopted in March 2013, NYC Health + Hospitals signed a joint venture agreement with Northwell (the "JV Agreement") to establish a joint venture for the operation of a joint laboratory; and

WHEREAS, the JV Agreement depended on various ancillary agreements to carry forward the joint venture purposes including the Participation Agreement which was signed simultaneously with the JV Agreement; and

WHEREAS, to fully participate with Northwell in the joint venture, NYC Health + Hospitals will need to order tests and get results using an NYC Health + Hospitals Cerner LIS which is interfaced with a Northwell Cerner LIS and the Participation Agreement permits NYC Health + Hospitals to participate with Northwell in the Cerner Agreement as if NYC Health + Hospitals' hospitals were Northwell hospitals with the additional cost to Northwell being passed on to NYC Health + Hospitals; and

WHEREAS, the roll-out of the Cerner LIS must proceed in coordination with the Epic roll-out as the two systems must work together and the original contractual arrangement had required the Cerner roll-out to follow the original Epic schedule; and

WHEREAS, with the change in the Epic roll-out schedule necessitated by the addition of the Epic Revenue Cycle modules, the roll-out of the Cerner LIS has had to be rescheduled and its configuration modified to include interfaces with Epic Revenue Cycle causing some work previously performed by Cerner to be extensively revised; and

WHEREAS, the Cerner LIS is already rolled out at Elmhurst, Queens and Coney Island Hospitals; and

WHEREAS, EITS and the lab management have determined, based on the prior roll-outs of the LIS, to contract for additional support and training services from Cerner through Northwell which will be reflected in the proposed amendment and accounts for a portion of the additional cost; and

WHEREAS, the Senior Vice President of EITS and the Senior Vice President and Chief Medical Officer will jointly be responsible for the administration of this contract.

NOW, THEREFORE, BE IT

RESOLVED, the New York City Health and Hospitals Corporation ("NYC Health + Hospitals") is hereby authorized to execute an amendment to the Participation Agreement with Northwell Health, Inc. ("Northwell") to support an amendment to the agreement between Northwell and Cerner Corporation ("Cerner") by which Cerner will provide implementation and support services to complete the installation and roll-out of the Cerner laboratory information system across all of the NYC Health + Hospitals system with the resulting amendment to the Cerner Agreement increasing the total budgeted cost by $12,955,085 bringing the cost of such implementation and roll out to a not to exceed total, inclusive of all expenses, of $34,379,677 over the period required for such implementation and roll-out, currently estimated to be approximately June, 2020.

EXECUTIVE SUMMARY
AMENDMENT TO AGREEMENT WITH NORTHWELL HEALTH INC.
AS TO ITS AGREEMENT WITH CERNER CORPORATION

Lab Background: In 2015 NYC Health + Hospitals entered into a joint venture with Northwell for shared hospital laboratory services. Under the Joint Venture Agreement, the parties created a new 501(e) hospital cooperative corporation to operate a joint laboratory. Several ancillary agreements were signed or negotiated for later signature as necessary to carry forward the purposes of the Joint Venture. Among these agreements were: an agreement establishing the governance of the new corporation, an agreement whereby NYC Health + Hospitals could lease some or all of its lab employees to Northwell, an agreement whereby NYC Health + Hospitals could send its lab tests to the existing Northwell lab at favorable prices pending the construction of a new joint lab and the Participation Agreement providing for NYC Health + Hospitals' hospitals to be treated as Northwell hospitals under Northwell's agreement with Cerner so that NYC Health + Hospitals can order lab work and receive results on the Cerner LIS which Northwell uses.

LIS Benefits The implementation of an LIS is key to NYC Health + Hospitals' laboratory initiative. An LIS will bring to laboratory operations the same kinds of benefits that will be obtained from NYC Health + Hospitals' adoption of an EMR: it will promote standardization and best practices and will permit visibility across the entire system. Having an LIS will impact every aspect of laboratory operations from outpatient primary care to our emergency departments. Currently, NYC Health + Hospitals is using multiple interfaces to connect to Northwell's Cerner system which impairs visibility and depresses our potential volume of tests that can be sent to Northwell.

Lab Status: Currently, NYC Health + Hospitals sends to Northwell approximately 1,347,514 lab specimens for testing which represents approximately 25% of NYC Health + Hospitals' total annual test volume. These tests are charged by Northwell to NYC Health + Hospitals at the same rates as Northwell charges its own hospitals which is substantially less than NYC Health + Hospitals had previously been paying when it sent its tests out to Quest. As a result, NYC Health + Hospitals pays less per year on lab tests than it had prior to the joint venture. The only costs of the joint venture that offset these savings are the costs of installing the LIS, however, as indicated above, an LIS would have had to be implemented in any event. The joint venture is planning to open its new state-of-the-art facilities in Little Neck Queens on or about October 2018 and in Lake Success in February 2019. The Joint Venture has been successful to date in achieving incremental savings, with full savings anticipated with the complete roll-out of the Cerner LIS and the opening of the two new lab buildings in 2019, and the shift in remaining outpatient volumes those developments will permit. Savings to date include $6 million from the shift of reference tests from Quest to Northwell. NYC Health + Hospitals has also benefited from reduced pricing for laboratory equipment and blood products through joint procurement processes. Personnel savings (through attrition) are anticipated as test volumes shift. Overall, *annual* laboratory expenditures are down by approximately $10 million from the 2012 baseline. .

LIS Background: The Cerner LIS has been already been implemented at Elmhurst, Queens and Coney Island Hospitals. The LIS roll-out has been delayed as has the Epic roll-out due to the determination to add the Epic Revenue Cycle module. With the addition of Epic Revenue Cycle, some implementation work already done by Cerner will have to be extensively modified.

Proposed Amendment: By suspending the original Epic and Cerner roll-out and redesigning the roll-out to include revenue cycle, costs have been added to the LIS part of the project. These costs are attributable, in part, to the need to rework some designs already prepared for implementation. Further costs are added to purchase additional implementation, training and support services based on NYC Health + Hospitals' experience with the Cerner LIS implementation at Elmhurst, Queens and Coney Island Hospitals.

With the proposed amendments, the proposed Cerner implementation and technical support costs to build, install and roll-out the LIS that will be charged to Northwell and then billed by Northwell to NYC Health + Hospitals will total $34,379,677inclusive of all expenses. This amount includes $12,955,085 additional costs

New Agreement With Cerner to go Into Effect after go Live is Complete or Advanced: NYC Health + Hospitals will want to restructure the current three-party agreement among Cerner, Northwell and NYC Health + Hospitals to become a bi-lateral agreement between Cerner and NYC Health + Hospitals. This will create a simplified structure that will facilitate administration avoid the possibility of redundancies. It is best not to attempt such restructuring during the early stages of the Cerner/Epic rollout due to the complexity of re-assigning to Cerner the support services now being performed by Northwell staff that are intimately familiar with the operation. This restructuring will be a priority once the Cerner rollout is complete or perhaps once it is completed at several facilities.

Future Financial Cost of New Cerner Agreement: When it is possible to restructure the current three-party agreement, the resulting agreement will include support services now reflected in the Amended three-party agreement and it will also include costs that Northwell currently invoiced to NYC Health + Hospitals. Among these costs are the cost of the licenses to Cerner proprietary software used in the LIS and certain support and training services currently provided by Northwell.

NYC HEALTH+ HOSPITALS

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32215

Keith Tallbe
Associate Counsel, Director of Procurement
Legal Affairs, Supply Chain Services

TO: Mitchell Jacobs, Director
Procurement Systems/Operations
Division of Materials Management

FROM: Keith Tallbe KT

DATE: September 17, 2018

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Northwell,** has submitted to the Supply Chain Services Diversity Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: _____ Project: Laboratory Services

Submitted by: Division of Materials Management

EEO STATUS:

1. [X] Approval Pending

2. [ ] Approved with follow-up review and monitoring

3. [ ] Not approved

4. [ ] Approved Conditionally - Subject to EEO Committee Review

COMMENTS:

KT/srp

Cc: Jeremy Berman
Keith Tallbe
Mitchell Jacobs

NYC HEALTH+ HOSPITALS

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Keith Tallbe
Associate Counsel, Director of Procurement
Legal Affairs, Supply Chain Services

32111A

TO: Mitchell Jacobs, Director
Procurement System Operations
Division of Materials Management

FROM: Keith Tallbe KT

DATE: April 20, 2017

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Cerner Health Services, Inc.** has submitted to the Supply Chain Diversity Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Central Office

Contract Number: _____

Project: Professional Services Agreement

Submitted by: Division of Materials Management

EEO STATUS:

1. [X] Approved

2. [ ] Conditionally Approved with follow-up review and monitoring

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

KT:srf

Cerner Laboratory Information Systems
Application to Approve an Amendment to the Participation Agreement with Northwell
Board of Directors Meeting
September 20, 2018

Kenra Ford
Senior Assistant Vice President
Laboratory Services

Al Garofalo, DPM
Senior Assistant Vice President
Clinical Information Services

Background

In 2015 NYC Health + Hospitals entered into an agreement for a joint venture with Northwell; per the agreement

- A. Health + Hospitals would send outpatient lab tests to the existing Northwell lab, pending construction of a new joint lab venture.
- B. The Joint Venture lab services will utilize Cerner LIS

Benefits

- The benefits of a Lab Information System (LIS) is a standardized, enterprise-wide model, encompassing all enterprise lab services with seamless integration to the joint venture laboratory.

EPIC Financials Timeline

- The Cerner LIS has been implemented at Elmhurst, Queens and Coney Island Hospitals; further build is necessary to align with the Epic financials.
- Based on prior experiences/"lessons learned" with the Cerner LIS implementation at Elmhurst, Queens and Coney Island Hospitals, additional services are needed for training and support services for the remaining facilities.
- Some of the build/implementation work already preformed by Cerner for remaining sites requires updating/modification, to alignment with revised Epic timeline.
- As a result of the above, the amendment to the Cerner Agreement will increase the total budgeted cost by $12,955,085 bringing the cost of such implementation and roll-out to a not to exceed total, inclusive of all expenses, of $34,379,677, thru the completed implementation date of June, 2020.

Future State Cerner Agreement

- Following the Epic and Cerner implementation:
  - Health + Hospitals will restructure the current three-party agreement (Cerner, Northwell and Health + Hospitals) to become a two party agreement (Cerner and Health + Hospitals), for the ongoing management of Cerner LIS services.

CRC Approval Request

- We are seeking approval to execute an amendment to the Participation Agreement (the "Participation Agreement") with Northwell Health, Inc. ("Northwell") by which:

  Cerner will provide implementation and support services to complete the installation and roll-out of the Cerner laboratory information system (the "LIS") across all of the NYC Health + Hospitals system, for a total budgeted cost by $12,955,085, bringing the total cost not to exceed $34,379,677, through June, 2020.

RESOLUTION

Authorizing New York City Health and Hospitals Corporation (the "System") to execute an agreement with Fusion, a division of Fusion Capital Management, to procure a Correctional Health specific electronic medical record for the System's Correctional Health Services division with primary care, pharmacy, specialty services, mental health and drug treatment in 11 NYC jails, with an initial term of three years with two one-year options to renew solely exercisable by the System and with total amount over the combined five-year term not to exceed $12,999,354 to pay Fusion.

WHEREAS, an application to issue a request for proposals was presented before the Contract Review Committee at its August 16, 2018 meeting and was approved by its approval letter dated August 16, 2018; and

WHEREAS, after the Office of Supply Chain Services issued a request for proposals, three (3) proposals were received and upon final evaluation by the Selection Committee, Fusion was rated the highest; and

WHEREAS, under the proposed agreement Fusion will install, configure and set up its Correctional EMR for Correctional Health Services by March 31, 2019; and

WHEREAS, Fusion will provide EMR and interface maintenance; and

WHEREAS, the proposed agreement for Fusion services will be managed by the Senior Vice President for Correctional Health Services.

NOW THEREFORE BE IT:

RESOLVED, that New York City Health and Hospitals Corporation be and hereby is authorized to execute an agreement with Fusion to purchase, install, configure and set up its EMR for the System's Correctional Health Services with a term of three years with two one-year options to renew solely exercisable by the System and with total amount over the combined five-year term not to exceed $12,999,354.

EXECUTIVE SUMMARY
RESOLUTION TO AUTHORIZE CONTRACT
WITH FUSION

BACKGROUND: The purpose of the proposed agreement is to replace Correctional Health Services electronic medical record vendor before it migrates to a web-based ambulatory product which would undermine the delivery of healthcare in the correctional environment. Conversion to a correctional specific vendor will improve efficiency and patient safety, and minimize the need for labor- and paper-intensive workarounds.

PROCUREMENT: The System issued a Request for Proposals on August 21, 2018. Proposer questions were accepted through August 23, 2018, 3pm. Three (3) proposals were received, evaluated and scored. Final evaluation and scoring was completed by August 31, 2018. Through this process the Selection Committee evaluated the proposals and presentations on the basis of the proposed EMR functionality, technical requirements and interoperability, previous experience, and cost. Fusion was selected on these criteria.

BUDGET: The cost of the proposed agreement will not exceed $12,999,354 over the full five year term. The costs consist of the System's projected payments to cover software purchase, installation, set up, interfaces, maintenance and annual license fees. The total amount has been budgeted and signed off by the Central Finance.

TERM: The term of the proposed agreement is three years with two one-year options to renew solely exercisable by the System.

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Keith Tallbe
Associate Counsel, Director of Procurement
Legal Affairs, Supply Chain Services

TO: Mitchell Jacobs, Director
Procurement Systems/Operations
Division of Materials Management

FROM: Keith Tallbe KT

DATE: August 31, 2018

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Fusion Capital Management, LLC,** has submitted to the Supply Chain Services Diversity Office a completed Contract Compliance Questionnaire and the appropriate EEO documents. This company is a:

[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Corporate-wide

Contract Number: _____ Project: Correctional Health Services (Electronic Medical Record Software)

Submitted by: Division of Materials Management

EEO STATUS:

1. [X] Approved

2. [ ] Approved with follow-up review and monitoring

3. [ ] Not approved

4. [ ] Approved Conditionally - Subject to EEO Committee Review

COMMENTS:

KT/srp

NYC HEALTH+ HOSPITALS

Correctional Health Services EHR Replacement

Presentation to Board of Directors
September 20, 2018

Patsy Yang, DrPH

Senior Vice President, CHS

NYC HEALTH+ HOSPITALS

Background on Current CHS EHR Vendor

- eClinicalWorks (eCW) has been CHS' EHR vendor since 2008
  - Selected by NYC DOHMH and had to be retrofitted for Correctional Health Services with myriad workarounds.

- With the transition to H+H, CHS identified the opportunity for an alternative EHR and secured funding for same.

- $155M eCW-DOJ settlement in 2017 for falsifying capabilities.

- eCW has since focused on a new web-based product.

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Limitations of Current EHR

Examples include:

- Providers must toggle between two different applications to determine accurate medications.
- In-jail prescriptions still require paper workarounds, increasing medication errors and requiring extra reporting and surveillance.
- Nursing workflows that consist of Standing Orders and recurring tasks within a single day are not supported (e.g. wound care, finger sticks, etc.).
- Additional staff resources must be used to monitor and flag critical labs and referrals.
- Workarounds required for prioritization, scheduling and call down.
- Generic and brand name drugs are separately listed.

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Correctional Health EHR Deliberation Timeline

Q2 2017

May: eCW $155m settlement with D.O.J for falsifying capabilities; EITS recommends CHS begin exploring alternatives

Q3 2017

July: CHS explores CH EHR market; invites EHR vendors to demo their products

September: Sandbox with CH EHR vendor

Q4 2017

November: CHS conducts 1st gap analysis with Epic; Too many gaps to be viable without significant customization

December: CHS, with EITS leadership, discuss EHR with interim H+H President and Special Advisor

Q1 2018

January: EITS and special advisor press eCW to address outstanding issues and stabilize EHR

March: CHS visits with Elmhurst Hospital Epic trainer to explore CHS workarounds; CHS and Epic Go Team meet for deeper evaluation of Epic, CHS gets sandbox access to Epic

Q2 2018

April-June: CHS and Epic Go Team continue to meet and explore Epic

May: eCW demos new ambulatory SaaS product requiring all new retrofits and workarounds for correctional health.

Development on existing product halted by eCW.

Q3 2018

July: Epic confirms its EHR is not a ready solution for CHS. EITS confirms it cannot take on another EPIC project until 2020 at the earliest.

August: CIO confirms CHS remaining with eCW is not a viable option; Supply Chain partners with CHS on solicitation process

Procurement Background

- **Historical spend.** $4.6M for the install and customization, ~$550k for annual license.
- **CRC Budget Authorization:**
  - One time capital expense of $6.468m for purchase of software, install, configuration, set up of interfaces and implementation.
  - Annual operating expense of $1.625m for annual maintenance, licensing, and interface support, FY20 through FY23.
  - FY19 operating expense of $30,000.

***Note**: Difference between annual expense historic vs. proposed explained by vast differences in EHR capabilities e.g. eCW lacks Nursing and Dental Modules, Bed Management, Group Notation, Infirmary Console.*

NYC HEALTH+ HOSPITALS

Overview of RFP Procurement Process

- CRC approved RFP request on 8/16/2018
- RFP posted 8/17/2018
- Proposer questions due 8/21/2018
- Submission deadline 8/30/2018
- 3 RFPs were received: Fusion, NextGen and Naphcare

Scope Requirements National Standards	Scope Requirements Correctional Health
• Clinical decision supports • Integration and interfacing • Interoperability • ONC-ACB certification • Order sets • Structured data • Med reconciliation	• Communication with DOC Inmate Information Management System • Ability to collect and report on federal, state and local regulatory and oversight requirements • Ability to follow patients and adjust pharmacy plan based on housing unit • Infirmary bed management with DOC daily list of approved medical devices • Suicide watch, aggressive patient, heat sensitive patient list updated by shift and sent to DOC • Transfer logic related to “turn-around” patients

Criteria for EHR RFP

Substantive Criteria

- EHR application functionality: 40%
- Proposed implementation plan: 25%
- Past experience with correctional health systems: 20%
- Cost: 15%

Evaluation Committee

- Dr. Al Garofalo, Sr. AVP, EITS
- Dr. Ross MacDonald, Sr. AVP/Chief Medical Officer, CHS
- Sara Gillen, Sr. AVP, CHS
- Jessica Laboy, AVP, CHS
- Jeffrey Herrera, Sr. Director, CHS
- Aaron Anderson, Sr. Director, CHS

NYC HEALTH+ HOSPITALS

Background on Selected Vendor

- Fusion is an Electronic Health Record system developed specifically for correctional settings.

- Current clients include over 150+ adult and juvenile corrections agencies, including:

  - Connecticut Department of Corrections
  - New Jersey Department of Corrections
  - Rhode Island Department of Corrections
  - Washington DC Department of Corrections
  - Harris County Jail (Houston, TX)

- Fusion is ONC-ACB 2015 Certified Electronic Health Record Technology as defined by the Office of the National Coordinator for Health Information Technology.

NYC HEALTH+ HOSPITALS

Fusion Contract Deliverables

- Fusion EHR, including medical, dental, and behavioral health
- Infirmary bed management
- Interface setup (JMS, pharmacy, radiology, labs, Healthix)
- Epic CareQuality integration with H+H
- Project Management
- Consulting and Go-Live
- Training
- Annual licensing and support for core product and all interfaces
- Professional support – 24/7/365

NYC HEALTH+ HOSPITALS

Impact of New EHR on H+H

- Fusion and Epic can communicate via the Carequality nationwide interoperability and integration framework for data exchange.
- No consultants or additional staff will be required. CHS clinical support staff will work with the new EHR vendor.
- Impact on EITS resources will be minimal. EITS will assist with initial provisioning of virtual servers and storage space already allocated to CHS in the Sungard Data Center for vendor setup. Routine server maintenance and support will then follow.
- CHS has been working closely with numerous EITS teams, most notably Dr. Garofalo and Mr. Lutz and their teams.

Approval Request

- We seek approval to enter into contract with Fusion as an interim solution to provide software, configuration, set up and maintenance in all Correctional Health Services sites:
  - Effective October 1, 2018
  - Three year initial and two one-year extensions
  - Comprehensive and complete correctional-focused EHR
  - Total not to exceed $12,999,354 for the five-year period
  - CHS has OMB approved capital and expense funding to replace the current EHR.

RESOLUTION

Adopting the attached Mission Statement, Performance Measures and additional information to be submitted on behalf of New York City Health and Hospitals Corporation ("NYC Health + Hospitals") for Fiscal Year 2018 to Office of the State Comptroller's Authorities Budget Office (the "ABO") as required by the Public Authorities Reform Act of 2009 (the "PARA").

WHEREAS, the Public Authorities Accountability Act was amended by the PARA to add additional reporting and oversight features; and

WHEREAS, the PARA requires local public authorities such as NYC Health + Hospitals to adopt each year a mission statement and performance measures to assist NYC Health + Hospitals in determining how well it is carrying out its mission; and

WHEREAS, the ABO requires reporting of NYC Health + Hospitals' mission and performance measures, as well as responses to certain questions on a form provided by that office and requires that the NYC Health + Hospitals Board of Directors read and understand the mission statement and the responses provided to the ABO; and

WHEREAS, NYC Health + Hospitals will post on its website the Mission Statement as hereby adopted; and

WHEREAS, the attached Mission Statement, Performance Measures and additional information supplied on the required ABO form will, once read, understood and adopted, comply with the requirements of the PARA as stated above and reflect the mission of NYC Health + Hospitals and the performance measures being used to measure its achievement of its mission;

NOW, THEREFORE, be it

RESOLVED that the attached Mission Statement, Performance Measures and additional information supplied on the required Office of the State Comptroller's Authorities Budget Office form are hereby adopted as required by the Public Authorities Reform Act of 2009.

AUTHORIZATION TO MAKE ANNUAL FILING
PURSUANT TO THE PUBLIC AUTHORITIES REFORM ACT

Executive Summary

NYC Health + Hospitals is required by the Public Authorities Reform Act of 2009 (the "PARA") to adopt and to report to the New York State Office of the State Comptroller's Authority Budget Office (the "ABO") each year a mission statement and performance measures to assist NYC Health + Hospitals to assess its success in carrying out its mission. The ABO also requires completion of a specific form as part of the annual reporting. Attached is the Mission Statement, Performance Measures and the responses to complete the ABO form, all of which require the Board's adoption.

NYC Health + Hospitals has made annual filings in compliance with the PARA since its adoption. There have been minor variations in the Mission Statement over these years but all have been refined versions of the purposes of NYC Health + Hospitals as expressed in its enabling act and in its By-Laws. The Mission Statement on the ABO form is the version that will be posted on the NYC Health + Hospitals' website.

AUTHORITY MISSION STATEMENT AND PERFORMANCE MEASUREMENTS

To extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services of the highest quality in an atmosphere of humane care, dignity and respect; To promote and protect, as both innovator and advocate, the health, welfare and safety of the people of the City of New York; To join with other health workers and with communities in a partnership which will enable each of our institutions to promote and protect health in its fullest sense -- the total physical, mental and social well-being of the people.

List of Performance Measures (as Reported July 2018)

		EXECUTIVE SPONSOR	REPORTING FREQUENCY	TARGET	ACTUAL FOR PERIOD	VARIANCE TO TARGET	PRIOR PERIOD	PRIOR YEAR SAME PERIOD
Increase Primary Care				FY 2018				
Unique primary care patients seen in last 12 months		VP PC	Annually	430,000	N/A	N/A	432,000	447,000
Access to Care				Q4 2018				
2	Number of e-consults completed/quarter	CPHO	Quarterly	11,000	9,745	1,225	8,090	4,790
Financial Sustainability								
3	Patient Care Revenue/Expenses	CFO + SVP MC	Quarterly	60%	56%	N/A	55%	53%
4	# insurance applications submitted/month	CFO + SVP MC	Quarterly	20,100	17,582	-12.5%	17,473	15,105
5	% of M+ medical spend at H+H	SVP MC	Quarterly	42%	39%	-3%	37%	36%
6	Total AR days per month (excluding in-house)	CFO	Monthly	45	45.3	+0.3	45.5	47.6
Information Technology								
7	Epic implementation milestones	CIO	Quarterly	100%	100%	0	100%	N/A
8	ERP milestones	CIO	Quarterly	100%	100%	0	100%	N/A
Quality and Outcomes				CY 2018				
9	Sepsis 3-hour bundle	CMO + CQO	Quarterly	63.5%	67.7%	+4.2%	61.88%	-
10	Follow-up appointment kept within 30 days after behavioral health discharge	CMO + CQO	Quarterly	66%	64.4%	-1.6%	N/A	N/A
11	HgbA1c control < 8	CPHO + VP PC	Quarterly	66.6%	63.9%	-2.7%	64.4%	64.4%
12	% Left Without Being Seen in EDs	CMO + CQO	Monthly	4%	7%	-3%%	-	6%
Care Experience				CY 2018				
13	Inpatient care - overall rating (Top Box)	CNO + SVP AC	Quarterly	65.4%	61.9%	-3.5%	60.8%	-
14	Ambulatory care (medical practice) – Recommend Provider Office (Top Box)	CNO + SVP AC + VP PC	Quarterly	83.6%	81.8%	-1.8%	82.1%	-
15	Post-acute care - likelihood to recommend (mean)	CNO + SVP PAC	Semi-Annually	84.3%	84.1%	-0.2%	83.7%	-
Culture of Safety				CY 2018				
16	Acute Care – Overall Safety Grade	CNO + CQO + SVP AC	Annually	76%	62%	-14%	59%	N/A
17	Post-Acute Care – Overall Safety Grade	CNO + CQO + SVP PAC	Annually	74%	72%	-2%	62%	N/A
18	Ambulatory (D & TC) – Overall Safety Grade	CNO + CQO + VP PC	Annually	50%	39%	-11%	41%	N/A

System Scorecard Glossary

Increase Primary Care			
1	Unique primary care patients seen in last 12 months	New metric	Measure of primary care growth and access; measures active patients only, period = FY 17
Access to Care			
2	Number of e-consults completed/quarter	New metric	Top priority initiative and measure of specialty access
Financial Sustainability			
3	Patient Care Revenue/Expenses	New metric	Measures patient care revenue growth and expense reduction adjusting for changes in city/state/federal policy or other issues outside H+H management's control
4	# insurance applications submitted/month	New metric	Top priority initiative and measure of efforts to convert self-pay to insured
5	% of M+ medical spend at H+H	New metric	Global measure of M+ efforts to steer patient volume to H+H, removes pharmacy and non medical spend
6	Total AR days/month (excluding in-house)	Retained metric	Unity/Soarian. Total AR days, excluding in-house
Information Technology			
7	Epic implementation milestones	Updated metric	Reflects updated deployment schedule: Enterprise validation and build + four acute care + one ambulatory facility live; testing and training at two other acute care and two ambulatory facilities on track.
8	ERP on track	New metric	Reflects key milestones in finance/supply chain go live, human capital management upgrade, and payroll project design
Quality and Outcomes			
9	Sepsis 3-hour bundle	Retained metric	NYSDOH Quarterly Facility Sepsis Report-aggregated to reflect a system score
10	Follow-up appointment kept within 30 days after behavioral health discharge	Retained metric	Follow-up appointment kept with-in 30 days after behavioral health discharge as reported by the MCO (Emblem & MetroPlus) data for VBP QIP submission
11	HgbA1c control < 8	New metric	Population health measure for diabetes control
12	% Left Without Being Seen in EDs	New metric	Measure of ED efficiency and safety
Care Experience			
13	Inpatient care - overall rating (Top Box)	Retained metric	Aggregate system-wide Acute Care/Hospital score HCAHPS Rate the Hospital 0-10 (Top Box)
14	Ambulatory care (medical practice) - Recommend Provider Office (Top Box)	Retained metric	Aggregate system-wide Acute Care/Hospital score HCAHPS Rate the Hospital 0-10 (Top Box)
15	Post-acute care - likelihood to recommend (mean)	Retained metric	Press Ganey Survey. Likelihood to recommend (mean)
Culture of Safety			
16	Acute Care – Overall Safety Grade	New metric	Measure of patient safety, quality of care, and staff psychological safety
17	Post-Acute Care – Overall Safety Grade	New metric	Measure of patient safety, quality of care, and staff psychological safety
18	Ambulatory (D & TC) – Overall Safety Grade	New metric	Measure of patient safety, quality of care, and staff psychological safety

ADDITIONAL QUESTIONS:

1. Have the board members acknowledged that they have read and understood the mission of the public authority?

Yes.

2. Who has the power to appoint the management of the public authority?

Pursuant to the legislation that created NYC Health + Hospitals, the President is chosen by the members of the Board of Directors from persons other than themselves and serves at the pleasure of the Board. (Unconsolidated Law, section 7394)

3. If the Board appoints management, do you have a policy you follow when appointing the management of the public authority?

The Governance Committee to the Board of Directors has, among its responsibilities, the duty to receive, evaluate and report to the Board of Directors with respect to the submissions of appointments of corporate officers.

4. Briefly describe the role of the Board and the role of management in the implementation of the mission.

In addition to standing and special committees which have defined subject matter responsibilities and which meet monthly or quarterly, the Board of Directors meets monthly to fulfill its responsibility as the governing body of NYC Health + Hospitals and its respective facilities as required by law and regulation by the various regulatory and oversight entities that oversee NYC Health + Hospitals. Corporate by-laws and established policies outline the Board's participation in the oversight of the functions designated to management in order to ensure that NYC Health + Hospitals can achieve its mission in a legally compliant and fiscally responsible manner.

5. Has the Board acknowledged that they have read and understood the responses to each of these questions?

Yes.

AUTHORIZATION TO MAKE ANNUAL FILING PURSUANT TO THE PUBLIC AUTHORITIES REFORM ACT

NYC Health + Hospitals
Meeting of the Board of Directors
September 20, 2018
Presented by Andrea Cohen, General Counsel
Eric Wei, Vice President, Chief Quality Officer

Requirements for Filing

- NYC Health + Hospitals is subject to the Public Authorities Accountability Act (PAAA) which establishes minimum best governance practices for public entities.

- In 2009, the PAAA was amended by the Public Authorities Reform Act (PARA) which added various explicit reporting obligations for public authorities to ensure compliance with the PAAA.

- PARA requires that an annual statement be adopted by the board of directors of each authority subject to PARA that sets out the mission of the entity and the performance indicators that will be used to measure advancement of the mission. PARA also requires that a PARA form be completed. The mission statement, performance measures and completed PARA form are to be adopted annually by the NYC Health + Hospitals Board and then filed with the State.

- The filing deadline with the State is October 1 of each year.

MISSION STATEMENT

To extend equally to all New Yorkers, regardless of their ability to pay, comprehensive health services of the highest quality in an atmosphere of humane care, dignity and respect; To promote and protect, as both innovator and advocate, the health, welfare and safety of the people of the City of New York; To join with other health workers and with communities in a partnership which will enable each of our institutions to promote and protect health in its fullest sense -- the total physical, mental and social-well being of the people.

Notes:

- Mission statement is unchanged from version adopted by the Board on October 26, 2017 and currently included on our website.
- There have been minor variations on the Mission Statement over the years. All are refined versions of the purposes of NYC Health + Hospitals as expressed in the legislation which created NYC Health + Hospitals in its By-laws.
- Performance measures on the following pages are the same as those presented to the Board and the Strategic Planning Committee in July 2018.

NYC HEALTH + HOSPITALS

List of Performance Measures (as Reported July 2018)

		EXECUTIVE SPONSOR	REPORTING FREQUENCY	TARGET	ACTUAL FOR PERIOD	VARIANCE TO TARGET	PRIOR PERIOD	PRIOR YEAR SAME PERIOD
Increase Primary Care				FY 2018				
Unique primary care patients seen in last 12 months		VP PC	Annually	430,000	N/A	N/A	432,000	447,000
Access to Care				Q4 2018				
2	Number of e-consults completed/quarter	CPHO	Quarterly	11,000	9,745	1,225	8,090	4,790
Financial Sustainability								
3	Patient Care Revenue/Expenses	CFO + SVP MC	Quarterly	60%	56%	N/A	55%	53%
4	# insurance applications submitted/month	CFO + SVP MC	Quarterly	20,100	17,582	-12.5%	17,473	15,105
5	% of M+ medical spend at H+H	SVP MC	Quarterly	42%	39%	-3%	37%	36%
6	Total AR days per month (excluding in-house)	CFO	Monthly	45	45.3	+0.3	45.5	47.6
Information Technology								
7	Epic implementation milestones	CIO	Quarterly	100%	100%	0	100%	N/A
8	ERP milestones	CIO	Quarterly	100%	100%	0	100%	N/A
Quality and Outcomes				CY 2018				
9	Sepsis 3-hour bundle	CMO + CQO	Quarterly	63.5%	67.7%	+4.2%	61.88%	-
10	Follow-up appointment kept within 30 days after behavioral health discharge	CMO + CQO	Quarterly	66%	64.4%	-1.6%	N/A	N/A
11	HgbA1c control < 8	CPHO + VP PC	Quarterly	66.6%	63.9%	-2.7%	64.4%	64.4%
12	% Left Without Being Seen in EDs	CMO + CQO	Monthly	4%	7%	-3%%	-	6%
Care Experience				CY 2018				
13	Inpatient care - overall rating (Top Box)	CNO + SVP AC	Quarterly	65.4%	61.9%	-3.5%	60.8%	-
14	Ambulatory care (medical practice) – Recommend Provider Office (Top Box)	CNO + SVP AC + VP PC	Quarterly	83.6%	81.8%	-1.8%	82.1%	-
15	Post-acute care - likelihood to recommend (mean)	CNO + SVP PAC	Semi-Annually	84.3%	84.1%	-0.2%	83.7%	-
Culture of Safety				CY 2018				
16	Acute Care – Overall Safety Grade	CNO + CQO + SVP AC	Annually	76%	62%	-14%	59%	N/A
17	Post-Acute Care – Overall Safety Grade	CNO + CQO + SVP PAC	Annually	74%	72%	-2%	62%	N/A
18	Ambulatory (D & TC) – Overall Safety Grade	CNO + CQO + VP PC	Annually	50%	39%	-11%	41%	N/A

System Scorecard Glossary

Increase Primary Care			
1	Unique primary care patients seen in last 12 months	New metric	Measure of primary care growth and access; measures active patients only, period = FY 17
Access to Care			
2	Number of e-consults completed/quarter	New metric	Top priority initiative and measure of specialty access
Financial Sustainability			
3	Patient Care Revenue/Expenses	New metric	Measures patient care revenue growth and expense reduction adjusting for changes in city/state/federal policy or other issues outside H+H management's control
4	# insurance applications submitted/month	New metric	Top priority initiative and measure of efforts to convert self-pay to insured
5	% of M+ medical spend at H+H	New metric	Global measure of M+ efforts to steer patient volume to H+H, removes pharmacy and non medical spend
6	Total AR days/month (excluding in-house)	Retained metric	Unity/Soarian. Total AR days, excluding in-house
Information Technology			
7	Epic implementation milestones	Updated metric	Reflects updated deployment schedule: Enterprise validation and build + four acute care + one ambulatory facility live; testing and training at two other acute care and two ambulatory facilities on track.
8	ERP on track	New metric	Reflects key milestones in finance/supply chain go live, human capital management upgrade, and payroll project design
Quality and Outcomes			
9	Sepsis 3-hour bundle	Retained metric	NYSDOH Quarterly Facility Sepsis Report-aggregated to reflect a system score
10	Follow-up appointment kept within 30 days after behavioral health discharge	Retained metric	Follow-up appointment kept with-in 30 days after behavioral health discharge as reported by the MCO (Emblem & MetroPlus) data for VBP QIP submission
11	HgbA1c control < 8	New metric	Population health measure for diabetes control
12	% Left Without Being Seen in EDs	New metric	Measure of ED efficiency and safety
Care Experience			
13	Inpatient care - overall rating (Top Box)	Retained metric	Aggregate system-wide Acute Care/Hospital score HCAHPS Rate the Hospital 0-10 (Top Box)
14	Ambulatory care (medical practice) - Recommend Provider Office (Top Box)	Retained metric	Aggregate system-wide Acute Care/Hospital score HCAHPS Rate the Hospital 0-10 (Top Box)
15	Post-acute care - likelihood to recommend (mean)	Retained metric	Press Ganey Survey. Likelihood to recommend (mean)
Culture of Safety			
16	Acute Care – Overall Safety Grade	New metric	Measure of patient safety, quality of care, and staff psychological safety
17	Post-Acute Care – Overall Safety Grade	New metric	Measure of patient safety, quality of care, and staff psychological safety
18	Ambulatory (D & TC) – Overall Safety Grade	New metric	Measure of patient safety, quality of care, and staff psychological safety

State Comptroller's Authorities Budget Office
Form of Questions with Answers

- Have the board members acknowledged that they have read and understood the mission of the public authority? – **Yes**

- Who has the power to appoint the management of the public authority? – **By unconsolidated law, Section 7394 the President is chosen by the Members of the Board of Directors from persons other than themselves and serves at the pleasure of the Board**

- If the Board appoints management, do you have a policy you follow when appointing the management of the public authority? – **The Board of Directors Governance Committee has, among its responsibilities, the duty to receive, evaluate and report to the Board of Directors with respect to the submissions of appointments of Corporate Officers.**

- Briefly describe the role of the Board and the role of the management in the implementation of the mission. **- In addition to standing and special committee which have defined subject matter responsibilities and which meet monthly or quarterly, the Board of Directors meets monthly to fulfill its responsibility as the governing body of NYC Health + Hospitals and its respective facilities as required by law and regulation by the Various regulatory and oversight entities that oversee NYC Health + Hospitals. Corporate By-laws and established policies outline the Board's participation in the oversight of the functions designated to management in order to ensure that NYC Health + Hospitals can achieve its mission in a legally compliant and fiscally responsible manner.**

- Has the Board acknowledged that they have read and understood the responses to each of these questions? **– Yes**