

BOARD OF DIRECTORS MEETING
THURSDAY, JULY 25, 2013
A-G-E-N-D-A

<p>Call to Order - 4 pm</p>	<p>Dr. Stocker</p>
<p>1. Adoption of Minutes: June 27, 2013</p>	
<p><u>Chairman's Report</u></p>	<p>Dr. Stocker</p>
<p><u>President's Report</u></p>	<p>Mr. Aviles</p>
<p>>>Action Items<<</p>	
<p><u>Corporate</u></p> <p>2. RESOLUTION authorizing and approving its adoption to provide for the financing of equipment in an aggregated outstanding principal amount not to exceed \$40,000,000 from time to time for the purpose of financing equipment and various related capital projects and expenditures at the Corporation's facilities. <i>(Finance Committee – 7/09/2013)</i></p>	<p>Mr. Rosen</p>
<p><u>Multi-Network</u></p> <p>3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with Surgical Solutions, LLC to provide laparoscopic/endoscopic video equipment and other instruments, repair services, disposable supplies and preoperative, postoperative support services to Bellevue Hospital Center, Elmhurst Hospital Center and Kings County Hospital Center for a term of two (2) years with two additional two (2) year options solely exercisable by the Corporation in an amount not to exceed \$31,484,013 including an 8% contingency of \$2,332,149. <i>(Capital Committee – 7/18/2013) EEO: / VENDEX: Approved</i></p>	<p>Ms. Youssouf</p>
<p>4. RESOLUTION ratifying the engagement by the President of the New York City Health and Hospitals Corporation of Parson Brinkerhoff and Arcadis to each provide specialized engineering services to assess storm damage, estimate replacement costs, assess hazard mitigation opportunities, propose and design such work, develop cost benefit analysis' for the projects and to advise the Corporation in its application for reimbursement by the Federal Emergency Management Agency – FEMA, the State of New York and from Community Development Block Grants for Hurricane Sandy related repairs at a cost of not more than \$5 million and authorizing the President to increase the funding for such engagements by an additional \$6 million to make the total funding for the work \$11 million. <i>(Emergency Engagement Reported by the President – 3/21/2013 Board Meeting)</i> <i>EEO: Parsons Brinkerhoff-Approved; Arcadis-Pending / VENDEX: Pending</i></p>	<p>Ms. Youssouf</p>
<p><u>South Manhattan Health Network</u></p> <p>5. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a license agreement with the New York Legal Assistance Group for its continued use and occupancy of space at Coler/Goldwater Specialty Hospital and Nursing Facility to provide <i>pro bono</i> legal services to facility residents and patients, and training to Corporation staff. <i>(Capital Committee – 7/18/2013)</i> VENDEX: Pending</p>	<p>Ms. Youssouf</p>
<p>6. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to surrender to the City of New York a parcel of land and buildings, Block 1373, Lot 20, located on the campus of Goldwater Specialty Hospital and Nursing Facility, One Main Street, Roosevelt Island, New York. <i>(Public Hearing – 7/11/2013 & Capital Committee – 7/18/2013)</i></p>	<p>Ms. Youssouf</p>
<p><u>Southern Brooklyn/Staten Island Health Network</u></p> <p>7. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a license agreement with the New York City Department of Housing Preservation and Development – HPD for the Corporation's use and occupancy of Block 7061, Lots 16, 39, 40, 41, 42, 43, 44 and 45 in the Coney Island area of Brooklyn for the Corporation's operation of a temporary primary medical clinic in a pre-fabricated structure under which the Corporation will not have to make any payments to HPD. <i>(Capital Committee – 7/18/2013)</i></p>	<p>Ms. Youssouf</p>
<p align="right"><i>(over)</i></p>	

**BOARD OF DIRECTORS MEETING
THURSDAY, JULY 25, 2013 ~ AGENDA ~ PAGE 2**

<p><u>Committee Reports</u></p> <ul style="list-style-type: none">➤ Capital➤ Finance➤ Medical & Professional Affairs / Information Technology➤ Strategic Planning <p><u>Subsidiary Board</u></p> <ul style="list-style-type: none">➤ MetroPlus Health Plan, Inc. <p><u>Facility Governing Body / Executive Session</u></p> <ul style="list-style-type: none">➤ Elmhurst Hospital Center <p><u>Semi-Annual Reports (Written Submission)</u></p> <ul style="list-style-type: none">➤ Kings County Hospital Center➤ Dr. Susan Smith McKinney Nursing & Rehabilitation Center <p>>>Old Business<< >>New Business<<</p> <p>Adjournment</p>	<p>Ms. Youssouf Mr. Rosen Dr. Stocker Mrs. Bolus</p> <p>Mr. Rosen</p> <p>Dr. Stocker</p>
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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (hereinafter the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 27th of June 2013 at 4:00 P.M., pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Michael A. Stocker
Mr. Alan D. Aviles
Josephine Bolus, R.N.
Dr. Jo Ivey Boufford
Dr. Vincent Calamia
Ms. Anna Kril
Rev. Diane E. Lacey
Mr. Robert F. Nolan
Mr. Bernard Rosen
Ms. Emily A. Youssef

Ian Hartman O'Connell was in attendance representing Deputy Mayor Linda Gibbs; Dr. Amanda Parsons was in attendance representing Commissioner Thomas Farley; Linda Hacker was in attendance representing Commissioner Robert Doar; and Dr. Gerald Cohen was in attendance representing Executive Deputy Commissioner Adam Karpati, each in a voting capacity. Dr. Stocker chaired the meeting and Mr. Salvatore J. Russo, Secretary to the Board, kept the minutes thereof.

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on May 30, 2013 were presented to the Board. Then, on motion made by Mrs. Bolus and duly seconded, the Board unanimously adopted the minutes.

1. **RESOLVED**, that the minutes of the meeting of the Board of Directors held on May 30, 2013, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

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

Dr. Stocker informed the Board that there will be a public hearing on Thursday, July 11th at Goldwater Specialty Hospital concerning the transfer of the Goldwater Hospital land and building to the City of New York.

Dr. Stocker announced that the Corporation is looking at ways to improve the Corporation's ability to project and control construction expenses at the facilities as referenced in the attached report.

PRESIDENT'S REPORT

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

ACTION ITEMS

RESOLUTION

2. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute an **Affiliation Agreement** with the **State University of New York/Health Science Center at Brooklyn** for the provision of General Care and Behavioral Health Services at **Kings County Hospital Center** for a period of three years, commencing July 1, 2013 and terminating on June 30, 2016, consistent with the general terms and conditions and for the amounts as indicated in Attachment A; AND further authorizing the President to make adjustments to the contract

amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five (25%) of the amounts set forth in Attachment A.

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

RESOLUTION

3. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute an **Affiliation Agreement** with the **Staten Island University Hospital** for the provision of General Care and Behavioral Health Services at **Sea View Hospital Rehabilitation Center and Home** for a period of three years, commencing July 1, 2013 and terminating on June 30, 2016, consistent with the general terms and conditions and for the amounts, as indicated in Attachment A; AND further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

Dr. Stocker moved the adoption of the resolution which was duly seconded and adopted by the Board with 13 in favor. Dr. Calamia recused himself.

RESOLUTION

4. Authorizing the President of the New York City Health and Hospitals Corporation to **purchase Cisco SMARTnet maintenance** through a **NYS Office of General Services contract** from Cisco's authorized reseller, **Dimension Data North America, Inc.** in an amount not to exceed \$22,080,000, including a 15% contingency, over the term of three years.

Sal Guido, Assistant Vice President, Infrastructure Services, provided an overview to the Board of the maintenance contract. In response to Ms. Youssouf's question regarding

increases in services and costs, Mr. Guido explained that increases result from the new Henry J. Carter facility, as well as several other HHC facilities requiring new equipment.

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

RESOLUTION

5. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with **IBM Corporation** for the **procurement of a performance analytics/business intelligence platform**. The contract will be for an amount not to exceed \$10,054,721 for an initial term of one year, with three (1) one-year renewal options, exercisable solely by the Corporation.

Bert Robles, Assistant Vice President and Chief Information Officer, explained that the contract offers the Corporation an increased ability to improve reporting capabilities corporation-wide. HHC has approximately 1,800 databases and the volume of information generated would be managed in a structured environment that will simplify and improve the quality of how information is generated and reported. The goal is to be able to provide better care, better outcomes and reduce costs to the Corporation.

In response to Ms. Youssouf's question as to why more systems are necessary to support systems currently in place, Paul Contino, Chief Technology Officer, Information Services, explained that the distribution of data is an important component to the success of the Corporation's goals. Mr. Aviles also stated that the Corporation is attempting to integrate

operational, clinical and financial data in ways that give us more timely and more accurate results of reporting, in addition to alleviating a great deal of manual labor.

Dr. Stocker moved the adoption of the resolution which was duly seconded and adopted by the Board by a vote of 12 in favor with Ms. Youssouf and Mr. Nolan abstaining.

RESOLUTION

6. Authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract with **Allscripts Healthcare LLC** for a **web-based case management, and denials management and discharge planning software solution** accessible throughout the Corporation's acute-care and long-term care facilities for a three (3) year term with two (2) one year renewal options, exercisable solely by the Corporation, in an amount not to exceed \$5,201,255.

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

RESOLUTION

7. Authorizing the President of the New York City Health and Hospitals Corporation to execute **construction requirements contracts** with six (6) firms: **Gridspan Corporation; Vastech Contracting Corporation; Volmar Construction, Inc; Sierra Mechanical Contracting, Inc; Jemco Electrical Contractors, Inc; and Charan Electrical Enterprise, Inc.** to provide **construction services on an as-needed basis** at various facilities throughout the Corporation. 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 \$36 million.

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

RESOLUTION

8. Authorizing the President of the New York City Health and Hospital Corporation to Execute **construction requirements contracts** with four (4) firms: **Par Plumbing Co., Inc; Richard**

Plumbing and Heating Co., Inc; Empire Control Abatement, Inc.; and New York Environmental Systems, Inc., to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$2,000,000. The total authorized value of these contracts is \$8 million.

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

RESOLUTION

9. Authorizing the President of the New York City Health and Hospitals Corporation to **modify the scope and budget** for the **existing Boiler Plant project at Coney Island Hospital** to add an additional \$2,935,845, increasing the total project budget to an amount not to exceed \$9.94 million.

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

RESOLUTION

10. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable **license agreement** with the **American Academy McAllister Institute of Funeral Services** for its use and occupancy of space to provide instruction in the techniques of mortuary science on the campus of **Harlem Hospital Center**.

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

RESOLUTION

11. Authorizing the President of the New York City Health and Hospitals Corporation to execute a revocable **license agreement** with the **American Cancer Society, Eastern Division, Inc.**, for its continued use and occupancy of space to provide non-clinical patient support services on the campuses of **Elmhurst Hospital and Queens Hospital Centers**.

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

BOARD COMMITTEE AND SUBSIDIARY BOARD REPORTS

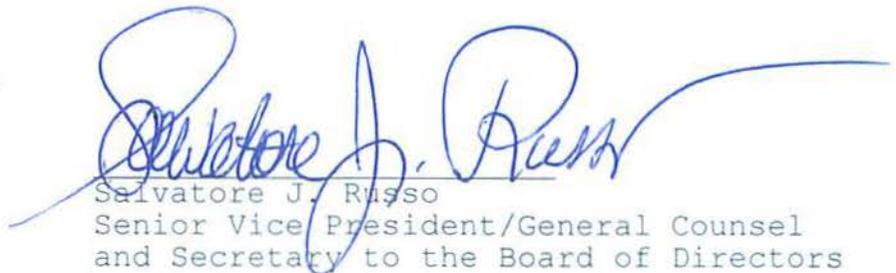
Attached hereto is a report of the HHC Board Committees that have been convened since the last meeting of the Board of Directors. The reports were received by the Chairman at the Board meeting.

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Stocker reported that the Board of Directors as the governing body of Queens Hospital Center discussed and adopted the facility report presented.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 5:55 p.m.



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

COMMITTEE REPORTS

Audit Committee – June 13, 2013

As reported by Ms. Emily Youssouf

Ms. Youssouf introduced Mr. Jim Martell, Lead Engagement Partner, KPMG to present the information item regarding the Fiscal Year 2013 Audit Plan. Mr. Martell saluted the Committee and introduced Maria Tiso, Client Care Partner, Camille Fremont, Senior Manager and Benny Hadnott, from BCA Watson Rice LLP who will be assisting them with the annual audit.

Mr. Martell continued by stating that their goal and role today is to present the 2013 planned audit approach. He said he used the word “planned” because as they go through the process the Committee may ask them to make changes. As in the past if there are other concerns or issues that the Committee may want us to look, we will incorporate that into the annual audit. Listed on page two is the client service team. There are a significant number of asterisks next to the individuals. Most of the individuals that have any asterisks are at the senior level. We do have a few new people who are rotating on due to resignations and things of that nature, but also to get a fresh perspective. The key item is that himself, Maria Tiso and Camille Fremont have gotten to know the organization very well in the past four years. They do have a new Concurring Review Partner, Greg Driscoll, who is one of their leading governmental partners in the New York office. After doing a rotation with the Government Accounting Standards Board (GASB) for two or three years they asked him to come back because of all the new GASB rules he has a first-hand knowledge of the new literature and can assist the engagement team in terms of assisting management as to how to implement them.

Ms. Youssouf stated that she is happy to hear that there is a staff member internally from Chris Telano's office that KPMG is using and that it is a bit more under control than it was. Mr. Martell added that they have tried to incorporate the internal audit group and it has been a pretty good result over the last several years.

Ms. Fremont then began the presentation by stating that on slide three they have laid out the other deliverables besides the Corporation's financial statements. They will issue various cost reports attestations that have to do with HHC's nursing homes, diagnostic and treatment centers and long term health care facilities. Additionally, they will issue the entire report for the 13 facilities along with statutory and financial statements. They will also issue HHC's statutory audited financial statements for the insurance company and MetroPlus Health Plan and then come back with management audit recommendations.

Ms. Fremont continued with slide four stating that they have laid out the objective of the audit, which is to enable the auditors to express an opinion about whether the financial statements are presented fairly in all material respects in conformity with Generally Accepted Accounting Principles (GAAP). In order to do that, they planned the audit to obtain reasonable but not absolute assurance that the financial statements taken as a whole are free from material misstatement, whether from error or fraud.

Ms. Fremont continued with slides five through seven in which they laid out the responsibilities of management, the Audit Committee and KPMG as it pertains to the audit. Some of management's responsibilities include adopting sound accounting policies and fairly representing the financial statements. She stated that as members of the Committee their responsibility is one of oversight. As HHC's auditors, KPMG is responsible for forming and expressing an opinion about whether the financial statements are appropriate. KPMG conducts the audit with an attitude of professional skepticism, and evaluate HHC's internal controls over financial reporting as a basis for designing our audit procedures, but not for the purpose of expressing an opinion on the effectiveness of those controls.

Ms. Youssouf said that all of this is the stuff that is said every year – so rather than reading it line by line she would appreciate a summary.

Mr. Martell added that he was just going to say that the reality is that from pages four through seven, the roles and responsibilities of the Committee and management of KPMG have not changed.

Ms. Fremont continued with slide eight – Time line for the financial statements. It started in April where they had planning meetings to determine the audit strategy and it will continue through November. In June and July they will perform certain tests during their site visit test work. Starting at the end of July through September they will come back and do their standards test work. During that time, they will have their traditional SAS 99 meeting, and will come back to the Audit Committee to present the final draft financial statement.

Mr. Martell stated that there is one key difference this year as it relates to timing. It is almost two weeks earlier, September 13th of this year. The same time last year was September 18th, in the past it was always October 1st.

Ms. Youssouf stated that she thinks it is great that there has been an improvement every year since she has been the Chair of the Audit Committee and that makes her very happy.

Ms. Fremont continued with slide nine where they have laid out the critical audit areas, as well as some of the non-routine transactions KPMG will consider. The critical audit areas have not changed from the prior year. In terms of non-routine transactions, KPMG will walk through the new accounting pronouncements on slide fifteen through eighteen and what impact they will have on the Corporation. KPMG will additionally have to consider what impact Super Storm Sandy had in terms of potential impairment or business interruption, as well as the FEMA claims process that is ongoing at the organization.

Ms. Youssef asked that given all the cuts that are proposed in Obama Care, is there anything in particular from your vantage point that you are going to be looking at?

Mr. Martell responded that typically they would not look at anything differently than what we have looked at in the past. Every year, we have looked at liquidity and going concern as part of our audit process. Obviously we look at cash flow, the future budget in terms of revenue streams and the strategic plans. They will talk with management as to how well our 2013 budget did compare to our 2013 actual. We have a slide in the back as to certain key trends that we have looked at; working capital, cash flow, day's revenue and accounts receivable. At the closing of last year he mentioned that HHC has a significant net deficit and have been generating operating losses. The bulk of the net deficit has always been and continues to be the one time or the ongoing reporting of Post-employment Benefits other than Pension (OPEB). That is why we have to at least address the going concern from a documentation perspective and a discussion for this purpose with management.

Ms. Fremont stated that on slide ten they included how they plan on using the Minority Business Enterprise, the Women's Business Enterprise and the Internal Auditor throughout the process.

Ms. Fremont continued with slide eleven and twelve where they are required to address the potential for fraud within the audit under SAS 99, and part of their key procedures are interviews that they have with various members of management and the Committee. Those interviews are laid out on slide twelve and will consist of Emily Youssef and Dr. Stocker along with Sal Russo.

Mr. Martell added that as they go forward throughout the audit, they may or may not, depending on how they feel, select someone from the facilities just to give us a little change, keep it a little fresh.

Ms. Fremont moved onto slides thirteen and fourteen which Mr. Martell has spoken about how they will consider liquidity and going concern. She said that on slide fifteen, they will start with the first new GASB Statement 61, which is effective for June 30, 2013. KPMG will have management look at all of HHC's component units and determine how they should be presented within the financial statements. In going through this process management has identified that MetroPlus' balances will need to be separately disclosed in the financial statements. In the past there has been one consolidated number on the balance sheet, now the activity of MetroPlus will be included in HHC's statement of activities as a footnote disclosure.

Mr. Martell said that it will end up having HHC being the parent, for lack of a better word; HHC is going to have MetroPlus as a column, and then a total. The literature is asking to break out separately identifiable components, subsidiaries that are unique and not part of the Board of HHC. They have separate Boards, separate Audit Committees and so forth. There is a little more detail associated with it, what it going to end up happening is that HHC is going to have MetroPlus, a billion dollar organization shown separately, with changes that also have to do with the last year also.

Mr. Jay Weinman, Corporate Comptroller, added that this is similar to the way it is reported within the City. HHC is a component unit of the City, and HHC is a column within their financial statements. HHC will also have similar presentations for MetroPlus. He thinks that MetroPlus is probably the only one that HHC will separately report.

Ms. Youssef added that since in the past MetroPlus has been combined it made HHC look better. To which Mr. Martell responded yes.

Mr. Weinman said that one of the key components of MetroPlus is the premium revenue and that has already been separated on the financial statements, so there is no change in that, it is just the rest of the expenses which will be presented.

Ms. Youssef asked if it impacts any funds that are due to HHC from MetroPlus. Mr. Martell said that this is purely presentation.

Ms. Fremont continued on to slide sixteen, the second GASB Statement 62 which is effective for the current year. This one will not have any impact on the organization. Turning to slide seventeen is the third GASB Statement 63 which is effective for the current year. This one will no longer call your net assets on the balance sheet net assets; they are now going to be net position. The other thing to consider is whether or not there are any deferred outflows and inflows for items that will be used in future periods. Mr. Martell added that he did not think this one will have conceptually a significant impact on the Corporation and that they won't know until management and us sit down and go through the literature.

Mr. Martell then turned to slide eighteen where it lists six or seven statements that are coming down the parkway in terms of what has to be changed. There are a lot changes to the presentation and going back to the management letter, we had an issue of oversight and the whole

issue of the public markets and so forth. He believes most of these things are reactionary to where the Securities and Exchange Commission (SEC) is going, but to have almost seven or eight new GASB literature implementations in two years, people are looking at not-for-profits and governmental institutions.

Ms. Youssef agreed and stated that especially the pending GASB 70, non-exchange financial guarantees and disposals of government operations and then of course pension plans that those are going to be big impacts. She then asked when they become effective. Mr. Martell answered that they come next June. This June we stopped at the first two and the next five will be tough. There will be a lot of planning associated with the pension aspect and the disposal aspect that it will be an interesting 2014 audit.

Mr. Martell added that this is actually their planned presentation. The actual audit process will start sometime in early July. In fact we are out there at some of the facilities as we speak doing interim test work.

Ms. Youssef asked if there were any questions. She thanked KPMG and announced the next item on the agenda to be presented by Chris Telano, Corporate Chief Internal Auditor, to provide his audit reports updates.

Mr. Telano saluted the Committee and stated that he will be discussing six reports. There are three purchasing reports, two PAGNY reports and the IT audit of the eCommerce application. The first one he would like to discuss is the IT audit on page 10. He asked the representatives of IT to come to the table.

Ms. Youssef asked them to introduce themselves. They did as follows: Enrick Ramlakhan, AVP for Corporate Applications; Jeff Lutz, Director of Corporate Applications; Bert Robles, SVP, Corporate CIO; Lorraine Szabo, Director of Corporate Applications.

Mr. Telano began his presentation by stating that he will discuss a few of the issues. The first one was that the eCommerce application does not lock out users after three login attempts. This is more of a concern since there was no formal review or follow-up of failed login attempts. Hence, a hacker can try an unlimited number of attempts to get an employee's password without recourse. The second issue is that eCommerce does not automatically disable user accounts due to inactivity for an excessive period of time. Instead, idle accounts are being monitored manually. We do not find that efficient, especially in light of finding 1,300 users that were not logged onto the system for more than 180 days. Mr. Telano commented that the eCommerce technical team is looking into both of these issues, and hope to resolve them in the near future.

Ms. Youssef asked how quickly they are going to be able to resolve this, because the first one obviously is a major problem.

Mr. Ramlakhan answered that the current eCommerce application is several releases behind so there is a need for us to do some custom programming that it is not part of the current release in place. That requires us to take a step back and either code around the current application, look to upgrade to the current release at a substantial cost to the organization or continue using the manual process in a more periodic basis.

Ms. Youssef asked if their response satisfactory enough? Mr. Telano responded that we will be doing a follow-up audit in six to twelve months to ensure that there is progress being made to resolve this. I know that with the disabled users, they were initially receiving a report on a quarterly basis to address this and it was changed to a monthly basis. So there was action taken during the course of the audit to address that.

Board Chairman, Dr. Michael Stocker asked for more details on the function where you try to enter the pass code multiple times and you are not locked out. Mr. Lutz responded that Mr. Ramlakhan's response is really something we could do somewhat immediately, but it is really an interim plan as opposed to the greater plan, which is on the way. That is reengineering our active directory, which is the way; it is at a very high level. It is the engineering software that allows us to control who gets access and who does not. The access which takes the application, it is done by the user role. Depending on your job description or your role, it is role based, it really controls what you can have access to, either getting on the network. Then based on what applications you are entitled to look at, it can be programmed for inactivity, which we do in some cases today for those sites that have active directories. Complicated by the release levels of the current software in eCommerce, which is not conducive to that, but the correct way to ultimately engineer it, which is work that has already been started to year ago. It requires another year to complete, because it is a substantial effort.

Ms. Youssef stated that she does not understand about the disabling. In most organizations when you try to get on, and by the third time, you can't, you fail. We apparently do not have that. Mr. Telano and Mr. Lutz answered, yes, for eCommerce.

Ms. Youssef then stated that that is incredibly difficult – that she just wants the question answered. Mr. Robles stated we cannot programmatically do this because of the antiquity of the architecture of eCommerce right now, the way it has been set up. The correct way to do this, and we do this today is we migrate it to an active directory. It is a high level of provision.

Ms. Youssouf asked that if you can make a fix now to prevent this, why wouldn't you do that now? To which Mr. Ramlakhan responded we are, we are working on that fix. It is custom programming that we will have to do.

Dr. Stocker added that it sounds like you have a work around now, and a year from now, you have an ongoing project that would resolved it. Mr. Ramlakhan responded correct. Mr. Robles added that it is one structure that controls both the access to the network, as you know when you first sign on, and what number of applications you are entitled to, you have access to. You can time it and recycle it. Just like today, you have the 90 day password reset. There is some protection, what you focus on is just one application. You have to really intrude through many layers before you can get at the application. But the best practice is to have both applications and network totally controlled.

Ms. Youssouf asked how long it is going to take to put in this quick fix. Mr. Ramlakhan responded that within the next 30 to 60 days we should have a fix. We have had our engineers looking at it. We have come up with a couple of different ways, especially with the inactivity, which is fairly simple. With the lockout, we are going to have little more of a complication, but that should also be within that 30 to 60 day time frame.

Ms. Youssouf asked to have an update about the progress at the next Audit Committee meeting. Mr. Ramlakhan responded absolutely.

Committee member Josephine Bolus, RN asked why it takes so long to ask them why they are not getting in. To which Mr. Ramlakhan replied that is also part of the program. What they are going to do is go through the blocked files and have an automatic blurb sent out to the systems administrator so that some custom programming is getting done on those blocked files.

Mrs. Bolus asked if out of the 1,300 user who have not logged in over a long time, are those people who have left the service. Mr. Ramlakhan responded that is a little bit more difficult – they just have not used the application. Often times they are not, they are still active.

Mrs. Bolus asked if they are still active people. Mr. Ramlakhan said yes, but they just do not use the application. Mr. Telano added that some of them were active and some of them were not.

Ms. Youssouf thanked them.

Mr. Telano continued with the next item by stating that he would like to discuss the purchasing audits on pages three, four and five of the briefing. Since we have discussed the procurement process at length during the last two Committee meetings, we are not requiring the individuals from the facilities to come to the table to discuss these audits. Instead, Mr. Paul Albertson, the Chief Procurement Officer is presenting an update of the status of the centralization of the purchasing function, and of Operating Procedure 100-5.

Mr. Albertson saluted everyone and introduced himself as Paul Albertson, Senior Assistant Vice President overseeing the centralization process of procurement. He asked two of his colleagues to introduce themselves: Jun Amora, Consultant, working out of the Breakthrough office; Francine Freise, representing the Greater New York Hospital Association for HHC.

Mr. Albertson continued by stating that he would like to be able to provide a kind of a context and an overview of where we are moving as it relates to our procurement approach. Then we are going to be talking about the process that we have actually been engaged for the last six weeks and what was established in the Road Ahead transformation documentation as it relates to the corporate agreement to achieve reduced costs across the organization. One of the goals is the standardization of the procurement process which will be driven by value, volume and cost. The need to have a centralized environment at a multi-million dollar savings it's already achieved and there are many more as we move forward in that centralized environment. In the context of looking at our current governance, technology and culture, our transformation efforts really require us to have good understanding of what is currently taking place. Towards that end we visited and met with purchasing and material management directors to talk about what is currently taking place and what some of their opportunities and concerns are and to have a chance to introduce myself in a way that we hope we will work together.

Ms. Youssouf stated that the Committee knows the background.

Mr. Albertson continued adding that in terms of our statement, we are looking at our deficit of \$1.3 billion and using the Breakthrough methodology. Our current decentralized procurement infrastructure does not allow us to get to where we would like to go. We are working on an integrated system that provides the appropriate clinical input for evaluating products and the standardization. With that as our mantra, we are looking at a new machine, as it relates to how we would actually be able to transform our procurement process. Mr. Jun Amora has been very helpful in developing this and will take a moment to explain it and the phases we are taking.

Mr. Amora stated that in looking at the target statement, it illustrates the design for the future state of procurement for HHC. They looked at literature and at some of the best practices from previous experience, on how to put together a centralized model for procurement. On the left side of the slide there some funnels, those are value analysis funnels. Their chief job is to do two things, evaluate products based on clinical evidence assuring patient safety and mission quality; and second, our quality of products to assure patient safety. The second is price and value. As we select products, there are decisions on what products to contract for and what products not to purchase. As those products

flow through value analysis, they go through a centralized negotiation of the procurement department where we aggregate all of our volume of usage as a Corporation to assure best price. Then it flows cleanly into our Virtual Item Master so that we can transact through our favorite list and use our systems like ORACLE and GHX to produce POs. This is the kind of target state we have built; we are going to tackle this phase by phase. Phase 1 is building out the VIM through cleaning up the procurement process which is all aligned against preparing for centralization. Phase 2 is the actual centralization, building up a design for value analysis and building out what the centralized structure looks like as well, but the meat of phase 2 is centralization and integration. Phase 3 is continuous improvement and the launch of value analysis teams. We have worked very closely with Dr. Wilson's office and the Chief Nursing Officer to build out what the structure of value analysis looks like. There are already those existing committees that look at clinical practice. We want to see how we can leverage those committees so that they can address supply chain issues as well, and become the structured value analysis.

Ms. Youssouf asked if this is going to be in effect by September.

Mr. Martin responded yes.

Mr. Amora then added that basically it is marked by the launch. The nomenclature that we have been tossing around is how we have HHC, which is one entity. We call it an integrated delivery network, or an IDN, how do we function as one IDN in front of our vendors, in front of our suppliers and in front of those who we buy from. A couple of examples that we look at was the Stryker Craniomaxillofacial. It is a contract with Premier and Stryker Corporation as well. These are two different contracts where savings have been identified. If we function as an IDN, and made corporate decisions on how we manage these contracts, instead of how we currently manage it, which is facility by facility, we would realize savings immediately.

Ms. Freise added that what they see across our 300 members is that this is just a starting point. What you can do with this information is leverage it further and make better product decisions in order to derive the best value as well as effectiveness. The savings here that you see are just a small representation.

Mr. Amora continued with the next slide where there is another example of that. Both of these examples are Premier contracts, but the process we are going to employ is going to be GPO diagnostic. It is going to be ensuring again best clinical value and best price. Suppose we talk about our proposed table of organization and how we intend to do this.

Mr. Albertson said that our interest is transforming ourselves from a decentralized model to a centralized model, and being to effectuate what Mr. Amora said. The best way for us to do that is really following the models that exist kind of across the country with a huge array of integrated facility setups that have, in fact, centralized their procurement. We would transform ourselves to having a single line that is more of the traditional purchasing. When we turn those requisitions into orders that go out to the companies that would be done in a centralized model with a director who would be managing that. Our interest is really having category experts as it relates to service lines. We would like to be able to specialize around areas like the business office support services. We have our perioperative radiology lab, cardiology, pharmacy and med surg categories as examples. We have more than 1,000 contracts that are currently in our system. For example, we have 171 that relate to perioperative services, we would like to be able to have a category director be that expert as it relates to those contracts. They would be serving as the principal staff to the value analysis committees, some of them are clinically oriented and some of them are not. Below that we would like to be able to establish category analysts, individuals with a skill set to be able to analyze the data that we have as it relates to our purchasing. Associated with that service line to be able to pull together our "what ifs" as it relates to doing scenarios as to the best buy, and to help us set up in negotiating.

Ms. Youssouf asked what the Capital Category Director is. To which Mr. Albertson responded that we bring in capital through the Finance Department, though the Office of Facilities Development and there is also some done through traditional purchasing. The interest is how do we leverage or consider if we will going to a single source, for example, for imaging services how that facilitates its way through what you buy to support it, to be able to look at value and the way that we may be able to save money. We are interested in being able to sort out if there is a way for those offices to work together up front in that kind of decision making with the appropriate clinical committee. The interest is being able to then also look at our business analytics. The second box talks about being able to manage the array of assistance that we have to work with, being able to keep track of our savings and key performance indicators. The last box is about strategy and innovation as we continue to process this forward to be able to assure that we are working effectively with changes that occur that can affect this and also how we can help the rest of the supply chain process.

Mrs. Bolus asked if all the titles are in place now. Mr. Albertson replied that these are functional job titles and are working with Human Resources to match the appropriate HHC title.

Mrs. Bolus asked if the category analysis person is the only ones he is trying to create and where would they fit. Mr. Martin added that what Mr. Albertson is doing is looking at the different forms of purchasing directors that we have across the Corporation and is evaluating them. Based upon the level of expertise that they bring, they are going to be the people that head up those different divisions.

Ms. Youssouf asked why IT was not included considering that we do massive amounts of purchasing in IT. Mr. Albertson said that that is included in the Business Analytics box. There is a current existing screen where IT is being valued and going through a process and coming up through the series of committees. There would be some linkage with the supply chain committee.

Ms. Youssouf stated that that is the largest, probably the most expensive. Mr. Martin said that we spend a lot of money on IT and that we have already made a commitment to EPIC, which is a major vendor. That encompasses a lot of our IT systems and there are other IT purchases as well. Maybe that is something that we will look at, this is a draft. He stated how proud he is of the work the guys have done in a short period of time to come up with a real roadmap to success.

Ms. Youssouf stated that she agreed, but she thinks part of the reason to bring it here is for comments and suggestions and she would really encourage them to look at IT and let them know.

Mr. Amore said that he thinks that is a great point and as Mr. Martin mentioned, this is in draft form. They are actually playing around with what the role of the business/office support service category directory. It may be exactly that, IT. They have worked a lot with Mr. Ramlakhan and his team to really understand the purchasing behavior and where it makes sense to put that value analysis decision making.

Ms. Freise added that traditionally in other major IDN, for example, the North Shore model, IT is treated as separate and outside of the typical supply chain, because it does not involve the procurement of goods that actually make it to the patient. The supply chain can be structured as you see it fit.

Ms. Youssouf said that she thinks we should look at it because it is so much.

Dr. Stocker inquired if the yellow boxes with those categories are those functional jobs that will be done by people who currently work in procurement in geographically distinct areas. Mr. Albertson responded yes, everyone I have met in the facilities is great, and we are interested in understanding either their expertise and helping to build these roles with individuals who are interested, and the skill set.

Dr. Stocker wanted to know if their objective is to provide a system to the people who actually need it; the hospitals and doctors and so on, that is easier and faster, not slower and more cumbersome. Mr. Albertson responded that that is clearly their goal. If we lose anything between now and then, and as we process through, we believe that by having these category directors and service lines, we can standardize across the Corporation, and be able to give better value and be able to have better relationships with our vendors. The next slide illustrates the fact that we would be having each of those category directors work very closely with those committees that we talked about, who in turn would be reporting to the Supply Chain Council, whose role becomes much more directive in being able to hear those reports and deciding on actions recommended by those committees to facilitate this implementation across the Corporation.

Ms. Youssouf asked if the new vendors are vetted and where does it occur. To which Mr. Albertson answered that that is a major transition also. We would like that instead of them going to the facilities to come to the corporate office so that the products being considered would be vetted in that manner and then go through the category directors up through their task force as appropriate.

Ms. Youssouf added that that means it would be essential to look at financials, capabilities, experience, etc. Mr. Albertson said that that is why we would like the analytics staff to be able to help us with that. That is the kind of the overview of what we are doing as it relates to our centralization process. We are moving to work with our labor relations and human resources to do the rest of the mapping then talk to the facilities. Our next step is we are evaluating our space and all of the activities that are associated with that, so that we make the transition occur before the summer ends.

Mr. Albertson continued by stating that in his conversations with Mr. Telano and with some of the other staff on 100-5, we have looked at three components as it relates to finalizing the procedure. That is addressing the internal audit findings, having a policy of a centralized procurement department and also revising the SOPs that support it. From those internal audit findings, there has been a lot of work done by Mr. Quinones and Mr. Berman in Legal Affairs to be able to add some missing definitions, and clarify any ambiguities in the internal audit findings. Then refer the other remaining items to an SOP work group that was established yesterday at the Supply Chain Council.

Mr. Albertson continued with the next slide – Centralization Component. They drafted a centralized procurement by going through 100-5, made those revisions which will be circulated. Their plan is that by the end of June, they will have finished the definitions that needed to be added, revise the policy to reflect the centralized approach and be completed with that for review by Mr. Martin. The other component is the SOPs, there are a series of them that need to be reviewed and revised to reflect the changes. That group has committed itself to finish those by the end of August.

Mr. Albertson continued with the last slide which is the wrap up. As he mentioned, they are finalizing the table of organization. The solutions as it relates to the contract issues and our current state in terms of our statistics to our managing what we currently finding on our current state, which is where we would like to achieve, and the value analysis infrastructure to finalize what that looks like for consideration. Then we are working on a communication plan to assure that the leadership as well as all the facilities is kept apprised of how we are moving along.

Everything we make in procurement affects material management and finance; we have to make sure our partners are well equipped. The last component is the partnerships that we have with an array of external facilities that we really need to enhance, whether it is the Premier, the Cardinal, the agencies that we use for providing support like the Advisory Board. There is a lot of collaboration that will bring to this as well.

Ms. Youssef stated that she just wanted to say it looks good. She thanked all for the work that they put into it and the management in general, Tony Martin in particular, who has really taken this on. The Board appreciates it. Mr. Martin added that it is a lot of work, but they are doing the work though.

Mrs. Bolus thanked them for this marvelous piece of paper and appreciates them.

Mr. Telano resumed with the audit updates by stating that the last two audit reports he would like to discuss is Physician Affiliate Group of New York (PAGNY) affiliations. In general, we found a need to improve record keeping and internal controls. However, instead of discussing those issues in detail, Dr. Marcos has been asked to come to the table to provide us with an update of the PAGNY affiliations.

Dr. Marcos saluted everyone and introduced himself as Luis Marcos, MD, CEO of PAGNY and introduced Mr. Anthony Mirdita as the new Chief Financial Officer, he just started last week. He also thanked Mr. Milton Nuñez who helped us very much for several months. He asked if anyone had any questions.

Ms. Youssef said that perhaps he can spend a minute describing what he is planning to do here.

Dr. Marcos responded that he assumes that everyone here knows how PAGNY was developed and some of the challenges they have gone through. He stated that he would also like to acknowledge the help he received from everyone at Central Office, from the Executive Vice President, Antonio Martin, to the General Counsel Sal Russo, obviously the President, Corporate Chief Financial Officer, Marlene Zurack, Chief Medical Officer, Ross Wilson and many others. He has been the CEO officially for two months, but was there before and from day one, it was a challenge. The basic legal matters were a challenge, the status of the company and so on. Those were the issues they had to deal with and that are their priority. It is important to remember that PAGNY was formed fast and also from five different affiliates that came with their own culture, their own history and their own way of doing things. From that we created this family, and it is going to take a little while until we all focus on the future and the strategic direction of this company that I am sure and my team is also sure that it has a great future. It is important to recognize that while we were doing this, we have been able to achieve some important goals. For example, in December, we reached an understanding with HHC for a three year affiliation contract, to me that is a very positive thing. We have a letter of intent, and it included our 25, 26 points, which are very important. We are working with the lawyers to finalize the legal aspect of the contract, but the Board of HHC approved those three years and I think that gave a lot of stability and was very instructing and helpful.

Dr. Marcos continued by stating that secondly, before PAGNY, not all of the physicians were part of the union. Today every physician in PAGNY except the chiefs are all part of the union. We have been working with the union, and for the most part, we have been doing well as relationships go. We have an extension until June of 2014 of the current contract. That gives us some stability and some time to work things out. There have been also very positive, with the help of HHC, achievement for the benefit of the physicians. One is, for example, starting in July 1st of this year, the contribution of PAGNY to the 401K will increase to 10 percent. Average was about 7 and a half, this is a very positive thing for the physicians. We are working very hard with the performance indicators, and with Dr. Ross Wilson, and with the help of HHC, we are able to identify what we call academic activities funds. These are funds that are designated for Resident training as well for development of the faculty. These are just examples of many good things that we have been able to do because of the collaboration of our team.

Dr. Marcos stated that specifically to the audits of Harlem and Metropolitan, we are very concerned about some of the findings. They show mistakes and they show the struggles of going through this process in an incremental way, and meeting all of these very important requirements. Our commitment to you and the Board is that we will do everything we can do comply with every rule and every expectation.

Dr. Stocker stated that there has been amazing amount of change. You started a year and a half ago, a very short period of time. Each of these organizations has a life of their own, and putting them all together, not only is there a payroll function in all those, but there is a billing function also. To bring them all together in a single organization is very helpful for HHC, but difficult for them. We talked mainly about the Kaiser Model, where you have physicians who are organized and work as partners with the organization and management. I am sure they have contention, but from the outside, it looks to be successful, we are really glad to have you.

Ms. Youssef said that what they would like to see is for you to come back with whatever kind of plan you have. Because the internal audits have not been very good and we are anxious to see what is going to put in place to fix it. I know that your CFO just started, but if you could just be in contact with Chris Telano to give him a time period you are comfortable with in coming back on some of the permanent fixes.

Dr. Stocker asked for the CFO to give them some of his background. Mr. Mirdita said that he started his career in 1990 at Jacobi as a budget analyst, and ultimately wound up working as deputy CFO for Coler Goldwater. Since then, he went to on to take on positions as CFO of a hospital up in Carmel, as well as a Physician Group in Hudson Valley and he is glad to on board with Dr. Marcos.

Dr. Stocker said welcome back.

Ms. Youssef said thank you – it has been a pleasure to meet you both and we look forward to seeing you back here hopefully shortly.

Mr. Telano added that just to finalize my presentation, on page eleven is a list of the audits in progress. The majority of them are the remaining affiliations throughout the corporation. Three of the audits were impacted by Hurricane Sandy, as a result of the lapse in time; we will have to start all over. The last page is the status of our follow-up audits. That concludes my presentation.

Ms. Youssef thanked Mr. Telano and turned to Mr. Wayne McNulty.

Mr. McNulty saluted everyone and introduced himself as Wayne McNulty, HHC's Chief Compliance Officer. He then directed the Audit Committee to turn to page three of the Compliance Report ("Report"). Mr. McNulty informed the Audit Committee that the Compliance Training for the Board of Directors module was completed. He stated that all of the members of the Board of Directors were enrolled into the course. He advised the Audit Committee that Information Services and the Office of the Chairman were working on a process to facilitate the remote access of the training module by Board members. He reported that there were several technological difficulties present, which he advised the Audit Committee were being addressed by Information Services.

Mr. McNulty continued by stating that, with the regard to the other training modules, the health professionals module, the general work force module, and the physicians module, were all in place. He informed the Audit Committee that all covered personnel were enrolled into the aforementioned modules. He further advised the Audit Committee that the training period would conclude on June 30th. He continued by stating that, moving forward, the training period would be on a fiscal year basis. He informed the Audit Committee that a report providing the results of their (Office of Corporate Compliance's ("OCC")) training activities would be presented in September to the Audit Committee. He asked the Audit Committee if there were any questions before he moved on to item number two of the Report.

Mr. McNulty moved on to item number two – the Corporate Compliance Work Plan. He informed the Audit Committee that the OCC continued to make progress with its Corporate Compliance Work Plan items. He added that, given the confidential, investigatory information contained in the OCC's risk assessment process and OCC's findings, such processes and findings would be discussed during Executive Session at the conclusion of the Report.

Mr. McNulty continued with item number three of the Report and stated that the OCC started to identify and prioritize corporate risks. He provided that, in May, the Executive Compliance Work Group ("ECW") and the Executive Compliance Work Group Subcommittee on Compliance (and Quality) ("ECW-CQ") convened to review the OCC Corporate-wide Assessment of Risks document. He explained that potential Corporate risks were identified at both meetings, and the risk prioritization process was explained to the ECW members. He added that the Network Compliance Committees had also started to undergo the risk assessment process. Mr. McNulty reported that a subgroup of the ECW was formed to specifically focus on finance, billing, and payment (risk items). He informed the Audit Committee that the subgroup had already convened two times. He stated that the subgroup discussed different corporate risks and scored a series of corporate risks. He provided that he would present all raised risks to the Audit Committee in September, as well as how these risks were prioritized and scored. He added that he would also present HHC's Fiscal Year 2014 Corporate Compliance Work Plan to the Audit Committee in September.

Mr. McNulty then went on to item number four – the Compliance Index. He informed the Audit Committee that, for the first quarter of calendar year 2013, there were 90 compliance-based reports - - one Priority A report; 27 Priority B reports; and 62 Priority C reports. He advised the Audit Committee that the Priority A report would be discussed in the Executive Session. Mr. McNulty then moved on to the compliance privacy index. He provided that, for the first quarter of calendar year 2013, there were 22 HIPAA-related complaints - - five were found after investigation to be actual violations of the HIPAA privacy operating procedures; five were determined to be unsubstantiated; six were found not to be a violation of the HIPAA privacy operating procedures; and six were still under investigation. He explained that, out of the five confirmed violations, there was one breach. He advised the Audit Committee that, given the confidential nature of the informants who provided information regarding the breach, the details of said breach would be discussed in Executive Session.

Mr. McNulty provided a staffing update. He informed the Audit Committee that there were three vacant compliance officer positions within the OCC. He stated that he was hopeful that one of these positions would be filled by the conclusion of the day. He further stated that he was hopeful that he would be able to fill the other vacant positions by the following week.

Mr. McNulty continued by discussing excluded providers. He informed the Audit Committee that there were no disclosures related to excluded providers made since the last time the Audit Committee convened.

Mr. McNulty concluded his Report.

Ms. Youssef thanked Mr. McNulty, and then indicated that the Committee was going into Executive Session. (Executive Session was then held).

Dr. Stocker stated that they are back from the Executive Session and have approved the Internal Audit Plan 2014, received the Compliance Report and received a report of the EITS Security Assessment Program.

Capital Committee – June 13, 2013
As reported by Ms. Emily Youssouf

Assistant Vice President's Report

Alfonso Pistone, Assistant Vice President, Office of Facilities Development, provided an overview of the meeting agenda, which included seven action items and four information items. He advised that information items would provide; 1) an update of the status on the Henry J. Carter modernization project; 2) an air conditioning readiness report, included in the committee package, for which representatives from Johnson Controls were available to answer any questions; 3) a presentation about remedial measures that were taken to address deficiencies in the Health and Hospitals Corporation's construction program; and, 4) brief delay reports for the Kountz Pavilion project at Harlem Hospital Center; the Emergency Department project at Lincoln Medical and Mental Health Center; and the Women's Health Center at Elmhurst Hospital Center. He noted that in the future, changes would be made to the Project Status Reports to reflect additional information, as requested by members of the Capital Committee, and hopefully those changes will be in place by the next capital meeting.

Finally, Mr. Pistone gave notice of a Public Hearing to be held on Thursday, July 11, 2013, at 6:00 p.m. at Goldwater Specialty Hospital and Nursing Facility, located at One Main Street, Main Floor Auditorium, Roosevelt Island, concerning the transfer of land and building to the City of New York of approximately 9.9 acres located on the campus of Goldwater.

That concluded his report.

Action Items

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with the American Cancer Society, Eastern Division, Inc. ("ACS" or the "Licensee"), for its continued use and occupancy of space to provide non-clinical patient support services on the campuses of Elmhurst Hospital and Queens Hospital Centers (the "Facilities").

Robert Rossdale, Deputy Executive Director, Queens Hospital Center, read the resolution into the record on behalf of Ann Sullivan, MD, Senior Vice President, Queens Health Network. Mr. Rossdale was joined by Dean Mihaltses, Associate Executive Director, Elmhurst Hospital Center.

Mr. Rossdale noted that the resolution would be the second renewal for this agreement. It was first approved six years ago and then again three years ago. The program is a navigator program that refers services, such as meals on wheels, transportation, legal and financial information to newly diagnosed cancer patients who are many times in need of guidance and assistance. Mr. Mihaltses advised that space at both facilities was already allocated and occupied by the licensee.

Ms. Youssouf said that she thinks it is an important program, and asked if there were any questions.

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

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

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with the American Academy McAllister Institute of Funeral Service (the "Licensee") for its use and occupancy of space to provide instruction in the techniques of mortuary science on the campus of Harlem Hospital Center (the "Facility").

Denise Soares, Senior Vice President, Generations+/Northern Manhattan Health Network, read the resolution into the record. Ms. Soares was joined by Louis Iglhaut, Associate Executive Director, Generations+/Northern Manhattan Health Network, and Meg Dunn, American Academy McCallister Institute of Funeral Services.

Ms. Soares advised that the program was previously operated out of Bellevue Hospital Center but due to the effects of Super-storm Sandy the basement area in which it was located was flooded and rendered inoperable. Mr. Iglhaut explained that alternate space had been identified within the existing mortuary at Harlem Hospital Center. Ms. Youssouf asked if the program would permanently be located at Harlem. Ms. Soares advised that the agreement was for a five (5) year term.

Committee member, Josephine Bolus, RN, asked how many community members would be involved in the program. Ms. Dunn advised that students come from all over the New York/New Jersey Metropolitan area but she did not have specific demographical information.

Ms. Yossouf asked what the proposed space was originally intended for. Ms. Soares advised that it was regular mortuary space that they would be using.

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

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

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to modify the scope and budget for the existing Boiler Plant project at Coney Island Hospital (the "Facility") to add an additional \$2,935,845, increasing the total project budget to an amount not-to-exceed \$9.94 million.

Daniel Collins, Director, Coney Island Hospital, read the resolution into the record on behalf of Arthur Wagner, Senior Vice President, Southern Brooklyn/Staten Island Health Network.

Mr. Collins explained that the reason for this increase was to raise the newly installed boiler plant above the 100 year Federal Emergency Management Agency (FEMA) flood plan level. He said the design will modify the structure and raise the existing plant 12 feet four inches above sea level, or, one foot four inches above the mandatory 100 foot level, the highest that the plant can be raised in the existing structure.

Ms. Yossouf asked if meeting the 100 year flood plan was acceptable or if it was required that the Corporation meet the 500 year flood plan. Mr. Collins noted that the 500 year flood plan is 15 feet higher than the 100 year level, and that because of the existing building the highest they can get the plant is four foot four inches above the 8 foot level, meeting the 100 year plan. The existing structure and the existing piping will only allow for the plant to be moved so far. He noted that the most vulnerable parts of the plant will be some two feet above the 100 year level, raising it to 13 feet. It's the best that could be done.

Mrs. Bolus asked if it would pass inspection. Mr. Collins said yes.

Ms. Yossouf asked if FEMA would cover the reimbursement being that only the 100 year plan levels are being met. Mr. Collins said that the FEMA consultant working with HHC indicated that FEMA would reimburse based on the fact that the Corporation made the best possible effort given the existing situation.

Mrs. Bolus asked if the elevation of the boilers would affect their functions. Mr. Collins said all those factors were taken into consideration during planning.

Ms. Yossouf asked if these changes would further delay the project. Mr. Collins said yes, however the boilers are in storage, equipment has been delivered, design is complete and the only portion of the project remaining is support and installation.

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

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

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute construction requirements contracts with six (6) firms: Gridspan Corporation; Vastech Contracting Corporation; Volmar Construction, Inc.; Sierra Mechanical Contracting, Inc.; Jemco Electrical Contractors, Inc.; and Charan Electrical Enterprises, Inc. (the "Contractors"), to provide construction services on an as-needed basis at various facilities throughout the Corporation. 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 \$36 Million.

Peter Lynch, Senior Director, Office of Facilities Development, read the resolution into the record.

Ms. Yossouf asked for an explanation of the contracts and how they are utilized. Mr. Lynch explained that these are a continuation of the Indefinite Quantity Construction Contracts that have been in use for several years now. The contracts have a life cycle, with some having just recently expired, and this will allow the program to continue. He noted that these types of contracts work well for smaller projects that need a timely response and they allow facilities to draw down off existing contracts and get mobilized quickly.

Mrs. Bolus asked whether all six contractors have to be used and whether all six were used in the previous cycle. Mr. Lynch said all were used previously but the facility can choose who they want to work with.

Ms. Yossouf asked if bidding is done between the contractors when a facility is ready to mobilize. Mr. Lynch explained that prices are locked into place prior to contracts being issued. The Gordian Group establishes unit prices and each contractor bids on a multiplier. That multiplier is then applied to prices for that contractor throughout the contract duration.

Mrs. Bolus asked why only one vendor had Vendex approval. Mr. Lynch said that Vendex documents go through the Mayor's Office of Contracts and that's just how the system works sometimes. Mrs. Bolus asked if all documents were submitted at the same time. Mr. Lynch said no.

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

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

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute construction requirements contracts with four (4) firms: Par Plumbing Co., Inc.; Richard Plumbing and Heating Co., Inc.; Empire Control Abatement, Inc.; and New York Environmental Systems, Inc. (the "Contractors"), to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$2,000,000. The total authorized value of these contracts is \$8 Million.

Peter Lynch, Senior Director, Office of Facilities Development, read the resolution into the record.

Ms. Youssouf asked if these contracts were the same as the previously approved. Mr. Lynch said yes, this group was separated because the individual contract values are for \$2 million and the previously presented contracts were valued at \$6 million each.

Mrs. Bolus asked if there were Equal Employment Opportunity (EEO) requirements for these contracts. Mr. Lynch said yes, and all contractors are expected to meet those goals.

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

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

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to increase the New York City Economic Development Corporation's (NYCEDC) work order threshold by fourteen million, one hundred thirteen thousand, seven hundred sixty-seven dollars (\$14,113,767) to one hundred thirty-two million, four hundred fifty thousand, seven hundred fifty-six dollars (\$132,450,756) to provide project management services that will manage the architectural, engineering design services, pre-construction, construction, construction management services for the Construction of the New Skilled Nursing Facility (SNF) to be built in the parking lot of the former North General Hospital.

Robert Hughes, Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility, presented the work order on behalf of Lynda Curtis, Senior Vice President, Queens Health Network. Mr. Hughes was joined by Michael Buchholz, Senior Associate Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility, and Emil Martone, Vice President, Capital Programs, New York City Economic Development Corporation.

Mr. Hughes explained that previously authorized funds for this project had been expended and this increase approval would allow for additional funds to be released in order to level current project costs and spending. H noted that all funds are within the approved total project budget.

Ms. Youssouf asked if this was simply a work order increase and not an increase in project cost. Mr. Martone said yes. This authorization would realign the budget lines within the work orders between the Long Term Acute Care Hospital (LTACH) and the Skilled Nursing Facility (SNF) to accurately reflect current spending on the project. He said it also included the decommissioning funding, and explained that there was a net increase but not to the hospital project itself, simply from including that additional part of the project.

Ms. Youssouf asked how many more approval requests would come before the Committee. Mr. Martone said that this would likely be the last time the project would come to the Capital Committee for authorization. The only instance would be simply if existing funding needed to be reallocated, specifically for medical equipment and/or furniture, fixtures and equipment (FF&E).

Mrs. Bolus asked if the Committee was aware that the previously authorized \$14 million brought the level to \$132 million. Mr. Martin said yes, there was a reporting of the total project cost. Ms. Youssouf agreed, and added that it had been discussed at length. Mrs. Bolus said she remembered the discussion but did not remember that the increase was that significant. Mr. Berman explained that it was not an increase but a releasing of funds that had already been approved. It is drawing down of funds that are already allotted and approved.

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

On motion by the Chair, the Committee approved the work order.

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to decrease New York City Economic Development Corporation's (NYCEDC) work order threshold by four million, ninety-nine thousand, three hundred and sixty-seven dollars (-\$4,099,367) to one hundred twenty-four million, three hundred forty-one thousand, four hundred and twelve dollars (\$124,341,412) to continue providing project management services to manage the architectural, engineering design services, pre-construction, construction, construction management services for renovating the existing North General Hospital building into a new 201 bed Long Term Acute Care Hospital building (LTACH).

Robert Hughes, Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility, presented the work order on behalf of Lynda Curtis, Senior Vice President, Queens Health Network. Mr. Hughes was joined by Michael Buchholz, Senior Associate Executive Director, Coler-Goldwater Specialty Hospital and Nursing Facility, and Emil Martone, Vice President, Capital Programs, New York City Economic Development Corporation.

Mr. Martone explained that the proposed decrease in the threshold represents a shifting of costs related to FF&E that HHC will be purchasing in lieu of EDC.

Mrs. Bolus asked for an explanation of why funds are being added to one project and taken away from another. Mr. Pistone explained that the money is simply being taken from one pot and placed in another pot. The dollar amount remains the same it is just a shifting of funds.

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

On motion by the Chair, the Committee approved the work order.

Information Items

Henry J. Carter – Major Modernization – Status Report

Emil Martone, Vice President, Capital Programs, New York City Economic Development Corporation provided the status report on the progress of the Henry J. Carter project. Mr. Martone advised that the project was on schedule and on budget. He noted that progress is approximately 80% complete on the LTACH and SNF. The exterior envelope of the SNF is virtually buttoned up with only minor, mostly decorative features to be completed. The LTACH exterior work is also vastly complete. The project was on track to obtain temporary Certificates of Occupancy on both buildings in July, on schedule. He added that the activation plan to get from Temporary Certificate of Occupancy (TCO) to "move-in" is an aggressive plan and planning is well underway. As is the plan to move patients when the time comes.

Mr. Martone noted that staff at the facility has been immensely helpful.

He advised that the budget had not changed and remained at \$284,492. At the beginning of project there was approximately \$37 million contingency, and at present \$4 million remain, meaning roughly 15% of the overall direct work budget, or 13% of the remaining construction dollars are left. A value and burn rate that was expected at this point in the project and the team was comfortable with.

Mr. Martone said that recent State inspections had been performed and results came back at a rate of approximately 75% for both facilities. It explained that it was valuable to get comments early on and avoid doing much work later on in the project after final inspections had been completed. Mr. Martin asked if the inspection went well. Mr. Martone said yes, there were a few minor things that had to be addressed but no "show stoppers" and HHC was working on their formal response. Ms. Youssouf asked if it is usual that some comments come out of these inspections. Mr. Martin said yes, and it is beneficial that this was completed earlier on in the process.

Ms. Youssouf asked that a site visit be scheduled so that Committee members could see the project firsthand. Mr. Martone said he would be happy to show them around. Ms. Youssouf expressed excitement that everything was moving along on schedule and within budget. She thanked HHC staff and EDC for maintaining a great partner so far.

That concluded the status report.

Mrs. Bolus asked how the Community Advisory Board (CAB) felt about the project. Mr. Martin said that things were coming along and Executive Director, Robert Hughes was to be credited with keeping them informed and engaged in the process. Mr. Hughes said that both CABs had been kept fully informed of progress and that keeping patients and residents informed was also important, communication is crucial he said.

Air Conditioning Readiness Report

Mr. Pistone advised that there were no issues with the report and Committee members determined that they had no questions.

Presentation – HHC’s Construction Program

Mr. Pistone provided a power point presentation regarding the application of controls to improve facility construction project outcomes. He explained that the presentation would focus on recently completed reviews of the three most recent modernization projects and the most repetitive findings found by the office of Internal Audits. He thanked the Breakthrough Office, the Office of Internal Audits (OIA) and the staff of the Office of Facilities Development (OFD) for their efforts in assisting with this project.

The first slide discussed deficiencies found as a result of a review that was conducted of the major modernization projects at Henry J. Carter, Gouverneur and Harlem. Those projects are being constructed by managing agents, the Economic Development Corporation (EDC), and the Dormitory Authority of the State of New York (DASNY). The review found that there were deficiencies in reporting, record keeping, inadequate project estimates and allowance for contingencies, as well as inadequate management of changes made to the projects through the change order process. Each project has experienced cost overruns, albeit with respect to the Henry J. Carter project, which Mr. Pistone noted had experienced an overrun prior to EDC being on board. Each project experienced cost overruns from when the project was initially funded to the point of reaching current funding levels. The review found that managing agents were not engaged as true Owner’s Representatives, keeping schedule and cost in perspective. It was also noted that the department of Finance should be involved earlier on as a project is developing through the approval process.

From the slide, Mr. Pistone pointed out that the first issue, a lack of formal guidelines for project initiation, budget, cost and contingency would be addressed using the Breakthrough process, which should assist in capturing the initiation process and allow for HHC to be better able to capture deficiencies in the development of project scope and budget, and therefore be able to establish a more fair and reasonable contingency. Mr. Pistone advised that there had been several Breakthrough events, five in the past six months, and OFD would be continuing with that aggressive schedule, another four events slated for future review. He noted that a completed event had successfully mapped out the current process for construction projects as well as the proposed future state, and future events would develop specific areas for which to develop standard work. Two tools had come out of completed Breakthrough events, one of which is being piloted and rolled out, and that Mr. Pistone said would be addressed issues that will be discussed in a subsequent slide and decided by the OIA. The second tool, which is more expansive, addresses the issue of development of project scope and budget.

The second issue, pointed out that there was no centralized repository of historical data or memorialization of project changes. With respect to that issue, he noted, OFD and the Department of Information Technology (IT) is in the process of evaluating an electronic tool that will allow the Corporation to capture historical data and memorialize project changes. With a combination of that proposed electronic tool, and paper process if necessary, the Corporation will be able to properly obtain historical data on projects.

On the third issue, inadequate project estimates and contingencies, Mr. Pistone advised that OFD is using the Breakthrough process to provide a standardized process for evaluating project estimates and contingencies for the larger modernization projects. For smaller projects this will be addressed by references in the next slide to scope development, budget and construction management. The Office of Legal Affairs (OLA) and OFD have discussed utilizing a methodology where the CM is placed “at risk” for budget and scheduling, and that would address the managing agent not being engaged as an Owner’s Representative.

The second slide provided a list of issues and recommendations specifically related to OIA’s repetitive findings. Four of the last five audits found a lack of clearly defined scope and adherence to budget on smaller projects. To resolve this issue, OFD will have a direct relationship with the facility Executive Directors (EDs) to develop an agreed upon scope and budget. OFD will be more proactive in the process, making sure there is a complete scope and adherence to the budget. Inadequate project management; monitoring prevailing wage obligations, continuous insurance, daily reporting, submission logs, etc., are issues that were also raised in four of the five recent internal audit reports, for which OFD proposes to expand the Corporation’s relationship with the Gordian Group to address. They will be charged with monitoring projects, cradle to grave, and ensuring the aforementioned items are properly adhered to. The final finding was the reconciliation or failure to reconcile deviations of +/- 10% in bids. The proper way to address this issue is to require the estimate be itemized and that the contractor put a price next to that item so that it is clear if there is an item where there is a discrepancy from the original bid. This method has been tested and appears to be working.

Ms. Youssouf asked for an explanation of statements made regarding Architectural and Engineering (A/E) firms. Mr. Pistone explained that the current structure involves requirements contracts, “on-demand” contracts, similar to contractor contracts, and that it is being proposed that rather than allowing the facilities to access the contracts directly, they will go through OFD and OFD will work with the architects, engineers and the facility to develop a scope and budget. Ms. Youssouf asked if that would be done prior to bidding. Mr. Pistone said absolutely.

Ms. Youssouf asked if these new processes would be written down and memorialized somewhere. She said that it seemed as though previously the facility would determine that they had specific money and needed a project to be completed with that money, and clearly that way was not working. If this is the new procedure it needs to be memorialized, she said. Mr. Martin agreed. He explained that the Corporation will have to reflect these changes in policy and procedure, and noted that the Breakthrough process was still be used to address a number of

these issues, but eventually determinations will be memorialized. He noted that the better a project is scoped out in the beginning the more successful it will be. So having OFD actually procure the A/E firm and work in conjunction with facility EDs to get a good scope will help tremendously.

Ms. Youssef said that at the facility level there also seemed to be a habit of change orders or changes that greatly affect a project. Mr. Pistone said that would be addressed as well.

Dr. Stocker noted that a lot of good work had been completed in reviewing these issues, and he stated that it is a sign of maturity in an organization if they can manage construction projects. He asked whether OFD, along with facility, will select A/E firm, and that A/E firm will complete the estimate, cost, and define the scope of the project. Mr. Pistone said yes, the next generation of AE contracts makes that a contractual obligation. To have a better handle on the estimate and be able to reconcile more easily language has been added requiring a better accountability by firms to be better partners in ensuring that estimates are more accurate relative to market conditions.

Ms. Youssef requested that if an A/E firm is constantly over or under estimating then there should be a procedure allowing them not to be used going forward. Mr. Pistone said that in the future it will be well documented that any A/E firm that continues along a path and becomes a repetitive offender the Corporation will seek not to do business with. Ms. Youssef said that the same should be done with the contractors. Mr. Pistone said yes, absolutely.

Marsha Powell, Director, Office of Facilities Development, explained that it has been written into the new contracts that a consultant will have to redesign if they submit a design that does not come within a percentage of the original estimate. If they design a project that does not come within the original estimate that was agreed upon at project conception, by the final estimate, if it is not within the budget then they have to redesign. Ms. Youssef said to be careful. Ms. Powell explained that this is common contract language and is done across the design and construction field.

Mr. Martin said that changes are underway. He noted that in the past it was common for a facility to identify an amount of money they were willing and able to spend, and then try to build what they desired into that amount. Moving forward, an accurate scope will be completed first and then appropriate funding will be identified. Ms. Youssef agreed with the importance of that and said she knows that Mr. Pistone and his team have worked very hard and have gotten needed advice along the way. She added that the Committee had previously repeated the issues being discussed, but this is a great way to ensure that we are more in line with good practices.

Dr. Stocker asked if the intent was that once the project is under way, the final responsibility and day to day management will rest with the facilities. Mr. Pistone said yes. Ms. Youssef said that also means the facility has the accountability to be sure these projects come in, within reason, within time and cost, because part of the problem has been that there is no accountability, and that cannot continue.

Mrs. Bolus advised that if a redesign was needed and that redesign did still not meet criteria then HHC should move on to another firm, and she noted that the project would virtually have to start over with new bids. Mr. Martin said the project needs to be defined at the outset. Defined and then funded. He explained that HHC used to try to fit the project into the budget and when it didn't work there would be constant changes in an effort to get everything that was desired but that would just increase cost as it moved along.

Mr. Martin advised that the Corporation was looking at reorganization of the Office of Facilities Development, to determine the types of people that may be needed within that department to move this process forward.

Dr. Stocker asked for a detailed explanation of the electronic system to be implemented to track construction progress, and what the time-frame would be. Mr. Pistone said that OFD was working with IT to identify which system to use and when the selection process was completed it should take approximately three (3) to six (6) months to get information loaded and get moving.

Ms. Youssef asked for regular status updates of how these changes are going. Dr. Stocker asked that when members of the Committee receive completion reports, it be noted how close the costs were to initial A/E estimates.

Project Status Reports

Central/North Brooklyn Health Network

Generations+/Northern Manhattan Health Network*

Queens Health Network*

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

Harlem Hospital Center – Kountz Pavilion

Louis Iglhaut, Associate Executive Director, Generations+/Northern Manhattan Health Network, provided the delay report. Mr. Pistone noted that delays were a result of weather related conditions that have halted roof installation. Mr. Iglhaut agreed and said the completion is currently forecasted for September, 2013.

Lincoln Medical and Mental Health Center – Emergency Department Project

Louis Iglhaut, Associate Executive Director, Generations+/Northern Manhattan Health Network, provided the delay report. Mr. Iglhaut advised that the completion schedule for the project remained unchanged since the last report, expected in December, 2013, and he noted that the project was within budget.

Dr. Stocker asked how long the project had been going on. Mr. Iglhaut said it had been on the books since 2000 and it included two phases. Phase I, construction of the Ambulatory Care Pavilion was completed and had been occupied in 2012. He said that Phase II was now well underway and the light at the end of the tunnel could be seen.

Mr. Iglhaut advised of a potential risk to the project. He explained that tracking of contract activities found that the general contractor's document submissions had been late, which could cause delay, but at his request Central Office had begun proceedings to protect the project schedule and budget. He advised that a hearing had taken place on June 6, 2013, but since the intent to default letter was written and sent to the contractor and his bonding company, the project had been properly supplied with labor and materials. After the initial hearing date the contractor had agreed to submit completion schedule, with milestones, that would allow the project to be completed as planned. Ms. Youssouf thanked the facility for initiating that process. Mr. Iglhaut credited Mr. Pistone and Mr. Lynch from the Office of Facilities Development. Mr. Pistone thanked the Office of Legal Affairs for their assistance.

Elmhurst Hospital Center – Women's Health Clinic

Dean Mihaltses, Associate Executive Director, and Thomas Scully, Senior Associate Director, Elmhurst Hospital Center, provided the delay report. Mr. Mihaltses explained that no additional delays had been experienced since last reporting and that completion was still expected for September, 2013, and was still within budget. Mr. Scully noted that initial delays due to a gas line issue impacted the project early on but otherwise it had been accelerating since the termination of Hunter Roberts Construction Group and the change in General Contracting management. Mr. Mihaltses thanked Mr. Scully for a being a crucial part of getting the project back on track.

Ms. Youssouf thanked everybody on behalf of the Capital Committee members. She acknowledged that members had been vigilant in their efforts to keep projects on track and to remain fully informed, and she felt that OFD and the facility counterparts had heard them and were responding.

Equal Employment Opportunity Committee – June 11, 2013

As reported by Rev. Diane Lacey

2011-2012 M/WBE Program Annual Report Facility Update

The Assistant Vice President, Affirmative Action/EEO reported on the status of the Corporation's M/WBE Program. The report shows that there was a decrease in the overall M/WBE expenditures in the Corporation by \$22,680,382 from \$64,288,695 in 2012 to \$41,608,313 in 2013.

Expenditures of MBEs decreased by \$18,259,669 while expenditures on WBEs decreased by \$4,520,713. The overall utilization rate for M/WBEs decreased by 2.40% -- from 7.30% in 2012 to 4.90% in 2013. WBE participation rates decreased by 0.44 from 2.28% in 2012 to 1.84% in 2013 while the MBE participation rate decreased by 1.96% from 5.02% in 2012 to 3.06% in 2013.

Gail Proto, Senior Director, Affirmative Action/EEO, reported on three conditionally approved contractors, Perkins Eastman Architects, PC which had one minority underutilization in the Professional Job Groups 2 and eliminated the minority underutilizations in Professional Job Groups 1 which it had in 2012. Sodexo Laundry Services, Inc., which had four underutilizations of women in the Management Job Group 4, Operators Job Group 1, Crafts Job Group 1, and finally Service Workers Job Group 5 in 2012. In 2013, the underutilization in Managers Job Group 4 and Craft Job Group 1 for women, were eliminated while the underutilization of women in operative Job Group 1 and Service Worker Job Group 5 remains. The third contractor Ms. Proto reported was A&P Coat, Apron & Linen Supply, Inc. which had one underutilization for women in Managers Job Group 3.

Finance Committee – June 11, 2013

As reported by Mr. Bernard Rosen

Senior Vice President's Report

Ms. Marlene Zurack stated that in addition to the routine reporting of HHC's cash on hand (COH), the status of the City's budget and two Rules that relate to Medicaid and Medicare Disproportionate (DSH) that were issued last month would be included. In terms of the COH, as of June 7, 2013, HHC's cash balance was \$695 million or 43 days of COH; however, the projected year-end balance is \$225 million. A \$51

million UPL payment for the D&TCs was moved from June 2013 to July 2013 and as approved by the City, a number of City payments were also moved to next FY 14 in order to maintain a positive cash balance.

Committee Member, Ms. Emily Youssouf asked which payments were being moved to next FY 14 and what would the \$225 million equate to in terms of days. Ms. Zurack stated that the projected year-end cash balance is 14 days of COH. The payments that are being moved included an EMS payment of \$148.5 million, malpractice of \$135.9 million, debt service of \$155.2 million and several other small payments for a grand total of \$465 million in deferred City payments. HHC is working with the City's OMB on the Community Development Block Grant (CDBG) disaster relief funding which is being spearheaded by Mr. Covino as part of the claim's process that is expected to generate approximately \$183 million with the expectation of claiming additional funds from that funding source.

Ms. Youssouf asked if the \$465 million in City payments were scheduled in the FY 14 budget. Ms. Zurack stated that Corporate Finance would be working with OMB in the coming weeks to schedule those payments as part of HHC's FY 14 cash flow which will be presented to the Committee next month.

Ms. Youssouf asked what the status of the CDBG funding is.

Mr. Fred Covino in response stated that a meeting with OMB has been scheduled to review the final submission that will be presented to HUD.

Ms. Zurack stated that the Committee would be informed of the status of the CDBG disaster relief funding as the process progresses.

Mr. Rosen asked if the expectation is that the \$183 million would be received in the first quarter of FY 14. Mr. Covino stated that it is contingent upon the approval and sign-off by HUD and after that is obtained those funds are expected to flow very quickly. The goal is to get those funds by the end of the first quarter of FY 14.

Ms. Zurack added that there will be claims in excess of the \$183 million; therefore, there will be additional allocations subsequent to the initial allocation of \$183 million. Moving to the next item in the reporting, the City budgets, some of the highlights of the issues related to HHC's City Council hearing that are both positive and negative. On a positive note, the Sexual Abuse Response Team (SART) program funding was restored at \$1.272 million for all the years of the financial plan. Part of the success in getting this restoration is due to the diligent efforts of Megan Meagher, Budget Analyst, OMB who assisted HHC in achieving this effort. There are pending restorations totaling \$8.467 million in City funded programs that include \$5 million in child health clinics (CHC), \$2 million in Rapid HIV testing, and \$1.467 million in developmental delayed clinics. As previously reported to the Committee, as part of the State matching funds for CHC programs, the State has changed the eligibility rules for matching funds. HHC is reviewing whether it can retain State public health funding, Article 6 for those programs. The imposed change will make it more difficult to claim those funds. For the child health program (CHP), HHC receives \$7.5 million in City funds matched by \$4.2 million in State funds. If HHC cannot find a remedy to this issue, those State funds are at risk. Additionally, if the City Council does not restore those funds, HHC is at risk of losing funding for those programs. HHC will continue to address this issue with the City and State and keep the Committee informed of the status.

Committee Member, Human Resources Administration (HRA) Commissioner Robert Doar asked what prompted the change in the rule. Ms. Zurack stated that it was an across the board budget cut.

Mr. Rosen stated that in the past the City Council has restored those funds year after year.

Ms. Zurack added that traditionally those funds were restored by the City Council; however, this would be the first year the State has taken this type of action relative to this program which Mr. Covino would further explain.

Mr. Covino stated that of the \$4.2 million at risk, it is anticipated that HHC will keep a portion of that as oppose to the restoration of the full amount. The change relates to primary versus preventive care and detail and documentation are needed to support the claims.

Commissioner Doar asked if it relates to compliance with a federal rule or a State issue.

Mr. Covino stated that it is not a federal compliance but rather how the categories of care are being described.

Commissioner Doar asked if it is by the State Department (SDOH) as opposed to the Legislature.

Ms. Zurack stated that for further clarification of the issue John Jurenko, Senior Assistant Vice President, Intergovernmental Relations would elaborate further.

Mr. Jurenko explained that the change was a recommendation from the County Health Officer Association who were trying to preserve Article 6 funding for uninsured children. In the case of HHC, a number of children who come to HHC facilities are uninsured and HHC has been very successful in getting those children insured which based on the change would have an adverse impact on HHC given that 87% of the

children seen by HHC facilities are insured. This was a budget action that for years, efforts have been made to cut Article 6 funding for certain categories and every year some things were cut and this year unfortunately it is the CHP.

Ms. Youssef asked if HHC get 87% in reimbursement and the City restores the funding where is the gap.

Ms. Zurack stated that the Medicaid reimbursements are not at cost so even though the reimbursement is at 87%; there is a loss on each visit.

Ms. Youssef asked if both funding sources are needed to make up for that loss. Ms. Zurack stated that both are need to cover the gap.

Committee Member, Josephine Bolus, RN, asked if the D&TCs would be affected by the change. Ms. Zurack stated that the child health programs are attached to the D&TCs so to a certain extent it would; however, the D&TCs do not receive Article 6 funding so in that regarding it does not directly impact them.

Medicaid and Medicare DSH Rules

Ms. Zurack stated that several weeks ago the federal government issued two proposed rules. As reported at Strategic Planning Committee meeting, as part of the Affordable Care Act (ACA) there was a substantial reduction to Medicaid DSH nationwide that equates to \$500 million in 2014 growing to \$5.6 billion in 2019. Medicaid DSH are federal funds that are matched by State funds. The State operates its own DSH programs that provide assistance to hospitals who treat a disproportionate share of uninsured and Medicaid patients. Each state has an allotment of DSH which is the maximum amount each state can claim in any given federal fiscal year (FFY). Therefore the cuts relate to the State allotment.

Mr. Rosen asked if there were caps in place prior to this action. Ms. Zurack stated that for at least twenty years there were caps that were put in place to limit the federal government exposure to DSH claiming. There are some States that do not provide any funding for the uninsured and therefore do not claim DSH funding. NYS has the largest allotment of DSH funding in the country. There was guidance in the ACA on how CMS would distribute the \$500 million increasing to \$5.6 billion in cuts against each State's allotment. Secretary Sibelius who is the person authorized for the issuance of the proposed rule may choose to allocate the proposed cuts to the States and in the statutes there is reference to the Secretary's option to review the number of uninsured and how much each State targets its DSH funding to hospitals that provide a substantial amount of care to Medicaid and uninsured patients. Given that the ACA is new, the Secretary's position is that there are some things that are not very clear such as which states will opt-out; how the uninsured will be addressed; and the fact that the data is inadequate. Based on those unknowns the Secretary issued a rule that is valid for the first two years, 2014 and 2015. As additional data is collected the rules will be adjusted later. The current rule that was issue states that the review will include 1/3 based on the number of uninsured and 2/3 based on how each state targets its DSH monies to high Medicaid hospitals and how it targets its DSH monies to high uninsured hospitals. In essence, how DSH funds are being used based on those two factors were blended into one. In NYS, the DSH program is larger proportionately in the country to its share of the uninsured; NYS has 8% of the uninsured and 14% of the DSH in the country which is due primarily to NYS expansive Medicaid program. On the first matrix NYS does worse than a straight proportionate cut. However, on the targeting of its DSH funding to Medicaid and uncompensated hospitals, NYS did better due mostly to the Intergovernmental Transfer (IGT) which largely is allocated to HHC. If NYS were to have taken a proportionate cut of the \$500 million it would be \$75 million. The methodology proposed by the Secretary would result in a \$65 million cut. It is important to note that this is a proposed rule that will eventually become final after the process is completed. Based on the current state law, all of the DSH cut for 2014 would accrue to HHC given that HHC's federal DSH maximization funding are in fact the last funds in current law. However, if the State can remedy the first couple of years of the cut for HHC by moving some of the voluntary hospitals DSH program into UPL programs which will require State law that HHC would need to pursue next year. The trade associations, GNYHA and HANYS are addressing this issue Medicaid DSH cut.

Ms. Andrea Cohen, representing Committee Member Deputy Mayor Linda Gibbs as her Agent Designee, asked if it is for one or two years. Ms. Zurack stated that it is two years, \$500 million in 2014; \$600 million in 2015, \$1.8 billion in 2016, \$5 billion in 2017; \$5.6 billion in 2018, and 2019 reduces to \$4 billion.

Mr. Rosen commented that HHC would be impacted by the cut for nine months in FY 14.

Commissioner Doar asked for clarification of the cut decreasing from \$75 million to \$65 million.

Ms. Zurack stated that the cut is based the State's allotment. Commissioner Doar asked if the \$65 million would be for the entire state to which Ms. Zurack replied yes but all of that cut would be imposed on HHC unless there is a change in the law due to HHC's DSH maximization if there is DSH leftover since the hospitals across the country have priority over HHC as well as the voluntaries.

Ms. Cohen asked if the DSH maximization is one of HHC's sources. Ms. Zurack stated that it is only one of HHC's sources.

Commissioner Doar asked what would left for HHC in DSH if the \$65 million would be imposed.

Ms. Zurack stated that HHC gets \$1.2 billion in DSH in total funding and the \$65 million is federal funds which have a City match of \$65 million which is still being supported by the City.

Mr. Rosen asked for clarification of the Medicaid DSH components as it relates to the Federal and City funds with no State funding.

Ms. Zurack stated that the Medicaid DSH funding is comprised of Federal and City funds of a 50/50 split. The DSH that HHC receives is from the IGT. For example if HHC get \$1.2 billion, \$100 million is funded from the pool that all of the hospitals receive in NYS; therefore, \$1.1 billion would come from the IGT portion which is 50/50 City and Federal. The \$100 million is 50/50 State and Federal. The portion of the DSH that HHC gets as the last priority draw is the DSH maximization which for HHC has averaged \$300 to \$400 million in total funds, 50/50 split, Federal and City. If the State loses \$65 million in DSH allotment and no other actions are taken that would affect NYC's ability to match the last DSH match piece and HHC would lose the \$65 million. However, based on discussions with the trade associations, there are ways for the State to remedy this issue as previously mentioned.

Medicare DSH

Ms. Zurack stated that as part of ACS there was a change to the Medicare DSH. Medicare DSH payments are very different from Medicaid DSH payments in that those payments function as a variable in the Medicare rate for each hospital. When the federal government calculates HHC's Medicare rate after the traditional formula, it multiplies that rate by a constant which is a function of the Medicare eligible days and SSI days. A number of HHC patients are Medicaid and some receive SSI. HHC's Medicare rate increase could be from 20% to 40%. Medicare rates were originally designed to cover hospitals' costs based on rigorous cost reports that demonstrated that hospitals empirically treat a large proportionate of SSI and Medicaid patients and have higher costs. Therefore, the Medicare DSH was a way to try to create an average cost that was fair. ACA assumes a dramatic reduction in the number of uninsured in the USA. Based on that assumption there would be no need to have this rate of add-ons as HHC has had in the prior years. The federal government is proposing to reduce all DSH by 75% and have a portion of that as budget savings that will vary based on the changes in the uninsured as the ACA is being implemented. Initially there is a portion of the 75% that goes for budget savings, 20% and the balance is per Congress to go into a pool of funds that would get redistributed to hospitals with high Medicaid and high uninsured patients. Similar to the Medicaid rule, there is a problem with the data, in that it is based on every hospital's Medicare cost report that is audited by the federal government and the auditing is five years lagging. However, HHC is more up-to-date as confirmed by Ed Brenner, Senior Director, Reimbursement Services. Currently the FY 11 audit has begun putting HHC ahead of some of the voluntaries. The source of the data would have come from the schedule that is on the cost report which is significantly lagging. The choice would be to use unaudited reports, looking for a proxy rather than the acute uncompensated care cost. The proposed Medicare rule is similar to the formula used before Medicare days plus SSI. However, instead of a rate increase based on actual number of days as a percentage of the total days, it will be based on the hospital days as a percentage of the nation-wide days which will determine the hospital percentage of the redistribution. HHC's issue with this methodology is that the cut was applied in the rule to Medicare managed care in addition to Medicare fee-for-service while the redistribution funds were only generated from the fee-for-service which is an error. The trade associations are addressing this issue and HHC will be pursuing this issue as well. When Secretary Sibelius as part of the calculation takes Medicaid days and SSI days as a proxy, if HHC was 1% of the total Medicaid and SSI days in the country, HHC would get 1% of the Medicare DSH. HHC will argue that it is a greater percentage of its business while it may not be a greater percentage of the country. Medicare DSH is intended for those hospitals that do a disproportionate share. In addition, the Federal government did not include psych and rehab and there is no labor or regional adjustment provided. In the current state based on the rule assuming that the managed care, this would be a positive for HHC of \$28 million. If HHC prevails in its efforts it could be much more than that amount. Comments regarding this rule are due June 24, 2013.

Ms. Youssouf asked for clarification of the positive \$28 million for HHC. Ms. Zurack stated that it would be a positive given that HHC provides a significant amount of care to SSI and Medicaid patients. Before concluding her report, Ms. Zurack informed the Committee of the passing of a finance employee, Christopher Provenzano who worked at the North Bronx Network and most recently at Generation Plus/Northern Manhattan Network. Mr. Provenzano was a very hard worker and well like by everyone. HHC extends its condolence to the family.

Key Indicators & Cash Receipts & Disbursements Reports

Mr. Fred Covino reported that utilization is down by 9.1% or 14,000 discharges a slight improvement from last month, excluding Bellevue and Coney Island from the data, the decrease is less than a ½ percent or 456 discharges. The D&TCs visits are down by 11.7% and Nursing Home days are down by 14.1%. The ALOS, all of the facilities with the exception of Lincoln and Metropolitan are within the corporate average, Lincoln is less than ½ day and Metropolitan is 4/10 day less than the average. The CMI is up by 1.4% compared to last year for the same period which is the highest it has been all year. FTEs are down by 857; receipts are down by \$291 million and disbursements are \$78.9 million down for a net negative variance of \$369.5 million. Page 3 a comparison of the year-to-date actual to the prior year FY 12 to FY 13, receipts are \$96 million worse than last year due to the decline in Medicaid fee for service which is down by \$199 million of which \$80 million is related to the impact of the storm at Bellevue and Coney Island. Expenses are \$210 million better than last year due to timing and a delay in payments to the City and pension payments of \$178 million pension and a \$23 million FICA payment which if offset by a \$100 million in OTPS payments for storm related damages at Bellevue, Coney Island and Coler hospitals. Page 4, inpatient receipts are down by \$296 million of that \$191 million is related to the storm for Bellevue and Coney Island in addition to the Medicaid fee for service which is down by

95 paid cases against the budget and a decrease in psych days of 52,000. Outpatient receipts are down by \$80 million of which half is related to Bellevue and Coney Island relative to the storm. All other revenues are up by \$85 million primarily in grants and Intra City and \$52 million in FEMA funding. Fringe benefits are \$25 million better due to the FICA recovery of \$23 million. OTPS expenses are \$92 million worse than budget; however, over a \$100 million of that is related to expenses for the storm. The report was concluded.

Information Item

Mr. Jay Weinman reported that the report covers the 3rd quarter of the current FY 13 compared to FY 12 for the same period. The total loss through the period is \$843 million compared to last year of \$596 million, a net increase deficit of \$246 million. Major variances included, a \$449 million decrease in the net patient service revenue; inpatient decrease by \$273 million.

Ms. Youssef asked how much of the decrease in net patient revenue is related to the storm.

Mr. Weinman stated that it was footnoted at the bottom of the page, \$273 million in net patient service revenue; \$48 million in outpatient revenue for a total of \$321 million in addition to \$83 million in OTPS, totaling \$404 million in storm related revenues and expenses. In addition to those reductions there was a \$28 million reduction in nursing home days based on volume and an outpatient adjustment of \$40 million due to a change in the accounts receivable.

Ms. Youssef asked for clarification of the nursing home adjustment. Mr. Weinman explained that the volume is down at the nursing homes by 14% as previously reported by Mr. Covino.

Mr. Rosen added that it was reported as part of the Key Indicators report as part of the utilization.

Mr. Weinman continuing with the reporting stated that patient revenue increased by \$320 million due to a pharmacy adjustment of \$75 million, a rate enhancement of \$173 million; 6% membership growth at MetroPlus. Grants revenue increased by \$136 million, \$57 million in federal and state funding in Meaningful Use of \$62 million from the City and \$17 million for grants. Personal Services increased by \$55 million although there was a reduction of 1,068 FTEs or 2.9%. The increase is related to an increase in collective bargaining payments. Last year, the \$67 million was understated. OTPS expenses increased by \$336 million due to \$281 million related to MetroPlus, \$55 million and \$83 million related to the storm and a \$28 million decrease in all other OTPS.

Ms. Youssef asked about the total reimbursement for revenue losses related to the storm. Mr. Weinman stated that there was no adjustment for revenue losses related to the storm only for expenses.

Ms. Zurack added that in reporting to the Committee for the potential of CDBG funding, it is yet to be determined what that amount will be, therefore it is not booked as a receivable. There were FEMA funds of \$61 million which is included. It is projected that by year-end there will be \$200 million in earned FEMA revenue.

Mr. Weinman reported that fringe benefits increased by \$51 million, \$13 million in health benefits or 3.5%, pension increased by \$41 million or 15%. Post-Employment benefit decreased by \$226 million compared to last year which increased by \$700 million. This year the accrual is at \$400 million based on last year's actuarial report. Affiliation expenses increased by \$24 million or 3.8% of which \$15 million is related to prior year budget recalculations and modifications.

Commissioner Doar asked for clarification of the increase in expenses although FTEs decreased by over 1,000. Mr. Weinman stated that last year there was an adjustment to the collective bargaining estimate based on the City's estimates for retroactive payments totaling \$67 million; therefore, the increase is related to the reduction taken last year.

Ms. Youssef asked for clarification of the increase in Affiliation expenses. Mr. Weinman stated that it is related to budget adjustments for recalculations of prior year expenses. The report was concluded.

Governance Committee – May 30, 2013 As reported by Rev. Diane Lacey

The Committee continued in Executive Session to discuss the request by President Aviles to consider the Corporate Officer appointment of Ms. Denise C. Soares to the position of Senior Vice President of the Generations+/Northern Manhattan Health Network.

Mr. Aviles explained that Ms. Soares has nearly 40 years of experience in health care professionally in the fields of nursing and hospital administration. Approximately fourteen of those years are attributable to HHC having served in the capacity of Chief Nurse Executive in the North Bronx Healthcare Network for about twelve years, with the remaining years as Deputy Executive Director/Chief Operating Officer for the North Central Bronx and in her current position as the Executive Director for Harlem Hospital Center and the Renaissance Healthcare Network Diagnostic & Treatment Center.

Mr. Aviles went on to say that she has done quite well as the Executive Director for Harlem Hospital and the community it serves. She had been a champion of the Corporation's Breakthrough work while at the North Bronx and has successfully carried that over to Harlem. Given her years of experience, and her demonstrated abilities throughout her HHC experience, Mr. Aviles believes that Ms. Soares is an excellent choice for this role.

The Committee unanimously approved the President's request to appoint Ms. Soares to the corporate officer position of Senior Vice President (Network) and will recommend this appointment to the full Board for its consideration.

Medical & Professional Affairs / Information Technology Committee
- June 20, 2013 - As reported by Dr. Michael Stocker

Chief Medical Officer Report:

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

Behavioral Health Annual Learning Session

On June 21, the Annual Corporate-wide Behavioral Health Learning Session will be held and is entitled "Collaborate and Implement: Standardizing Care to Achieve the Triple Aim". Presentations will focus on what consumers of behavioral health services want from their providers; effective strategies to redesign care in a managed care environment, changing culture; to standardize care; lessons learned from Kaiser Permanente; and expanding the continuum of ambulatory care. In addition, this year's annual award will be presented to Coney Island Hospital, Department of Behavioral Health acknowledging the overall improvement in the HHC Behavioral Health Key Indicators between 2011 and 2012 and the Best Performance in 2012. There are over 160 participants registered to attend.

HHC Presents at Statewide Readmission Learning Collaborative

On June 7, 2013 HHC had several facilities including, Kings County, and Coney Island Hospitals and Office of Behavioral Health at this statewide meeting on our work with regard to integrated mental health and substance abuse care, and engaging patients in care, and use of Peer Counselors running groups, as part of the interventions being used and tracked in this project. Early data indicates an overall reduction in readmissions to NYS hospitals, as identified by Medicaid claims data. All HHC facilities are participating.

NYS Hospital-Medical Home - Update

Facilities are on their way to strengthening integration of depression management in primary care, one of the objectives of the NYS Hospital-Medical Home Award. At least one multi-disciplinary team of nurses, social workers, internists and psychiatrists from all 17 facilities attended two day training by the University of Washington on how to improve depression, hypertension, diabetes and lipid outcomes using the collaborative care model - a team-based approach to manage care in patients with multiple chronic illnesses.

NYS Hospital-Medical Home Demonstration

The NYS Department of Health has amended the funding disbursement schedule for the NYS Hospital-Medical Home Demonstration Award. The remaining 75% of the \$38 million Year One Funding will now be disbursed in September 2013, contingent on the submission of the facility quarterly data and progress report due August 1, 2013.

HHC Health Home Update

HHC Health Home enrollments have continued to grow. HHC Health Home currently has 1,375 enrolled patients - 15.7% or 217 of enrollees were recruited from the NYSDOH Roster. Of the 1483 patients in HHC legacy COBRA, TCM and CIDP programs 1,046, or 70%, have transitioned to our Health Home Program. New staff is now focusing on outreach and engagement of new participants from the state roster.

On Friday, we learned that Gouverneur became our first site to receive NCQA Level III Recognition from NCQA with a score of 92.5 out of 100 points. The performance bar for this award was higher than with previous standards and required service elements for care management and screening for behavioral health conditions in primary care.

NYS Sepsis Regulations

All HHC acute facilities are preparing to meet the new state regulations to promote the early detection and standardized treatment for septic shock, which come into effect in August of this year. All facilities have been participating in a State-wide collaborative as part of our preparation, with benefits including standardized treatment protocols based on the sepsis bundle.

Opioid Prescribing

Based on ongoing work at HHC and then accelerated by the NYC Guidelines launched by the Mayor in January of 2013, HHC physicians have been able to reduce the number of prescriptions for opioids from our Emergency Rooms, by up to 20% over the last 12 months. This dramatic improvement is still the subject of ongoing effort, but should provide a significant public health benefit to New Yorkers.

MetroPlus Health Plan, Inc.

Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of June 7, 2013 was 427,758. Breakdown of plan enrollment by line of business is as follows:

Medicaid	366,017
Child Health Plus	12,668
Family Health Plus	33,394
MetroPlus Gold	3,236
Partnership in Care(HIV/SNP)	5,446
Medicare	6,799
MLTC	198

Dr. Saperstein provided the Committee with reports of members disenrolled from MetroPlus due to transfer to other health plans, as well as a report of new members transferred to MetroPlus from other plans.

MetroPlus has submitted their 2014 Medicare bid on time. The MetroPlus Finance team worked diligently to design a bid that was fiscally responsible and offered their membership the maximum benefits. For 2014, the products for their dual eligible population will remain stable and competitive with other plans, with little change to premiums or benefits. On the other hand, MetroPlus' Medicare HIV Special Needs Plan required significant increases to the premium rates, which will likely challenge the viability of that product line. This occurred due to very high HIV pharmacy costs, as well as a lowering of the HIV acuity scores by CMS which led to more than a 14% rate reduction, and a rate reduction due to the Affordable Care Act.

The New York State Department of Health (NYSDOH) has begun discussions with health plans regarding the carve-in of nursing home benefits for non-dual eligible members. The carve-in of the benefit and the transition of the population are scheduled to begin October 1, 2013. A workgroup consisting of plan, nursing home and consumer representatives are scheduled to define the details in the coming months. This change is part of several provisions that were included in the State Fiscal 2013-2014 Budget as well as Medicaid redesign proposals that the state will pursue in 2013-2014. Dr. Saperstein will continue to report on these changes as the effective dates get closer.

In the past month, MetroPlus, along with twenty-six other plans State-wide received preliminary approval to move forward with the readiness review process to participate in the Fully Integrated Duals Advantage (FIDA) demonstration. MetroPlus is currently preparing for a readiness review, which will include a desk review, a site visit and systems testing. MetroPlus has been informed that the total review process will take approximately four to five months.

Until recently, MetroPlus had only one Health Home contract with HHC. At the request of the State, MetroPlus was required to contract with additional Health Homes. MetroPlus recently executed contracts with VNS and Maimonides for Health Home services. A review of their data identified over 500 members who qualified for Health Home services, were not affiliated with HHC, and had been receiving case management services from these additional two vendors.

Lastly, MetroPlus has started their full Article 44 licensing audit by the New York State Department of Health. This audit was started on June 17th, and should be concluding tomorrow.

Action Items:

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to purchase Cisco SMARTnet maintenance through a NYS Office of General Services (OGS) contract from Cisco's authorized reseller, Dimension Data North America, Inc. in an amount not to exceed \$22,080,000, including a 15% contingency, over the term of three years.

The resolution was approved for the full Board of Director's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a contract with Allscripts Healthcare LLC. ("Allscripts") for a web-based case management, and denials management and discharge planning software solution accessible throughout the Corporation's acute-care and long-term care facilities for a three (3) year term with two (2) one year renewal options, exercisable solely by the Corporation, in an amount not to exceed \$5,201,225.

The resolution was approved for the full Board of Director's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute a contract with IBM Corporation for the procurement of a performance analytics/business intelligence platform. The contract will be for an amount not to exceed \$10,054,721 for an initial term of one year, with three (1) one year renewal options, exercisable solely by the Corporation.

The resolution was approved for the full Board of Director's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an Affiliation Agreement with the State University of New York/Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at Kings County Hospital Center ("KCHC") for a period of three years, commencing July 1, 2013 and terminating on June 30, 2016, consistent with the general terms and conditions and for the amounts as indicated in Attachment A; AND Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

The resolution was approved for the full Board of Director's consideration.

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an Affiliation Agreement with the Staten Island University Hospital ("SIUH"), for the provision of General Care and Behavioral Health Services at Sea View Hospital Rehabilitation Center and Home ("Sea View"), for a period of three years, commencing July 1, 2013 and terminating on June 30, 2016, consistent with the general terms and conditions and for the amounts as indicated in Attachment A; AND Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

The resolution was approved for the full Board of Director's consideration.

Information Item:

IT Disaster Recovery/Business Continuity Update

Michael Keil, Assistant Vice President, and Glenn Manjorin, Director, IT services presented to the Committee. The Business Continuity Program (BCP) time line was presented. Mr. Keil informed the Committee that they are analyzing previously compiled BCP engagement documentation and applying industry wide best practices and standards. The team's objective was to determine gaps in the following areas: disaster recovery program development; disaster recovery capability inventory and assessment; plan documentation development; and training and awareness.

Findings in 2012 were: 1) lack of an established program charter or policy; and 2) no published governance or standardized repeatable processes. Actions taken to date include: policy & charter ratified & distributed to Senior EITS Management; Governance Council created under the direction of the Chief Information Officer. The purpose of the Governance Council is to obtain senior management commitment and direction for the Information Technology Disaster Recovery (ITDR) program. 3) limited documentation of application information was available; 2) physical ability to recover key applications was untested; and 4) determined 19% of critical applications have recovery capabilities. Actions taken to date: created an application information matrix showing recovery capability and required remediation; application information matrix updates scheduled & reviewed with Governance Council; and infrastructure team has reviewed the gap has provided a resolution for all critical applications. 5) lack of standardized recovery plan or defined plan owner responsibilities and 6) Many Tier 1 (4 Hour Recovery Objective) and Tier 2 (24 Hour Recovery Objective) applications have no tested recovery plans. Actions take to date: created a standardized format for all recovery plans and created ITDR plans to be used in an event of a test/disaster. 7) no formal training provided; 8) disaster recovery needs were not part of the Information Technology portfolio Management Committee (ITPMC) process; and 9) no passive testing done for disaster recovery (e.g. Tabletop exercise). Actions taken to date: conducted EITS training [3 technical audience training sessions; 1 Senior EITS management training session; and incident management tabletop conducted with Senior EITS Management]; created disaster recovery requirements definition to be completed for ITPMC; and published SMO newsletter interview with Director of IT.

Mr. Keil concluded the presentation by describing the response structure and the five key recovery plans developed. Next steps include: Phase II - further review of Business Impact Analysis and continued analysis of Tier 3 and Tier 4; investigate DR software options for automation; continue to explore communication tools with the HHC Office of Emergency Management; and prepare to test EPIC failover prior to 'go live'.

Strategic Planning Committee – June 11, 2013
As reported by Josephine Bolus, RN

Senior Vice President Remarks

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

FEDERAL UPDATE

Medicare Disproportionate Share Hospital (DSH) Funding Proposed Rule

Ms. Brown reported that, on April 26, 2013, the Centers for Medicare and Medicaid Services (CMS) had issued the Medicare Inpatient Prospective Payment System (IPPS) proposed rule for Fiscal Year (FY) 2014. As a result of that rule, hospitals will experience an average payment decrease of 0.1% in FY 2014 compared to FY 2013. The proposed rule also includes CMS' proposal to implement the Affordable Care Act's (ACA) Medicare Disproportionate Share Hospital (DSH) changes.

Ms. Brown announced that, beginning on October 1, 2013, and as mandated by the ACA, each hospital will receive 25% of their traditional share of Medicare DSH payments. However, part of the remaining 75% will be used for savings (approximately \$1 billion in FY 2014), and the rest will be redistributed through a new "uncompensated care payment" (approximately \$8 billion to be redistributed in FY 2014). Ms. Brown explained that the portion of the 75% used for savings will increase in future years as the national uninsured rate decreases. Ms. Brown noted that only hospitals that qualify for Medicare DSH payments will be eligible to receive uncompensated care payments. Ms. Brown stated that HHC expects to see an increase in Medicare DSH payments under this new formula but the amounts are uncertain. She added that a significant issue is the flawed hospital cost data that CMS would likely use (i.e., hospital cost work sheet S-10).

Ms. Brown explained that CMS had proposed to distribute uncompensated care payments using each hospital's share of national total "low-income days," defined as Medicaid days + Medicare SSI days. Ms. Brown added that HHC was working with the Greater New York Hospital Association (GNYHA), the National Association of Public Hospitals (NAPH), the Healthcare Association of New York State (HANYNS) and others on proposals that would enhance the amount of funds that would be "redistributed" to safety net hospitals and the addition of psychiatric rehabilitation days in this calculation which would greatly benefit HHC.

Ms. Brown shared with the Committee a concern regarding CMS' proposal to distribute DSH funds on a periodic interim basis, which would benefit Medicare Advantage Plans. The American Hospital Association (AHA) has calculated that \$3 billion nationally would flow to Medicare Advantage Plans instead of the hospitals. Ms. Brown explained that using this method of distributing the DSH funds would result in a loss of \$64 million for HHC, negating the gains of \$59 million that HHC has estimated that it would gain from the new uninsured pool under the CMS proposed methodology. Ms. Brown noted that the intent was to use Medicaid fee-for-service in the calculation. Ms. Brown announced that comments to CMS concerning this IPPS (Medicare DSH) rule are due on June 25, 2013. She added that HHC's self-imposed deadline of June 24, 2013, would ensure that the requisite reviews and signatures would be in place to get HHC's comments to CMS on time. Ms. Brown informed the Committee that HHC staff has been in communication with staff of the New York trade associations, in particular, to ensure that they are on the same page as HHC. Ms. Brown added that it was also important that NAPH's and HHC's comments were well-aligned. She noted that multiple comments with the same message from organizations with influence could be helpful.

Ms. Brown added that, Mr. Leonard Guttman and Mrs. Judy Chesser, Assistant Vice Presidents of HHC's Office of Intergovernmental Relations had briefed the New York City delegation on the implications of the proposed rule. It is hopeful that the respective comments from the national organizations and the state trade associations will have a positive impact.

Medicaid DSH

Ms. Brown reported that, on May 13, 2013, CMS had released a proposed rule to implement the Medicaid Disproportionate Share Hospital (DSH) payment cuts mandated by the Affordable Care Act (ACA). She added that CMS' proposed formula for calculating cuts to Medicaid DSH payments was designed to incentivize states to target DSH payments to those hospitals serving the most low-income patients. Ms. Brown noted that the federal government cannot mandate such targeting for Medicare DSH but it can distribute the Medicaid DSH cuts in a manner that would incentivize states to target hospitals serving low-income patients. Ms. Brown reported that CMS would use state auditing data to determine the extent to which states are targeting DSH payments to hospitals with high levels of insured or uncompensated care. Moreover, CMS is adding to future audit reports a requirement that states report total hospital costs. Ms. Brown noted that this proposed rule would be for the first two years, FY 2014 and FY 2015. A new rule will be issued in the coming years after more is known about Medicaid expansion in the various states. Ms. Brown stated that the preliminary estimates for the Medicaid DSH cuts show that New York State and HHC would be cut less than what had been originally assumed. Ms. Brown reminded the Committee that across the nation, the overall Medicaid DSH cut was still projected at 5% while the projected cut for New York State is 3.8% in the proposed rule. Ms. Brown noted that, if

this rule goes through as it is currently written, the specific impact on HHC would remain uncertain because it would depend on what the State would do to get its allocation.

Immigration Reform

Ms. Brown reported that the Border Security, Economic Opportunity, and Immigration Modernization Act was scheduled to be brought to the Senate floor during the second week of June for consideration, with changes and amendments to this Act expected over the course of several weeks. Ms. Brown added that this comprehensive immigration legislation would allow undocumented immigrants who are present in the United States to enter a path to citizenship that would include 10 years as a Registered Provisional Immigrant (RPI) before they become eligible to become a Legal Permanent Resident (LPR) and to receive a green card. Moreover, after converting to LPR, they must wait another 5 years after receiving their green card before they can access Medicaid or CHIP, equaling a total of 15 years that immigrants must wait to be eligible for federal health care coverage. Ms. Brown noted that so far, undocumented immigrants do remain eligible for Emergency Medicaid. She stated that, in the House, where no comprehensive bill had been introduced, immigration talks were snagged on what kind of health benefits should be made available to undocumented immigrants seeking U.S. citizenship. Some Republicans in both houses support a proposal to make it mandatory for those on the path to citizenship to acquire health insurance but no subsidization would be allowed.

Mrs. Bolus, Committee Chairwoman, asked what health care options would be available for uninsured immigrants who were not on the path of seeking U.S. citizenship. Ms. Brown responded that in New York City, these individuals would continue to access public hospitals and community health centers. She added that, across the country, public, and safety net hospitals or Federally Qualified Health Centers (FQHCs) would remain their only option for health care services. Ms. Brown noted that HHC would continue to receive reimbursement from the state's indigent care pool.

STATE UPDATE

Ms. Brown announced that the State Legislature was expected to complete its 2013 session next week. She stated that there were a number of bills that were being considered that could significantly impact HHC. She reminded Committee members that there continued to be a big push – both for and against – on two bills related to nurse staffing: one mandating stringent nurse staffing ratios for hospitals and nursing homes and a second that would create a new Safe Patient Handling Program that mandates specific and inflexible new equipment, technology and staffing requirements for health care facilities. Ms. Brown stated that, while HHC supported the goal of the bills to improve patient safety and quality, the latest research indicated that simple mandates alone, which would require hundreds of millions in new spending for HHC, were not likely to achieve the intended outcome.

Ms. Brown reported that other legislation being considered would impose new requirements on hospitals to screen certain patients for Hepatitis C and to provide notices to patients in Observation Units clarifying that they have not been admitted to the hospital and detailing potential health insurance implications. In addition, the Legislature is considering a bill that would: 1) limit compensation and benefits for HHC employees (and those of other state and local authorities) to “similar” levels as civil service employees; and 2) prohibit bonuses for employees unless they were ratified by the Board and part of a written agreement with measurable performance goals. Ms. Brown stated that HHC also expected a last-minute push for legislation on a variety of liability and malpractice issues. She added that HHC would continue to remain vigilant on those and other proposals as the session draws to a close.

Ms. Brown informed the Committee that the Senate held a hearing on the future of SUNY Downstate and the proposed Sustainability Plan SUNY developed as required by the recently enacted State Budget. Ms. Brown reported that the State Department of Health and the Division of Budget were evaluating the Plan. She noted that it was unclear whether or not there would be action on legislation to create a new Brooklyn Health Improvement Public Benefit Corporation, which was envisioned as part of SUNY's Plan.

CITY UPDATE

HHC Testifies before Council

Ms. Brown reported that HHC had provided testimony on the FY 14 Executive Budget and Financial Plan before the City Council at the end of last month. She added that members of the Council had asked a host of questions that ranged from the status of HHC's application seeking FQHC designation for its diagnostic and treatment centers (D&TCs) to what programmatic funding that was needed to be restored to the size and scope of its new electronic medical record system. Ms. Brown stated that HHC was seeking \$8.5 million in funding that was restored last year but not base-lined. She explained that this funding would support HHC's child health clinics, expanded HIV-testing, and certain behavioral health programs. Ms. Brown concluded her remarks by stating that the Council and the Administration would be negotiating the budget in earnest over the next two weeks with a goal of adopting the budget by the end of the month, if not sooner.

Mrs. Bolus invited Ms. Joanna Omi, Senior Assistant Vice President to conduct the Breakthrough presentation. Michael Stocker, M.D., Board Chairman commented that, contrary to the previous Breakthrough presentations, this 60-page presentation is a comprehensive report, which

includes the history of Breakthrough and its accomplishments. He added that Ms. Omi would not be reviewing every slide as some slides are for information purposes only.

Information Item

Breakthrough - Developing a Culture of Continuous Improvement

Joanna Omi, Senior Vice President, Division of Organizational Innovation and Effectiveness

Ms. Omi greeted Committee members and invited guests. She stated that her presentation is a historical document which highlights the Corporation's Breakthrough work from its inception through the present. She informed the Committee that her presentation would cover the following topics:

- Why we came to Breakthrough
- Origins and Definition of Breakthrough
- Expectations
- Achievements
- Return on Investment
- Continuous Improvement

Ms. Omi described the key challenges that the Corporation had been faced with in the 1990s as the following:

- Several HHC facilities faced with the possible loss of TJC accreditation
- City attempts to decrease the size of the system by selling or privatizing certain facilities
- Private payers across the country move to managed care and reduce payments to providers; suddenly public hospitals have to compete for Medicaid patients
- HHC rallies
 - Restructures financial relationship with the city
 - Brings budget into balance for five years in a row
 - Establishes credit worthiness with bond rating companies
 - Dr. Luis R. Marcos becomes the longest tenured president

To address these challenges, Ms. Omi reported that HHC made dramatic progress in quality and in its operational and financial domains. In the 2000s, some of HHC's achievements included the following:

- Asthma treatment is standardized; 25% reduction in the rate of hospitalization for kids with asthma
- Diabetes Registry established; 46% of diabetic patients have 'healthy' blood sugar levels
- 90% reduction in ventilator acquired pneumonia (VAP) rates
- Value analysis introduced in facility finance offices, resulting in immediate local revenue improvements
- Primary care appointment cycle times fell from 130 minutes to 60 or less, and no-show rates dropped from more than 40% to below 20%
- We learn that team-based efforts work – the whole is greater than the sum of its parts
 - Interdisciplinary
 - Sharing best practices
 - Employee-based problem-solving

Ms. Omi reported that, even with these achievements, HHC's gains had been too fragile, improvements were difficult to sustain and drop-off rates were high. She noted that improvements too easily dissolved when individual champions would leave Corporation; and that improvements were isolated and large swaths of the workforce were not engaged. Ms. Omi reported on HHC's approach to resolve the lack of sustainability of its improvement initiatives. HHC researched Six Sigma and the Toyota Production System (TPS) or Lean. The TPS System was found to be a more ideal approach for HHC because of the following:

- Demonstrated success at Denver Health, a sister public hospital
- Demonstrated success at Virginia Mason and ThedaCare
- TPS/Lean is 'HHC-friendly':
 - Recognizes the need to engage and value the entire workforce
 - Simple, widely acceptable tools
 - Range of applications from strategic planning to human development to clinical, operational and financial improvements
 - Embedded sustainment processes
 - Top-down leadership direction and bottom-up innovation

Ms. Omi reported that HHC made a commitment to hire external consultants/experts to develop core teams at each site and develop a system-wide improvement effort.

Ms. Omi described HHC's plan for improvement and return on investment by employment a system-wide improvement effort. To measure success, Ms. Omi stated that HHC used a balanced scorecard with an unwillingness to sacrifice quality for financial gain. True north metrics included focused on quality/safety, human development, throughput/delivery, financial and growth/capacity. HHC's capacity building plan included a plan for self-reliance and for exploring staffing models. Consultant, staffing, event, and other variable costs are the direct and indirect costs to be considered when thinking about investing in the future.

Ms. Omi described HHC's initial model. She stated that a three-year contract was developed.

- Year 1 consultant spend: \$1.7m
 - Sensei at each active site 1-2 weeks/month
 - Initially assumed consultant need would diminish after 12 months with 6-12 months for full 'weaning'
- Staffing model: Deployment Officer and 2-5 facilitators/trainers per site (estimate \$300,000 to \$650,000/site annually)
- Corporate office with enterprise staff (training, development, standardization, corporate level improvement) (estimate an additional \$500,000)
- Cost of staff temporarily deployed to improvement activities or 'embedded' in operations NOT included (these staff would otherwise be paid and variation per event and per site are too great)

Ms. Omi defined Breakthrough and its principles as the following:

- Breakthrough is HHC's name for 'Lean', or the Toyota Production System (TPS).
- Toyota's founder, Sakichi Toyoda, made looms. The origins of TPS began with his invention of the Automatic Type G Loom that stopped automatically if a thread broke; no longer would defects in cloth be sent 'down the line'
- His principle of 'autonomous automation', or Jidoka, the concept of, '*automation with a human touch*', launched an approach to work that would become TPS
- Toyoda's descendants and Taiichi Ohno, a loom mechanic, further developed the concepts, principles, and values that define TPS

Ms. Omi described HHC's goals and achievements. HHC's goals were to eliminate waste, overburden, and unevenness – everywhere – to allow employees to work efficiently; standardize processes to ensure consistent quality and safety; and to continually improve (kaizen). Ms. Omi stated that incremental improvement is achieved through the institutionalization of a daily management system. Big bang improvements are achieved through Rapid Improvement Events/Value Stream-based activities. Ms. Omi noted that the sum of these two improvements added together results in continuous improvement through Breakthrough.

Ms. Omi shared with the Committee a video statement that was prepared by Mr. Aviles, HHC's President, describing HHC's Breakthrough initiative. Mr. Aviles' video statement is provided below:

"Breakthrough really is about taking our greatest asset, which is our workforce, our employees, who have so much experience doing what they do treating them as the world's greatest experts of the things we are trying to improve and really accessing that creativity and helping them to redesign the work that they do in ways that will increase their satisfaction as well as patients' satisfaction and give us more efficient operations."

Ms. Omi stated that this video clip, created in 2009, is still right on target. To date, it is still being used corporate-wide as part of the new employee orientation. Ms. Omi noted that this video exemplifies the simplicity of Breakthrough. She noted that, as part of top down leadership, Mr. Aviles participates in at several rapid improvement events a year to make sure that he is credible and knows what it is he is asking people to do.

Ms. Omi described the major milestones of the Breakthrough initiative for the period starting 2007 through 2013 as presented in the chart below:

Building Internal Capacity							
MAJOR MILESTONES	Evaluate Improvement Methods	Engage Simpler Begin Development and Application of BIS at Individual Sites	Develop Basic Training Program Build Additional Sites	Build Additional Sites	Begin Hoshin Kanri at Level 10 Training Program 2.0 Build Additional Sites	Initiate BDI	Hoshin Kanri Cascaded to Level 3 Begin DMC Development Build Additional Sites Begin DMC Testing
YEAR	2007	2008	2009	2010	2011	2012	2013
CONTRACT	\$1.7m	\$1.8m	\$3.5m	\$3.1m	\$4.4m	\$5.5m	-25%
FTES (cum.)	3	20	29	38.5	57.5	77	
FACILITIES	Enterprise QHC	CIH GHS JAC MET	H&HC CUMB ELM KCHC WDHL NCB BHE	LINC	HAR	REN BEL MOR	
EVENTS		17	165	276	295	316	330 (prjtd)
DMS	-	-	-	-	-	-	4

Ms. Brown commented that, while this slide only shows the facilities' involvement in Breakthrough, it is important to note that there were corporate divisions, the finance division in particular, that were also engaged in Breakthrough work. Ms. Omi agreed and added that other corporate offices had been engaged throughout the Breakthrough process including the finance division under the Mrs. Marlene Zurack, Senior Vice President/Chief Financial Officer in 2007; long term care through Ms. Brown's division; and communications through Ms. Ana Marengo. Other areas that have been involved in Breakthrough include psychiatric services and corporate construction management in late 2011.

Ms. Omi described the Breakthrough implementation process. She stated that Breakthrough starts with a vision of the future. She shared a quote by Jim Womack from the Lean Enterprise Institute, which states:

"Just as a carpenter needs a vision of what to build in order to get the full benefit of a hammer, Lean Thinkers need a vision before picking up our Lean tools. Thinking deeply about purpose, process, and people is the key to doing this."

Jim Womack, Lean Enterprise Institute

Ms. Omi reviewed the Breakthrough enterprise-wide improvement system matrix (presentation slide #14) that highlighted the Hoshin Kanri tool which was used to identify and align strategic priorities. Ms. Omi showed how HHC's strategic priorities are cascaded to the networks and facilities through the use of the Hoshin Kanri tool.

Ms. Omi highlighted the Breakthrough work that had been conducted within the perioperative value stream at Metropolitan Hospital Center. She stated that through rapid improvement events, waste was identified at different steps of the process, each represented by a sticky note on the 12 ft. map on presentation slide #14. The goal was to reduce the waste of 21 days at the medical clearance level. After a three and a half day process, a rapid improvement team had reduced the long wait for pre-op medical clearance. They were able to produce change throughout the entire value stream.

Ms. Omi stated that the daily management system (DMS) was the second largest body of work to be undertaken through Breakthrough. She described DMS as a system for identifying work site goals and managing performance to these goals. This is done through the engagement of staff and managers in real-time data collection and review; and the application of problem solving tactics to remove obstacles and continuously improve performance.

Ms. Omi explained that DMS is a foundational component of Breakthrough and DMS:

- Uses Breakthrough tools and concepts (i.e., root cause analysis, visual management, managing through data etc.)
- Eliminates waste and process variation
- Is the Gemba manifestation of Hoshin Kanri initiatives
- Engages all workers in the Gemba
- Includes processes for problem escalation and resolution through active participation of managers and leaders

Ms. Omi highlighted the work of the Kings County Hospital's Adult Primary Care DMS team. She explained that DMS tools were being deployed because:

- There are major challenges to be addressed in the foreseeable future
- HHC is ready to pull in more challenging tools and DMS requires great discipline
- Improvements achieved through events are difficult to sustain absent 'glue' between events
- Absent a system to embed a culture of continuous improvement, HHC risks plateauing its improvement development
- It will take HHC many more years before all staff have the opportunity to participate in events
- It provides another venue for broad staff engagement

Ms. Omi stated that presentation slide #18 titled, "Why both RIEs and DMS?" was the most important slide because HHC expects to achieve Breakthrough improvements through rapid improvement events but, in the absence of a management system, degradation of those improvements would occur. Combined, HHC achieves continuous incremental improvement punctuated with stair-step breakthroughs.

Ms. Omi presented the tenets of Lean/Toyota Production System, which included the following:

- The Customer Defines Value
- Deliver Value to Customers on Demand
- Standardize and Solve to Improve
- Mutual Respect and Shared Responsibility Enable Higher Performance
- Transformational Learning Requires Deep Personal Experience

Ms. Omi identified the eight wastes in health care, which included:

1. Overproducing
2. Transporting
3. Defects
4. Waiting
5. Over Processing
6. Unnecessary Motions
7. Inventory
8. Unused Human Potential

Ms. Omi reported on the major planning and improvement tools used as part of the Breakthrough improvement system. They include:

- Hoshin Kanri (strategy deployment)
- Value Stream Analysis
- Vertical Value Stream Mapping
- Rapid Improvement Events
- 2P (Process Preparation)
- Daily Management System

Ms. Omi explained that the planning improvement tools do not work alone. They work with a number of adjunctive tools, which include:

- Four-track training program
 - Breakthrough experts
 - General awareness
 - Managers
 - Executive leadership
- Breakthrough Development Initiative
 - Go see what good looks like (external gemba visits, continuing education)
- Communication
 - Annual conference
 - B-Blasts
 - Newsletters
 - Report-outs
 - Integrate into operations, i.e., quality improvement, councils, town hall meetings, executive staff meetings

Ms. Omi reported on the different tools and processes used to sustain Breakthrough's benefits. The following tools are used to manage, monitor, and sustain PDCA at all levels:

- Process Control Boards
- Site and value stream steering teams
- Enterprise steering committee
- Daily Management System
- Transformation Plan of Care (TPOC) reviews

Ms. Omi described the Breakthrough training program. The goal is to help employees to:

- Understand waste
- Develop A3 thinking and problem solving skills,
- Begin to use value stream thinking
- Develop Lean leadership and strategy

Ms. Omi explained that all employees are required to take the Breakthrough Awareness and the Green Level training classes, as represented at the bottom of the pyramid (on presentation slide# 34). Other Breakthrough training courses that are available to HHC employees include:

- Platinum Training (Strategic Execution)
- Gold training (Lean leadership and advanced tools)
- Silver Training (How to create Model Value Streams)
- Silver Training (How to create Model Value Streams)
- Bronze Training (A3 problem solving and using the tools for DMS)
- BMS: Process Owner (Owning RIE support a team, use DMS)

Ms. Omi described HHC's expectations regarding the implementation of the Breakthrough improvement system. These expectations included that HHC would learn from external experts (Simpler) but would build internal expertise deep and wide. HHC would be able to broadly define its return on investment and measure its success using a balanced score card (True North Metrics). These expectations also include the

development of a new way of doing business; a staff empowered to change how the work is done; leaders serving as coaches; and a system of staff engagement at all levels.

Ms. Omi stated that, while the Corporation had not met all the expectations, it was important to note that, as of April 2013, a total of 1,299 rapid improvement events had been completed. She highlighted that, if it were not for Hurricane Sandy, which caused the closure of three HHC facilities that had been actively involved in rapid improvement events; HHC would have achieved the projected number of events by the end of the fiscal year. As a result, the projected number of RIEs will be 55 less than what had been projected. Ms. Omi also reported that, while employee participation in events and training had also increased, the goal was to double that rate of increase every year.

Ms. Omi reported that HHC had achieved a combined total of \$317.24 million in cumulative revenue and cost savings from the inception of Breakthrough through April 30, 2013. The combined revenue and cost savings achievements from FY 08 through FY 13 are provided below:

- FY08 = \$ 0.38 million
- FY09 = \$19.77 million
- FY10 = \$89.35 million
- FY11 = \$92.87 million
- FY12 = \$55.59 million
- FY13 = \$69.30 million

Ms. Omi noted that the \$317.24 million does not include indirect benefits (i.e., increases in productivity), which enable maintenance of services despite a reduced workforce (through attrition without backfilling). Ms. Omi informed the Committee that, for every contract dollar authorized HHC had identified an average of \$17.52 in financial benefit. She explained that, by the end of this current contract period in October 2013 HHC would have spent \$20.5 million on an anticipated \$357 million in financial benefit. This holds true to the benefit/\$1 invested of \$17.52/\$1 ratio.

Ms. Omi reported on Breakthrough training accomplishments. She stated that, to date, a total of 2,613 staff members have participated in Breakthrough training. A total of:

- 12 staff - Platinum Pending
- 1 staff - Platinum Certified
- 13 staff - Gold Certified
- 19 staff - Gold Pending
- 38 staff - Silver Pending
- 51 staff - Silver Certified
- 130 staff - Bronze Certified
- 191 staff - Bronze Pending
- 1,920 – Green Certified

Ms. Omi stated the Green Level Training continued to roll out across the entire Corporation. She explained that Green Training is a one day long training which provided a background and an overview of Lean as well as an entry level course of A3 thinking. In addition, a 90-minute on-line Breakthrough awareness course is available. She noted that several thousand employees have already taken that course just at the beginning of the fiscal year.

Ms. Omi reported on the daily management system (DMS) achievements at four sites from March 2013 to May 2013. The results are the following:

1. Woodhull NBHN:
 - Closed visits by end of day at 97%
 - Appointment "Reminder Call" increase to 69%
 - Patients seeing their own Provider from 65% to 96%
 - Press Ganey mean scores up between 6% to 19.5%
 - Press Ganey Top Box Scores up between 15% to 44.4%
2. Metropolitan Hospital:
 - Patient discharge by 2PM rates up 6%
 - Completion of patient discharge documentation (\$) up 15%
 - Post D/C appointments within 7 days up 16%
 - Press Ganey Top Box scores up 24%
 - Press Ganey hospital recommendations up 10%
 - Press Ganey nurse communications up 24%

- 3. Kings County:
 - Patients seen at appointment time up from 21% to 62%
 - RIE participation up 25% over goal (42%)
 - Percent of visits closed by end of day from 50% to 100%

- 4. Lincoln Hospital:
 - Open visits <2 days down from 811 to under 80
 - Patient satisfaction questionnaire rating of 5 - at 65%
 - Patients planning to deliver at Lincoln from 60% to 67%
 - Number of walk-in Patients from 20/day to under 6/day

Ms. Omi highlighted other successful applications including:

- Reduced patient wait time from 57 minutes to 24 minutes at Lincoln Medical and Mental Health Center's Immunology Clinic
- 45% drop in Telemetry Alarms at Elmhurst Hospital Center
- Reduction of Cycle Time for Cast patients in Orthopedic Services at Elmhurst Hospital Center
- OR utilization with turnover at Queens Hospital Center
- Improve delays and cancelation of surgeries at Bellevue Hospital
- Enforce the discharge of patients over the weekend to meet the demand of Kings County Hospital Center's Emergency Department
- Improvement of charts documentation and coding in the surgery clinic at Harlem Hospital Center
- Redesign of the ED Admission Process at Coney Island Hospital
- Ensure that morning routine lab results are available by 8:30 a.m. so that clinical staff can effectively plan patient care at Woodhull Medical and Mental Health Center

Ms. Omi presented the projected Fiscal Year 2014 training plan to the Committee. This training plan is provided below:

Breakthrough Training Plan for Fiscal Year 2014

	Elements	Objectives
Embed learning Opportunities in Support of Organizational transformation	Daily Management System	• Engage staff and managers in daily improvement through empowered problem solving
	Model Value Streams	• Create learning laboratories/test environments of 'what good looks like'
	Infrastructure	• Enable the building blocks of a stable and sustained system of improvement
	Spread	• Teach and share the means of rapidly spreading what works

	Objectives
Ensure relevance to ongoing and strategic needs	• Closely align ongoing and spot training to business goals, i.e., psychiatric LOS reduction, deficit reduction
	• Develop Leadership Training
	• Continue to increase access for Bronze and Silver Trainings
	• Develop cadre of Platinum-certified internal consultants
	• Develop growth pathways for Breakthrough trainees
	• Provide CMEs for clinicians

Ms. Omi discussed developing internal capacity for the large scale spread of DMS. She explained that, by the end of June 2013, four sites would have been tested. These sites will begin to teach four more sites and areas within their sites will teach an additional four sites and so on. Ms. Omi noted that, while each new team developed more sites, new sites would also be coming on board. In addition, DMS is also being integrated into the model value stream. By December 2015, DMS will be in place in 244 individual areas.

Ms. Omi stated that to ensure that Breakthrough is being spread and the knowledge integrated, HHC's own students will be teaching a growing number up to a total of 168 with the internal 68 experts and 8 model value streams.

Ms. Omi reported on Breakthrough's plans going forward. She stated that:

- HHC needs consultant time longer than planned to continue to meet growing demand and embed learning/transfer technology to sites. Some of this is due to:
 - HHC's own stumbling
 - HHC's initial ignorance of what this would take

- Consultants will have a diminishing role but HHC will likely need some ongoing monitoring/coaching from an external agent
- Staffing model will continue to evolve
 - Estimate another 5-10 dedicated staff needed, but
 - This could be a significant underestimate depending on timing, emerging business needs, depth and breadth of applications
 - Developing 'embedded facilitator/trainers'
- Training program to focus on real-time training, emerging business needs (flexibility and anticipation)
 - Role of trained people in the organization
 - Retention and succession planning
 - Continually improving certification program
 - Leadership development
- Role of enterprise and site Breakthrough offices must continue to evolve
- Spread of the daily management system
- Spread of model value streams
- Greater alignment of effort and focus across the enterprise
- Go deeper: kata, training within industry
- Continued exploration – there is much we still don't know and much we can improve

Dr. Stocker thanked Ms. Omi for her presentation. He commented that Breakthrough is very impressive and would change the Corporation forever, like the electronic medical record (EMR). Ms. Omi responded that it takes a village.

Mrs. Bolus asked if the Corporation's achievements would ever be self-sustainable. Ms. Omi responded that it could be if HHC's choice was. However, she cautioned that past experiences from other Lean organizations like Bellwether Services show that it was very difficult to accomplish on their own. In addition, Ms. Omi stated that some non-healthcare organizations have kept Lean consultants on board for a longer period of time. She noted that self-sustainability results were unpredictable. Some organizations are capable to sustain their achievements over decades while other organizations were unsuccessful in sustaining those achievements with change of leadership. Ms. Omi stated that it would be beneficial to have a consultant come back once in a while to challenge HHC and to help us really think beyond our current paradigm and push us to do so much more. Ms. Omi concluded her presentation by stating that the Corporation still needs some assistance to get through some of the mechanics and with the anticipated reduction in the contract over the few years, HHC is taking very seriously the need and the desire to embed Breakthrough internally.

Mrs. Bolus thanked Ms. Omi for her presentation.

SUBSIDIARY BOARD REPORT

HHC Capital Corporation – May 30, 2013 As reported by Dr. Michael Stocker

Issuance of HHC 2013 Series A Health System Bonds

Ms. Linda Dehart, Assistant Vice President of the Debt Finance and Corporate Reimbursement, briefed the Board on the March 28, 2013 issuance of \$112,045,000 tax-exempt fixed rate bonds which refunded all of the outstanding 2003 Series A bonds and certain 2008 Series A bonds. The refunded bonds with an "all-in" interest rate of 2.44% allowed HHC to achieve a net present value savings of \$21.9 million. Due to investor demand, the underwriters were able to sell all the bonds in one day instead of two as previously planned. In response to Dr. Stocker's question about NY Presbyterian and Wyckoff, Ms. Zurack answered that although she did not know the ratings for those two entities, hospital systems would need at least a BBB credit rating to have affordable access to the capital markets.

HHC's Bond Issuance History

Ms. Dehart indicated that the outstanding par amount of HHC bonds subsequent to the refunding is \$917.4 million of which the majority is structured as fixed rate bonds.

Board member Mr. Bernard Rosen asked if the chart shows all of HHC's bonds. Ms. Zurack response was that there was a small bond issuance in 1985 but that the 1993 series is the first issuance under the lockbox structure.

HHC Debt Structure

Chief Financial Officer, Ms. Marlene Zurack reported that HHC's variable rate bonds constitute 18.4% of its portfolio of outstanding bonds. The variable rate bonds are supported by letters of credit provided by TD Bank and JP Morgan Chase Bank

None of HHC's current outstanding bonds are insured. The last of the 2002 Series A bonds which were insured by FSA have matured. The refunded 2003 Series A bonds were previously insured by Ambac. In the past, it was beneficial to sell insured bonds but the municipal market no longer views the added cost as advantageous.

Credit Ratings

Ms. Zurack described the chart showing credit ratings for HHC, the City of New York and HHC's two letter of credit providers. Ms. Paulene Lok added that JP Morgan's credit rating was downgraded once between 2008 and now, but that the current ratings (Aa3/P-1, A+/A-1 and A+/F1) are still favored by money market funds that purchase HHC's variable rate bonds.

Post-Issuance Compliance

As suggested by the IRS, Ms. Zurack explained that HHC adopted written procedures for post-issuance compliance for its tax-exempt bonds in May 2013. The procedures drafted by HHC's bond counsel, Hawkins, Delafield & Wood, includes the following: regularly scheduled due diligence reviews, identification and training of the official/employee who performs the review, retention of adequate records to substantiate compliance, procedures to ensure timely compliance submissions and steps to timely correct non-compliance.

Construction Fund Balance on the 2010 Bonds

Ms. Lok reported that of the approximate \$200 million construction fund for the 2010 series bonds, \$56.7 million remains unspent as of May 1, 2013. Total encumbrances equal \$182.6 million which leaves an encumbered balance of \$17.9 million. Ms. Zurack added that \$30.3 million of the encumbrances was allocated to the electronic health record system.

HHC Health System Bonds - Arbitrage Rebate

Ms. Lok explained that issuers often incur arbitrage when interest earnings on bond proceeds exceeds bond yield. The arbitrage rebate liability must be rebated to the IRS. In April 2013, HHC's rebate consultant (Hawkins Delafield & Wood) prepared Arbitrage Rebate Reports for the 2002 Series and 2003 Series A bonds after determining that no rebate was due on those two issuances.

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

**ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
JUNE 27, 2013**

GOUVERNEUR RECEIVES PCMH RECOGNITION FROM NCQA

This month, Gouverneur Health was the first HHC facility to resubmit an application for Patient-Centered Medical Home (PCMH) Recognition under the new rigorous quality standards established by the National Committee for Quality Assurance (NCQA) PCMH Recognition Program, achieving Level III Recognition with a score of 92.25 out of 100 points.

As you remember, PCMH is a collaborative, team-based approach to primary care that promotes the delivery of coordinated, integrated, and continuous care and cultivates long-standing relationships between the providers and their patients. In 2009, the New York State Department of Health aligned itself with the NCQA PCMH Recognition Program to provide enhanced reimbursement for Medicaid managed care and fee-for-service patients based on the level of recognition earned by primary care practices. In 2010, 39 HHC practices submitted applications and achieved Level III recognition, the highest of three levels, resulting in \$18-20 million per year in enhanced revenue.

PCMH Recognition is awarded for a 3-year period, and HHC adult, pediatric, and HIV primary care practices are currently in the process of reapplying for recognition under the 2011 standards. NCQA has raised the bar on performance with these new standards which are more difficult to achieve with a required passing score of 85 and demonstrated competencies in care coordination, care management, and quality improvement.

The Office of Ambulatory Care Transformation has facilitated the PCMH application development process at practices across HHC's 11 acute care hospitals and six diagnostic and treatment centers, and expects that all facilities will submit their applications for PCMH recognition by October 2013.

SEA VIEW GETS STATE'S TOP RANKING FOR NURSING HOMES

Sea View Hospital Rehabilitation Center and Home has received from NYSDOH the highest score in the state in the benchmarks that will be used to determine how to distribute the \$50 million in funding in the 2013 Nursing Home Quality Pool, that will be used to enhance nursing homes with high quality of care standards. Sea View's overall score of 84.86 was the highest score in the benchmarks, which are based on evaluations of 14 quality measures including falls, weight loss, depression, and pain in long-term care patients. Sea View excelled in virtually all areas, with its residents being over 90 percent less likely to experience major injury from falls or to have excessive weight loss than patients at similar institutions. In March, Sea View was given the highest five star ranking by *U.S. News & World Report* in that publication's 2013 list of the nation's best nursing homes.

LINCOLN HOSPITAL RECEIVES NATIONAL RECOGNITION FOR CANCER CARE EXCELLENCE, DIABETES EDUCATION

Lincoln Medical Center was recognized with the 2012 Outstanding Achievement Award by the American College of Surgeons' Commission on Cancer, becoming one of a select group of 79 healthcare facilities -- 16 percent of more than 500 accredited cancer programs to receive this national honor. Additionally, Lincoln's Diabetes Center of Excellence received four-year re-accreditation by the American Association

of Diabetes Educators (AADE). Lincoln's specialized program provides self-management education that meets and exceeds national standards, offering a culturally competent and patient centered bilingual curriculum focused on Type 2 diabetes, obesity and the prevention of diabetes complications. Congratulations to Lincoln Medical Center staff for these well-deserved recognitions of the outstanding care provided to patients in their community.

FEDERAL UPDATE

On May 10, the Centers for Medicare and Medicaid Services (CMS) released the proposed rule for hospital inpatient and long-term care prospective payment systems for fiscal year 2014. HHC submitted comments on June 24 focused on two suggestions.

First, to calculate the allocation of the 75% of Medicare DSH funds that would go into an uncompensated care pool for hospitals, CMS had considered using charity care, bad debt and other data from the hospital cost report worksheet, called the S-10, as the uncompensated care proxy. However, CMS decided that, since the worksheet is relatively new and many hospitals have had difficulties submitting accurate and consistent data, the S-10 should not be used for these purposes at this time.

In lieu of the S-10 data, CMS's proposed formula would use inpatient days of Medicaid beneficiaries plus inpatient days of Medicare supplemental security income (SSI) beneficiaries as a proxy for the relative amount of uncompensated care each hospital provides.

HHC recommended that a better proxy formula could be devised. We commented that including exempt unit days -- psychiatric and rehabilitation -- in the formula would be more representative of the full scope of uncompensated services. We suggested that a proxy using low income days weighted as a proportion of hospital total days would better identify hospitals likely to be treating many uninsured patients. We also recommended a labor cost adjustment, based on the Medicare wage index, a method consistent with current Medicare payment standards. The estimated increase to HHC if these suggestions were implemented would be \$83 million.

The second HHC suggestion is related to the CMS proposal to distribute the DSH pool dollars on a periodic interim basis, rather than on a per discharge rate basis. The result is to effectively exclude managed care discharges from the formula, benefiting Medicare Advantage Plans and disadvantaging providers. Using this method of distributing the DSH funds would result in a loss of about \$64 million for HHC. We recommend that CMS instead have the pool payments be made on a per-discharge basis. We are supported in this suggestion by the American Hospital Association, the Greater New York Hospital Association, the Hospital Association of New York State and others.

STATE UPDATE

The New York State Legislature concluded the 2013 Legislative Session last week without passing any of the legislation HHC had been most closely tracking. The legislation creating a new Safe Patient Handling Program that mandates specific and inflexible new equipment, technology and staffing requirements for health care facilities passed in the Assembly but died in the Senate. Neither house passed legislation to enact stringent new nurse staffing mandates, which would have resulted in an additional \$388 million in spending each year for HHC. They also chose to defer action on legislation to extend the statute of limitations for filing medical malpractice claims.

Although there was robust discussion on the future of SUNY Downstate Medical Center, ultimately lawmakers did not pass any new legislation or provide any additional funding for the struggling institution. In the last week of the session, Governor Cuomo advanced legislation that sought to implement key elements of the recommendations contained in the SUNY Downstate Sustainability Plan, which was required as part of the recently enacted State Budget. It would have created a new Brooklyn Health Improvement Corporation comprised of Downstate and any voluntary hospitals willing to be co-operated by the Corporation. This Corporation would have been a new vehicle to allow participating voluntary hospitals to receive Delivery System Reform Incentive Payments (DSRIP s) under the State's pending 1115 Medicaid Waiver. The Senate introduced a revised version of the Governor's bill, while the Assembly introduced a proposal advanced by organized labor that focuses on monetizing SUNY's Long Island College Hospital (LICH) and using the proceeds to expand the availability of primary care clinics and preserve as many health care services as possible at both LICH and the University Hospital located across from Kings County Healthcare Center.

Although staff will provide a detailed update at next month's Strategic Planning Committee meeting, I want to highlight a few of the bills impacting HHC that did pass both houses. The Legislature passed several new hospital mandates, including requirements for new patient screenings for Hepatitis C, maternal depression and congenital heart defects using pulse oximetry on newborns. They also passed legislation imposing new notice requirements for patients admitted into hospital Observation Units. Finally, the Senate and Assembly both passed legislation that would severely limit HHC's use of Job Order Contracting for capital projects.

At this juncture, it does not appear as though the Legislature will return to Albany prior to beginning of the 2014 Legislative Session in January. However, it is always possible that they will decide to return to address unfinished business such as the Women's Equity Agenda or Campaign Finance Reform. We will apprise you of any new developments that are likely to result in a special session.

CITY COUNCIL RESTORES FUNDING TO HHC IN BUDGET AGREEMENT

In the City Budget that was passed last night, the City Council restored nearly \$14.5 million in expense funding to HHC. I would like to thank the Council for their ongoing and generous support for HHC. I would also thank those public health, union and Community Advisory Board Members who have advocated on HHC's behalf with the Council. On the expense side, the Council provided funding for: \$6 million for HHC's Unrestricted City Subsidy; \$5 million to support the operation of Child Health Clinics; \$2 million for our expanded HIV Testing program and \$1.46 million for our Developmental Evaluation Clinics. On the capital side, we have not seen the final list yet, but we expect that the Council will allocate funds to support the purchase of new equipment and renovations at most of our facilities.

HHC FACILITIES SEE INCREASED DEMAND FOR LANGUAGE SERVICES

Since 2010, HHC's 11 hospitals and dozens of community health centers have experienced a 22 percent increase in requests for over-the-phone interpreter services for patients with limited English proficiency with 700,000 requests in 2012. The number of minutes spent on over-the-phone interpretations -- a service where an interpreter on the phone relays complex and sensitive medical information between doctor and patient -- increased by 55 percent during the same time period to 6.9 million minutes. To meet this increasing need, HHC will invest approximately \$31 million over the next five years for 24 hour-a-day, 7-day-a-week medical interpretation services provided by telephone to patients and doctors.

Phone interpretation is just one of several language services provided by HHC. We also offer the assistance of professional interpreters, trained staff interpreters, health instructions and literature for

patients in the 13 most common languages at HHC, and multi-language signage appropriate to the patient population of each hospital and health facility.

HHC's patient population now speaks more than 190 languages and dialects, and roughly 25 percent of patients have limited English proficiency, making our investments in language services more important than ever. When language barriers are eliminated, we increase patient safety and the healthcare provider and the patient can communicate with confidence.

GNYHA RECOGNIZES OUTSTANDING HURRICANE RESPONSE

On June 4th, the Greater New York Hospital Association held a gala awards ceremony to recognize the outstanding response made during Superstorm Sandy by so many New York City public agencies and most especially to honor New York's hospitals and nursing homes. Recognitions of merit were presented to Commissioners at the New York State Health Department, the NYC Health Department, the Office of Emergency Management and the Fire Department of NY. A compelling documentary film was premiered at the event -- "Taking Care: The Exceptional Story of New York's Health Care Response to Superstorm Sandy." The film interviewed leaders and staff at hospitals and nursing homes throughout the city and featured four HHC employees -- Daniel Collins at Coney Island Hospital, Monsey Nieves-Martinez and Jenny Rosario at Coler-Goldwater, and Dr. Leora Balsam at Bellevue. I know the board joins me in thanking them and the thousands of HHC employees who responded so heroically to ensure our patients' safety during the storm.

HHC BREAKTHROUGH LEADERSHIP AT LEAN CONFERENCE IN ORLANDO

On June 4th, the Lean Enterprise Institute and the ThedaCare Center for Healthcare Value convened a two-day conference of healthcare organizations interested in or deploying the "lean" performance improvement methodology, called "Breakthrough" at HHC. The conference in Orlando, Florida was attended by about 600 participants from the US and Canada, including 13 attendees from HHC. Attendees were leaders, board members, lean experts and staff from more than 150 organizations. I was a featured speaker in a plenary CEO panel with two other distinguished healthcare system leaders. My remarks during this panel session included personal insights about the challenges of leading a large organization through a long-term transformation, the engagement and enthusiasm of staff and the critical role of strong, involved leaders. I also spoke about the strong presence in our environment of labor unions and how the unions have been supportive and participatory in the process. The conference was a good opportunity for our Breakthrough leaders to share some of our best practices and to connect with counterparts who are tackling challenges similar to the ones we face.

HHC CHIEF MEDICAL OFFICER DELIVERS KEYNOTE ADDRESS AT NYC'S C5 COLON CANCER CONFERENCE

On June 7th, the Citywide Colon Cancer Control Coalition -- C5 -- held its annual meeting, bringing together stakeholders from various sectors to discuss current issues in colon cancer screening and control. This year, the Summit reported on the progress and successes of current initiatives, and discussed the implications of emerging issues and trends in the changing healthcare environment. HHC's Chief Medical Officer, Dr. Ross Wilson, gave the keynote address, "Affordable Care Act -- Implications for Preventive Screenings."

Dr. Wilson also received an award on HHC's behalf for the significant achievements of our Colonoscopy Screening Program. Over the last five years (2008-2012), more than 106,000 New Yorkers had a

colonoscopy at an HHC hospital. During the same period, nearly 22,000 people had colon polyps removed at an HHC hospital before they developed into colon cancer.

The C5 members are health professionals, clinicians, researchers, academics, administrators and advocates from various public and private institutions and organizations, dedicated to promoting colorectal cancer screening in New York City. C5 strengthens colon cancer prevention and control efforts by facilitating communication between the health department and relevant stakeholders -- health and social service organizations, academic institutions, governmental agencies and advocacy groups.

AFFILIATION AGREEMENTS FOR MEDICAL SERVICES AT KINGS COUNTY AND SEA VIEW HOSPITALS

There are two items for your consideration on today's agenda. The first is for approval of the renewal of an Affiliation Agreement with the State University of New York/Health Science Center at Brooklyn (SUNY/HSCB) for the provision of general care and behavioral health services at Kings County Hospital Center (KCHC). The agreement is a three-year contract commencing July 1, 2013 and terminating on June 30, 2016, for a total contract cost of approximately \$52.1 million for the three-year contract period. This agreement continues a half-century relationship between both organizations and the provision of high quality patient care to the residents of Central Brooklyn. For example, SUNY/HSCB and KCHC are conducting joint research projects in endocrinology, emergency medicine, oncology and radiation oncology to improve the health outcomes of their patients. Additionally, advanced hepatobiliary surgery has been re-established and has resulted in positive outcomes.

The second item is the renewal of the current affiliation contract with Staten Island University Hospital for the provision of general care and behavioral health services at Sea View Hospital Rehabilitation Center and Home. A three-year agreement is proposed for the provision of services commencing July 1, 2013 and terminating on June 30, 2016, for a total estimated cost of \$994,464 over the three-year contract. The proposed agreement will continue to compensate the affiliate for services provided on a part-time basis.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

That's So New York: City Healthcare, Alan D. Aviles, Kings County, Woodhull, Bellevue, Queens, Elmhurst hospitals, NYC Media, 6/24/13

Heat Exhaustion Risks, Dr. Fernando Jara, Lincoln Hospital, News 12 Bronx, 06/25/13

Lincoln Asthma Health Fair, Dr. Riyad Basir, Lincoln Hospital, News 12 Bronx, 05/29/13

Metropolitan Hospital Proudly Shows Disabled Artists' Work, Dr. Bijan Safal, NY1, 06/09/13

NYPD Officer Wounded By Gunfire Outside Harlem Hospital, NY1, 06/10/13

Print

Death toll on the rise: Diabetes killed 237 Staten Islanders in 2011, NYC reports, President Alan D. Aviles, HHC, Dr. John Maese, Coney Island Hospital, Staten Island Advance, 06/18/13

National HIV Testing Day observation serves as a reminder for Staten Islanders, HHC, Staten Island Advance, 06/25/13

Staten Island dentist is honored for service at Sea View, Dr. Howard Silverman, HHC, Staten Island Advance, 06/12/13

Modest decline in sweltering heat looms for New York, Dr. Mike Touger, Jacobi Hospital, NY Daily News, 06/25/13

New beginnings for Coney Island Hospital as first post-Sandy babies are delivered at reopened maternity ward , NY Daily News, 06/14/13 (Also covered in Sheepsheadbites.com and Metro)

Puerto Ricans in Health Services, Boricuas al servicio de la salud, Glenda Guzman, Senior Physician Assistant, Queens and Elmhurst hospitals; Dr. Ray Mercado, Lincoln Hospital; Dr. Denise Infante, Gouverneur Hospital, El Diario, 06/10/13

Parents get hospital rest, Jacobi Hospital, Bronx Times Reporter, 06/18/13

Elmhurst greenmarket opens for third consecutive year, Elmhurst Hospital, Times Ledger, 06/08/13

Elmhurst Hospital To Celebrate Greenmarket Opening, Queens Gazette, 06/05/13

Copperhead snake bites High Tor State Park worker, Jacobi Hospital, The Journal News, 6/1/13

Doctor Feelbad, Dr. Danielle Ofri, Bellevue Hospital, The New York Times, 06/17/13

What's New at Area Hospitals, Lincoln Medical Center, MD News, June 2013

'13

RECOMMENDATIONS TO IMPROVE FACILITY CONSTRUCTION PROJECT OUTCOMES

A RESPONSE TO DEFICIENCIES IN HHC'S CONSTRUCTION PROGRAM

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Office of Facilities Development
June 2013

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Executive Summary

This report outlines recommendations to address the major shortcomings in HHC's construction program. Many of these deficiencies were identified by HHC's Office of Internal Audits (OIA). Others surfaced from a careful review of HHC's three (3) recent modernization projects.

The report recommends the undertaking of certain short term and long term actions in order to significantly reduce cost overruns and delays by implementing controls and new reporting processes, and, evaluating its existing processes and procedures through utilization of the Breakthrough/Lean methodology.

The report highlights managerial actions taken thus far in response to deficiencies associated with HHC's three (3) major modernization projects as managed by the Dormitory Authority of the State of New York and the New York City Economic Corporation, known as the Harlem, Gouverneur and Henry J. Carter Skilled Nursing Facility Modernizations.

The purpose of this document is to report upon actions taken to limit any further delays and cost overruns associated with concluding the three current modernization projects, and to develop permanent solutions that avoid similar outcomes on future projects of similar magnitude, as well as for construction projects of smaller programmatic and fiscal magnitude managed at the local, facility level.

HHC'S MAJOR MODERNIZATION PROGRAM

Currently, HHC's modernization program lacks formal guidelines in project initiation, budget, and cost contingency management. It does not provide sufficient, centralized reporting, nor does it provide sufficient retention of historical project data, and is not suited to adequately document and record deviations or modifications made to the initial project scope and budget, and cannot provide adequate evidence that such deviations or modifications have received appropriate approvals. Budget and cost contingency issues have been attributed to untimely and inadequate input from Finance during the project approval process. The engagement of managing agents as true partners in the success of project outcomes has proved lacking.

HHC’s OFFICE OF INTERNAL AUDITS

HHC’s Office of Internal Audits has provided continuous, constructive involvement and participation in management’s utilization of the Breakthrough/Lean methodology, which has helped to identify and address the most frequent and egregious findings in its review of HHC’s facility based construction program. As a result, processes are being piloted and advanced for enterprise wide use that will address significant areas of exposure such as adequacy of project budget with scope, and assuring that bids and estimates are reasonably reconciled to assure accepted bids represent fair and reasonable value of work. The Breakthrough/Lean process will continue with the objective of continuous review and improvement that will be reflected in revised construction policies and procedures.

Some program exposures have already been addressed, while several others are currently in process of being adopted (i.e., ‘cradle to grave’ project management, and continuous insurance monitoring by a third party. (See pages 7-15 of the report).

This following represents actions taken to address vulnerabilities in HHC's current modernization program deficiencies identified by the Office of Internal Audits or by the Breakthrough process for facility managed construction projects. Combined, the actions and recommendations represent a comprehensive approach to resolving the most difficult challenges facing HHC's construction program. This report provides a status update of previous actions, and offers additional remedial actions taken to address such challenges.

A) HHC'S MAJOR MODERNIZATION PROGRAM

There have been cost overruns in all three (3) major modernization projects currently being managed externally - two by the Dormitory Authority of the State of New York (DASNY), and one by the New York City Economic Development Corporation (NYCEDC). The total percent variance (in aggregate) between the final approved budget and initial approved budget is as follows:

TABLE 1 - VARIANCE IN INITIAL AND FINAL APPROVED MAJOR MODERNIZATION BUDGETS

PROJECT	INITIAL APPROVED BUDGET (\$ MILLIONS)	FINAL APPROVED BUDGET (\$ MILLIONS)	VARIANCE (MILLIONS)	PERCENT VARIANCE
HENRY J. CARTER (EDC)	198	284.5	85.70	43.11
HARLEM MODERNIZATION (DASNY)	225	325.03	100.03	44.46
GOUVERNEUR MODERNIZATION (DASNY)	101	247.48	145	143.56
TOTAL	524.8	857.01	330.73	63.02

Deficiencies are found to lie in six core areas: 1) Lack of formal guidelines for project initiation, budget, cost and contingency management, project reporting, and centralized reporting; 2) No centralized repository of historical project data and memorialization of project changes; 3) Imprecise estimating of necessary project elements in initial project estimates, and inadequate project contingency to reflect project risk; 4) Lack of a formalized change management process; 5) Lack of Finance involvement during the project approval process; 6) Inadequate engagement of managing agent as a true owner's representative.

In February 2013, the Office of Facilities Development advised of its intent to utilize Breakthrough as a means of achieving a comprehensive and sustainable approach to addressing deficiencies that were not capable of being addressed in the immediate

RECOMMENDATIONS TO IMPROVE FACILITY CONSTRUCTION OUTCOMES – A 6
 RESPONSE TO DEFICIENCIES IN HHC’S CONSTRUCTION PROGRAM
 term. In those instances, immediate corrective actions were implemented or
 targeted for implementation within a reasonable time period.

The following chart provides an update of the remedial measures that were
 reported in February 2013, to address the cited deficiencies:

TABLE 2 – MAJOR DEFICIENCIES VERSUS CORRECTIVE ACTIONS

<u>DEFICIENCY</u>	<u>ACTIONS</u>
LACK OF FORMAL GUIDELINES	BREAKTHROUGH
DOCUMENTATION NOT RETAINED IN CENTRALIZED LOCATION	CURRENTLY IN SELECTION PROCESS FOR CENTRALIZED ELECTRONIC REPORTING REPOSITORY (on schedule)
IMPRECISE ESTIMATING/EXCLUSION OF NECESSARY PROJECT ELEMENTS	BREAKTHROUGH. DEVELOPMENT OF PROJECT IMPLEMENTATION GUIDELINES AND BID MATRICES (ONGOING)
LACK OF FORMALIZED CHANGE MANAGEMENT PROCESS	NO PROGRAM RELATED CHANGES PERMITTED ON REMAINING MODERNIZATIONS. REVIEW OF PROCESS AS COMPONENT OF BREAKTHROUGH
INCREASE FINANCE INVOLVEMENT IN PROJECT APPROVAL PROCESS	BREAKTHROUGH. ESTABLISH CRITICAL POINTS OF FINANCE INVOLVEMENT
MANAGING AGENT AS TRUE OWNER’S REPRESENTATIVE	USE OF CM BUILD/CM AT RISK CONSTRUCTION METHODS UNDER CONSIDERATION IN APPROPRIATE CIRCUMSTANCES

B) ADDRESSING FINDINGS BY THE OFFICE OF INTERNAL AUDITS –

**PROJECTS MANAGED AT THE FACILITY LEVEL (NON MODERNIZATION
CONSTRUCTION PROJECTS)**

Using Breakthrough to establish a weighted method of determining audit findings
 having greatest exposure to the organization, an analysis of the last four (4) audit
 reports conducted by HHC’s Office of Internal Audits (OIA) from the North Bronx,
 Central Brooklyn, Queens, and Southern Brooklyn Networks was conducted. The
 analysis identified repetitive findings common across each Network, identifying the
 frequency and severity of each deviation from existing policies and procedures. The
 analysis cited the most egregious deficiencies as (in no order of severity): a) failure
 to maintain continuous evidence of insurance; b) bid award with deviations of
 greater or less than 10% of the estimate; c) failure to adequately define project
 parameters sufficient to establish fair and reasonable cost for the value of
 construction work (payments approved in excess of work that could not be

substantiated); d) compliance with Labor Law Section 220, (satisfying prevailing wage requirements); e) no mechanism to report all sources of project funding.

Over the past year, the organization has undertaken an aggressive review of its construction program through rapid and continuous improvement (Breakthrough) The Breakthrough events serve to address common issues that affect facility based construction projects monitored through HHC's Office of Internal Audits, as well as projects of much greater monetary and programmatic impact that would be advanced as major modernization projects. In the development of corrective and permanent solutions, Breakthrough will engage all levels of central office and facility personnel.

Six (6) events have been held thus far, including two major events involving a description of the existing (current) state, and the proposed (future) state of a successful construction program/project. Two standardized processes (standard work) have thus far been developed, with one having been successfully piloted. The second is in the initial stages of implementation [The second standardized process has just been completed and is being discussed for piloting on a construction project yet to be identified].

The organization continues to advance additional Breakthrough events, and will conduct detailed, in-depth examination of essential elements of the construction program as identified by the current and future/ideal state. A list of previously completed and proposed future events identified thus far is shown as Exhibit 1.

The organization has established a committee composed of senior facility and central office management to support and maintain the long term success of the Breakthrough process, and will meet as required to assure that steady and constructive progress is achieved.

The following represents those issues that have been identified in the previously held Breakthrough process, or directly cited as a finding by HHC's Office of Internal Audits.

1) DEVELOPMENT OF PRELIMINARY IMPLEMENTATION GUIDELINES THAT ACCURATELY DEFINE PROJECT SCOPE AND ADHERENCE TO BUDGET

Development of a detailed Project Initiation Guide to identify a comprehensive project scope is being advanced through the breakthrough process. This guide will be used for all HHC projects, as it universally challenges observations and addresses issues regarding scope definition, and will provide for a comprehensive identification of all components of the project scope of work.

Every project scope of work will be fully developed before final cost estimates are applied to the project budget and validated.

In all projects the project design will be reconciled with the budget at key project milestones such as preliminary design, fifty percent (50%), design development, ninety percent (90%) final design and bid documents (100%). Assurances as to the comprehensiveness of the design (i.e., adequate budget for furniture, fixtures, equipment; inclusion of remedial work to correct regulatory deficiencies; relocation of staff/equipment if required to access space, temporary clinical operations, interim life safety requirements, etc.) will be incorporated into establishing a project’s budget.

When project scope and budget are validated by OFD, an appropriate project contingency can be assigned. Upon approval this guide will become policy and will be used universally, so there is proper alignment between these project-defining parameters. The guidelines are currently being finalized, and its method of implementation and future refinement is being discussed. The preliminary document is attached as Exhibit 2.

IMMEDIATE REMEDIAL ACTION FOR FACILITY INITIATED PROJECTS – ALL PROFESSIONAL SERVICE REQUIREMENTS CONTRACTORS FOR ARCHITECTURAL AND ENGINEERING SERVICES WILL BE ACCESSED BY OFD, AND OFD WILL COLLABORATE WITH FACILITY TO ASSURE PROJECT SCOPE ADHERES WITH PROJECT BUDGET

All professional service contracts for architectural and engineering services are currently accessed and managed directly at the facility level. OFD will now assume the role of accessing these professional service contracts directly, and on behalf of the facility, collaborating with both the facility and design professional to assure scope and adherence to budget. Once fully vetted and approved, guidelines developed through the Breakthrough process will be utilized and implemented.

Additionally, the next iteration of architectural and engineering contracts anticipated for Board of Director consideration (Fall 2013), will require greater responsibility in the adherence of scope and estimate, and the contracts will require enhanced reporting to OFD as an obligation under the contract.

FOR FUTURE MODERNIZATION PROJECTS –

No Modernization projects are presently under consideration, however, OFD will continue to move forward with full development of the project implementation guideline developed as part of the Breakthrough process, which will become a tool to assess the feasibility and cost of a modernization project. Other elements of the Breakthrough process will continue to develop solutions to broader issues.

2) FAILURE TO ADEQUATELY DEFINE PROJECT PARAMETERS - ESTABLISHING FAIR AND REASONABLE COST FOR THE VALUE OF WORK [FACILITY BASED PROJECTS ONLY]

HHC's Office of Internal Audits reported facilities as authorizing payments for work that could not be substantiated, indicating that there was no mechanism to reconcile labor and material to project cost.

REMEDIAL ACTION - IMPLEMENTATION OF COMPETITIVELY BID, ON-CALL CONSTRUCTION CONTRACT WITH PRE-ESTABLISHED LABOR AND MATERIAL RATES

The Indefinite Quantity Construction Contract (IQCC) methodology provides prequalified construction contractors approved through competitive bid selection. These are contracts having a maximum spending limit, with pre-set labor and material rates. Before any work can proceed, the facility and the contractor agree upon a scope of work that establishes material quantities necessary to complete work. This process eliminates uncertainty with respect to reconciling labor and material quantities needed to appropriately value a project. Rather than bid work on a project-by-project basis, facilities are given access to a competitively bid, on call construction contractor that is ready to execute work. The Office of Facilities Development administers access to the program by maintaining contracts with IQCC contractors and a consultant that administers the program. Under the current process, a facility must provide supervision through its own internal staff or a third party construction manager (also accessed through requirements contracts administered through the Office of Facilities Development) to assure that quality and material quantity requirements are met.

This remedial action has been implemented, and takes the place of previous requirements contracts which lacked comprehensive material pricing essential to substantiate value of work.

3) NON-COMPLIANCE WITH LABOR LAW SECTION 220, FAILURE TO COMPLY WITH PREVAILING WAGE RATE REQUIREMENTS [FACILITY BASED PROJECTS ONLY]

Compliance with prevailing wage affects projects performed by third party, independent contractors - it does not involve HHC trade employees represented by labor unions. The findings of HHC's Office of Internal Audits pertains strictly to those construction projects performed by contract labor not directly employed by HHC.

WHAT IS 'PREVAILING WAGE'

Prevailing wage is the wage and benefit rate set by law for each trade or occupation for employees of contractors that perform public works projects and building service work for government agencies. Prevailing wage rates for construction,

RECOMMENDATIONS TO IMPROVE FACILITY CONSTRUCTION OUTCOMES – A 10 RESPONSE TO DEFICIENCIES IN HHC’S CONSTRUCTION PROGRAM

replacement, maintenance or repair work on New York City public works projects are contained in the Comptroller’s Labor Law schedules, for which at last count, there are no less than 65 titles.

Prevailing wage rate law is enforced by the New York City Comptroller’s Office (Comptroller) pursuant to the New York City Administrative Code, Section 109. HHC’s Office of Facilities Development (OFD) is often called upon to assist and cooperate with the Comptroller on prevailing wage rate investigations initiated by the Comptroller against contractors providing construction services on HHC projects against which complaints have been alleged, and provides wage information in instances where Freedom of Information requests are made to disclose bid information.

RESPONSIBILITIES OF A CONTRACTOR ON HHC PROJECTS

Contractors and subcontractors on public works projects and all other covered employers must maintain: 1) certified payroll reports which specify hours worked, trade classification, wages and benefits received by each covered employee; 2) sign in (and out) sheets; 3) Posted notices concerning applicable prevailing or living wage rates and employees’ right to contact the Comptroller to request an investigation.

RESPONSIBILITY OF HHC IN COMPLYING WITH PREVAILING WAGE ENFORCEMENT

HHC’s responsibility is to monitor contractor compliance by assuring the contractor properly specifies the hours worked, the trade classification, posting of notices, and contractor maintenance of employee job sign in (and out) sheets. HHC facilities currently have the option of achieving compliance through use of internal construction management staff, or through use of third party construction managers that serve as extension of staff.

CIRCUMSTANCES THAT TRIGGER PREVAILING WAGE AUDIT FINDING – INADEQUATE PROJECT SUPERVISION

HHC’s Office of Internal Audits, in four of its last audits, cited a failure to notify workers on their pay stubs of protection under prevailing wage laws, improper designation of employees on certified payroll reports, resulting in underpayment of wages. Additionally, there were some discrepancies between the daily log, contractor’s daily report, and certified payroll, also suggesting possible underpayment of wages.

Compliance with prevailing wage rate requirements has proven challenging for all public agencies, as it directly collides with the legal requirement of selecting the lowest responsible bidder. When selecting the lowest responsible bidder, the issue is always raised as to whether an independent contractor bidding on a public works

project can perform such work in compliance with prevailing wage rate requirements.

Trade unions continuously file complaints with the Comptroller's Office, alleging independent contractors as undercompensating its hired labor force for the value of skills they provide, thus circumventing prevailing wage rates. Trade unions argue that this allows a contractor to inappropriately reduce its bid for purposes of being selected. Trade unions maintain that since the Comptroller's Office establishes most prevailing wage rates commensurate with trade union rates, it is unlikely that an independent contractor can perform work for the price reflected in its bid, and still comply with prevailing wage rate requirements. Thus, when projects are let to an independent contractor through a competitive bid process, trade union representatives often monitor the project - either directly or through its rank and file members employed at the public agency.

Complaints by trade unions have risen dramatically over the past several years, as current economic conditions have exacerbated this situation, particularly as trade unions continuously seek to re-engage members having difficulty in gaining employment. The Comptroller's Office is obliged to investigate these complaints, and often looks to HHC's Office of Internal Audits, Office of Inspector General, and the Office of Facilities Development to assist in assuring compliance. Compliance with prevailing wage rates remains the responsibility of an independent contractor, however, a public agency is under obligation to monitor that appropriate notice and opportunity is given to contractor employees to assure they are aware of their employment rights. Citing this as a deficiency strongly indicates inadequate application of sufficient resources at the project level.

CORRECTIVE ACTION – ADOPTION OF A COMPREHENSIVE ‘CRADLE TO GRAVE’ CONSTRUCTION PROCESS FOR SMALL PROJECTS

For most projects under \$1 million, work will likely be performed through prequalified, construction requirements contracts previously identified as Indefinite Quantity Construction Contracts (IQCCs) process. The Office of Facilities

Development will seek to expand services of the consultant administering the IQCC program to include construction management services. Expansion of this contract will allow for project administration from inception to completion, the consultant being responsible for assuring that adequate prevailing wage rate provisions are complied with. OFD will offer this option to facilities as a means of complying with the prevailing wage rate requirement.

Decision to use this enhanced service will rest with the facility, as some facilities possess sufficient internal resources or have capacity to manage third party construction management staff engaged through requirements contracts. OFD will confer with facility administration and offer recommendations on whether use of this process is necessary in achieving compliance. Facilities will overtly commit to this obligation in assuring compliance with prevailing wage rate notice

Contract amendment is currently being completed.

4) FAILURE TO MAINTAIN CONTINUOUS EVIDENCE OF INSURANCE [FACILITY BASED PROJECTS ONLY]

In all four (4) audit reports, OIA cited a finding of no evidence of required insurances. In all instances, insurance coverage was in force, but evidence of it being in force could not be produced on demand.

CORRECTIVE ACTION – INCLUDE CONTINUOUS MONITORING OF INSURANCE AS A TASK OF CONSULTANT ADMINISTERING IQCC (3 ABOVE)

The task of assuring continuous evidence of insurance can be incorporated as an obligation of project administration under the IQCC program by the consultant conducting services on the project.

OPTION 2 - CONTRACTORS WILL BE REQUIRED TO REGISTER AND MAINTAIN PROOF OF ALL REQUIRED INSURANCES THROUGH A THIRD PARTY VENDOR

The Office of Facilities Development has identified and interviewed one vendor that provides the service of assuring contractor compliance with maintaining adequate insurances, and will continuously monitor contractor compliance, providing HHC with continuous proof that required insurance is in effect. It is anticipated that the nominal cost of maintaining this service will be absorbed by the contractor as a condition of its contract.

OFD anticipates issuing a public bid solicitation via a Request For Proposal (RFP) in late June, with recommendation for selection of a service in August.

5) BID AWARD WITH DEVIATIONS OF GREATER OR LESS THAN TEN PERCENT (10%) OF ESTIMATE [FACILITY BASED PROJECTS ONLY]

In three (3) of its last audits, OIA found construction projects were being awarded having bids outside a plus/minus 10% range, which is not acceptable under HHC procedures unless a reconciliation process takes place between the bid and estimate. This procedure serves as a control to provide some assurance as to the reasonableness of the bid relative to the estimate.

In instances where the bid exceeds 10% of the estimate, the control is intended to assure appropriate value is received before bid acceptance.

In instances where the bid is below the 10% estimate, the control is intended to draw attention to issues involving inadequate material quantities, materials pricing, as well as validation of appropriate prevailing wage rates for the labor component

of work, as the contractor is required to abide by prevailing wage rate requirements on public projects.

Estimates are most often prepared by third party architectural and engineering firms engaged by facilities through OFD administered requirement contracts. The architectural and engineering estimates support the project budget provided by the facility, but there has been issue in the accuracy of the underlying estimate as measured against the contractor's bid proposal.

As has been past practice in instances where the bid exceeds the 10% threshold, OFD has asked architectural and engineering firms to reconcile their initial estimate against the contractor bid proposal to identify discrepancies, and to recommend award in support of the bid. This has met with very limited success, and in coordination with OIA, OFD has sought third party independent cost estimates by estimating firms, which have proven costly and also have had limited success.

CORRECTIVE ACTION - BID TABULATIONS WILL REQUIRE ITEMIZED AND DETAILED MATERIAL QUANTITIES AND PRICING

A Breakthrough Rapid Improvement Event (RIE) developed a detailed material and quantity matrix that has been successfully piloted on several projects, and is scheduled for more extensive use which will assist in circumstances where bids exceed the plus/minus 10% estimate.

It is anticipated that the success of this change will result in permanent change to the existing process. To support this process, the next series of professional service requirements contracts will require design and engineering firms to provide estimates that conform to the new procedure. A sample itemized quantity matrix is shown as Exhibit 3.

6) NO METHOD OF MONITORING ALL PROJECT FUNDING SOURCES/PROJECT MONITORING

OIA has cited an inability to provide adequate project monitoring and funding source identification. The existing project monitoring program cannot provide complete reporting of project costs, because the reporting system does not capture expenditures from all funding sources [e.g., it does not capture expense (OTPS costs), only capital (bond) expenditures].

CORRECTIVE ACTION - SELECT A SOFTWARE PROGRAM THAT CAN ACCURATELY REPORT PROJECT EXPENDITURES FROM ALL FUNDING SOURCES AND ACCURATELY MONITOR/REPORT PROJECT STATUS

OFD is currently working with Information Technology to select a software program to accurately report project cost and work progress. Implementation is anticipated within 3-6 months of software program selection.

**7) CONSIDERATION OF ALTERNATE CONSTRUCTION DELIVERY METHODS –
CM/BUILD AND CM ‘AT RISK’ METHODOLOGY**

Consideration is currently being given to advance construction projects in a format where the construction manager (CM) assumes risk for assuring the cost of a project. Alternatively, and less adversarial, is a process where the CM holds the construction contracts in lieu of HHC, and serves as HHC’s agent. It is anticipated the process will provide access to premium contractors. When appropriate, this construction delivery method has capability of being used on small and medium sized projects.

CONCLUSION

The report address the most pressing matters cited as in need of immediate correction. From a more permanent and sustainable perspective, it identifies long-term measures being addressed through the Breakthrough process that will improve the efficiency and effectiveness of HHC’s construction program.

Exhibit 1

Schedule of Breakthrough Events

COMPLETED EVENTS:

- 1) CONSTRUCTION BID PROCESS RAPID IMPROVEMENT EVENT
12/21/12
- 2) CONSTRUCTION MANAGEMENT/FACILITIES DEVELOPMENT
VISIONING WORKSHOP – 2/20/13
- 3) CAPITAL PROJECTS PLANNING AND MANAGEMENT
WORKSHOP VALUE STREAM – 3/22/13
- 4) CAPITAL PROJECT PLANNING AND MANAGEMENT VALUE
STREAM ANALYSIS – 4/19/13
- 5) CAPITAL PROJECTS PLANNING PHASE RAPID IMPROVEMENT
EVENT – 5/24/13
- 6) MAINTAINING THE CAPITAL PLAN – 6/18/13

CURRENTLY IDENTIFIED FUTURE EVENTS:

- 1) CAPITAL PLAN/PROJECT APPROVAL PROCESS
- 2) IMPROVE PROCESS FOR DISQUALIFYING NON-
RESPONSIVE/RESPONSIBLE BIDDERS
- 3) REVIEW/UPDATE PROJECT MANAGEMENT PROCESS AND
MANUAL

EXHIBIT 2

Breakthrough Generated Standard Work

Bid Matrices

MJCL Estimate					Apparent Lowest Bidder										
Description of Items	Qty.	UNIT	FEC Material	Total Line Item Cost	Description of Items	Material				Labor		Total Line Item Cost	Variance	% Var/FEC	Comments
						Qty.	Unit	Price / Unit	Subtotal	Rate / Unit	Subtotal				
GENERAL CONSTRUCTION					GENERAL CONSTRUCTION										
Bonds	LS	0		\$ -	Bond	1	LS	\$ 35,000	\$ 30,000	\$ 5,000	\$ 5,000	\$ 35,000	\$35,000.00		
Insurance	LS	0		\$ -	Insurance	1	LS	\$ 10,000	\$ 10,000	\$ 5,000	\$ 5,000	\$ 15,000	\$15,000.00		
				Bonds & insurance Subtotal: \$ -								Bonds & insurance Subtotal: \$ 50,000	\$50,000.00		
General Conditions	1	ls	\$ 165,554.00	\$ 165,554	General Conditions										
Material Submission	LS			\$ -	Material Submission	1	LS	\$ 5,000	\$ 5,000	\$ 10,000	\$ 10,000	\$ 15,000	\$15,000.00		
Shop Drawings	LS			\$ -	Shop Drawings	1	LS	\$ 15,000	\$ 15,000	\$ 5,000	\$ 5,000	\$ 20,000	\$20,000.00		
Daily Reports	LS			\$ -	Daily Reports	1	LS	\$ 2,000	\$ 2,000	\$ 1,000	\$ 1,000	\$ 3,000	\$3,000.00		
Project Meetings	LS			\$ -	Project Meetings	1	LS	\$ 3,000	\$ 3,000	\$ 2,000	\$ 2,000	\$ 5,000	\$5,000.00		
Permits	LS			\$ -	Permits	1	LS	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 10,000	\$10,000.00		
Controlled Inspections/Special Inspections	LS			\$ -	Controlled Inspections/Special Inspections	1	LS	\$ 4,500	\$ 4,500	\$ 10,000	\$ 10,000	\$ 14,500	\$14,500.00		
Project Document closeout	LS			\$ -	Project Document Closeout	1	LS	\$ 1,500	\$ 1,500	\$ 2,000	\$ 2,000	\$ 3,500	\$3,500.00		
DOB Inspections	EA			\$ -	DOB Inspections	1	Ea	\$ 2,000	\$ 2,000	\$ 3,000	\$ 3,000	\$ 5,000	\$5,000.00		
As Built Drawings	LS			\$ -	As-built Drawings	1	LS	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000	\$ 2,000	\$2,000.00		
Progress Photographs	LS			\$ -	Progress Photographs	1	LS	\$ 500	\$ 500	\$ 500	\$ 500	\$ 1,000	\$1,000.00		
Manuals	LS			\$ -	Manuals	1	LS	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,000	\$ 2,000	\$2,000.00		
Daily Cleaning / Housekeeping	LS			\$ -	Daily Cleaning / Housekeeping	1	LS	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 10,000	\$10,000.00		
Dust Protection	LS			\$ -	Dust Protection	1	LS	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 10,000	\$10,000.00		
Scheduling & Coordination	LS			\$ -	Schedulig & Coordination	1	LS	\$ 2,000	\$ 2,000	\$ 2,000	\$ 2,000	\$ 4,000	\$4,000.00		
Mobilize/setup staging & restore	LS			\$ -	Mobilize/Setup Staging & Restore	1	LS	\$ 10,000	\$ 10,000	\$ 10,000	\$ 1,000	\$ 11,000	\$11,000.00		
Temporary water/electric/toilets setup, maintenance & restoration	LS			\$ -	Temporary Water/ Electric/ Toilets Setup, Maintenance & Restoration.	1	LS	\$ 3,000	\$ 3,000	\$ 2,000	\$ 2,000	\$ 5,000	\$5,000.00		
Subtotal General Conditions - Carried Forward to Summary				\$ 165,554								General Conditions Subtotal: \$ 121,000	(\$44,554.00)	-26.91%	
11000 DEMOLITION					DEMOLITION										
Remove partitions, doors/frames, topping slab, floor covering, ceilings, temporary barriers, translogic, shoring allowance etc.	LS	1	65,983	\$ 65,984	Remove partitions, doors/frames, topping slab, floor covering, ceilings, temporary barriers, translogic, shoring allowance etc.	1	LS	\$ 40,000	\$ 40,000	\$ 60,000	\$ 60,000	\$ 100,000	\$34,016.00	51.55%	
Subtotal Demolition - Carried Forward to Summary				\$ 65,984								Demolition Subtotal: \$ 100,000	\$34,016.00	51.55%	
12000 GENERAL CONSTRUCTION					GENERAL CONSTRUCTION										
Rigging	LS	1			Rigging	1	LS	\$ 10,000	\$ 10,000	\$ 10,000	\$ 10,000	\$ 20,000	\$20,000.00		
Earthwork - Hand excavate and dispose, filling and grading	167	cy	\$ 90.56	\$ 15,123.94	Earthwork-hand excavate, dispose, filling and grading	110	CY	\$ 200	\$ 22,000	\$ 200	\$ 22,000	\$ 44,000	\$28,876.06	190.93%	
Cast in place Reinforced Concrete	150	cy	\$ 1,350.00	\$ 202,860	Cast in place Reinforced Concrete	120	CY	\$ 200	\$ 24,000	\$ 220	\$ 26,400	\$ 50,400	(\$152,460.00)	-75.16%	
Concrete Reinforced Topping	56	cy	\$ 1,700.00	\$ 95,605	Concrete Reinforced Topping	60	CY	\$ 200	\$ 12,000	\$ 220	\$ 13,200	\$ 25,200	(\$70,404.60)	-73.64%	
Drywall partitions	322	lf	\$ 125.00	\$ 40,250	Drywall Partitions	300	LF	\$ 25	\$ 7,500	\$ 120	\$ 36,000	\$ 43,500	\$3,250.00	8.07%	
Single HM door, frame and hardware	1	ea	\$ 2,415.00	\$ 2,415	Single HM Door frame and hardware	1	LS	\$ 3,000	\$ 3,000	\$ 3,600	\$ 3,600	\$ 6,600	\$4,185.00	173.29%	
ACT Ceiling assembly	1,000	sf	\$ 9.66	\$ 9,660	ACT Ceiling assembly	1200	SF	\$ 7	\$ 8,400	\$ 8	\$ 9,600	\$ 18,000	\$8,340.00	86.34%	
GWB ceiling assembly	350	sf	\$ 18.11	\$ 6,339	GWB Ceiling assembly	480	SF	\$ 8	\$ 3,840	\$ 10	\$ 4,800	\$ 8,640	\$2,300.63	36.29%	
Rubber flooring	1,350	sf	\$ 9.66	\$ 13,041	Rubber Flooring	1176	SF	\$ 7	\$ 8,232	\$ 14	\$ 16,464	\$ 24,696	\$11,655.00	89.37%	
VCT	250	sf	\$ 4.23	\$ 1,057	VCT	405	SF	\$ 6	\$ 2,430	\$ 9	\$ 3,645	\$ 6,075	\$5,018.44	474.98%	
Wall base	350	lf	\$ 3.92	\$ 1,374	Wall base	360	LF	\$ 5	\$ 1,800	\$ 5	\$ 1,800	\$ 3,600	\$2,226.47	162.10%	
Painting	1,931	sf	\$ 1.81	\$ 3,498	Painting	2750	SF	\$ 2	\$ 5,500	\$ 3	\$ 8,250	\$ 13,750	\$10,252.48	293.14%	
FR wood veneer paneling	980	sf	\$ 78.49	\$ 76,918	FR Wood veneer paneling	952	SF	\$ 40	\$ 38,080	\$ 60	\$ 57,120	\$ 95,200	\$18,282.25	23.77%	
Architectural woodwork	1	ls	\$ 80,000.00	\$ 80,000	Architectural Woodwork	1	LS	\$ 38,300	\$ 38,300	\$ 65,000	\$ 65,000	\$ 103,300	\$23,300.00	29.13%	
Unit Msonry (exclusive of Rad. Shielding)					Unit Masonry (exclusive of Rad. Shieldg.)	1	LS	\$ 35,500	\$ 35,500	\$ 30,000	\$ 30,000	\$ 65,500	\$65,500.00		
Wall Protection (Acrovyn)	1	ls	\$ 15,574.00	\$ 15,574	Wall protection (Acrovyn)	1	LS	\$ 10,000	\$ 10,000	\$ 17,000	\$ 17,000	\$ 27,000	\$11,426.00	73.37%	
Temporary partitions install and remove	800	sf	\$ 18.11	\$ 14,490	Temporary Partitions install and remove	1	LS	\$ 10,000	\$ 10,000	\$ 14,000	\$ 14,000	\$ 24,000	\$9,510.00	65.63%	
Temporary doors,frames and hardware	1	PR	\$ 2,415.00	\$ 2,415	Temporary doors,frames and hardware	2	EA	\$ 2,000	\$ 4,000	\$ 4,689	\$ 9,378	\$ 13,378	\$10,963.00	453.95%	
Misc. Work: Corner Guard, Crash rail					MISC work: Corner guard, Crash rail,	1	LS	\$ 3,000	\$ 3,000	\$ 2,011	\$ 2,011	\$ 5,011	\$5,011.00		
Subtotal General Construction - Carried Forward to Summary				\$ 580,618								General Construction Subtotal: \$ 597,850	\$17,231.72	2.97%	
13000 RADIATION PROECTION					RADIATION PROTECTION										
Pre-manufactured high-density concrete block to construct one free standing maze radiation Treatment Room	1	ls	\$ 700,000.00	\$ 700,000	Pre manufactured High Density concrete block to construct one free standing maze radiation treatment room:	1	LS	\$ 150,000	\$ 150,000	\$ 100,000	\$ 100,000	\$ 250,000	\$ (450,000)	-64.29%	
All wall shielding					All wall shielding	1	LS	\$ 50,000	\$ 50,000	\$ 25,000	\$ 25,000	\$ 75,000	\$ 75,000		
All ceiling support beams/bearing plates					All ceiling support beams/bearing plates	1	LS	\$ 100,000	\$ 100,000	\$ 60,000	\$ 60,000	\$ 160,000	\$ 160,000		
All ceiling shielding					All ceiling shielding	1	LS	\$ 30,000	\$ 30,000	\$ 20,000	\$ 20,000	\$ 50,000	\$ 50,000		
Dosimetry cable passage					Dosimetry cable passage	1	LS	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 10,000	\$ 10,000		
Mechanical penetration shielding for maze entry room					Mechanical penetration shielding for maze entry room	1	LS	\$ 5,000	\$ 5,000	\$ 5,000	\$ 5,000	\$ 10,000	\$ 10,000		
Non unon labor for installation												\$ -			
New York State licensed Engineer Seal					New York State licensed Engineer Seal	1	LS	\$ 5,000	\$ 5,000	\$ 2,500	\$ 2,500	\$ 7,500	\$ 7,500		
Radiation Shielded door complete with sub frame, motion sensor, automatic dor operator and 3 year warranty	1	ls	\$ 115,262	\$ 115,262	Radiation Shielded door complete with sub frame, motion sensor, automatic dor operator and 3 year warranty	1	LS	\$ 35,000	\$ 35,000	\$ 15,000	\$ 15,000	\$ 50,000	\$ (65,262)	-56.62%	
Subtotal Radiation Protection - Carried Forward to Summary				\$ 815,262								Radiation Protection Subtotal: \$ 612,500	\$ (202,762)	-24.87%	

Facility: Kings County Hospital Center
 Project: Linear Accelerator Building "S"
 Trade:
 Project Number:

Bid Comparison Spreadsheet

14000 PNEUMATIC TUBE				PNEUMATIC TUBE											
Demo existing PT piping and X-fer station, install new PT, misc assoc. cutting patching etc.	1	ls	\$ 105,000	\$ 105,000	Demo existing PT Piping and X-Fer station, Install new PT, misc associated cutting patching and architectural work	1	LS	\$ 30,000	\$ 30,000	\$ 75,000	\$ 75,000	\$ 105,000	\$ -	0.00%	
Subtotal Pneumatic Tube - Carried Forward to Summary				\$ 105,000					Pneumatic Tube Subtotal:				\$ 105,000	\$ -	0.00%
15100 PLUMBING WORK / FIRE PROTECTION				PLUMBING WORK											
Plumbing piping and connections	1	ls	90,100.00	\$ 90,100	Plumbing piping and connections	1	LS	\$ 8,800	\$ 8,800	\$ 28,000	\$ 28,000	\$ 36,800	\$ (53,300)	-59.16%	
Plumbing at 1st floor	1	ls	25,423.00	\$ 25,423	Plumbing at first floor	1	LS	\$ 28,200	\$ 28,200	\$ 55,000	\$ 55,000	\$ 83,200	\$ 57,777	227.26%	
Subtotal Plumbing Work - Carried Forward to Summary				\$ 115,523					Plumbing Work Subtotal:				\$ 120,000	\$ 4,477	3.88%
21000 Fire Protection				FIRE PROTECTION											
Remove piping and heads, misc. demo	1		2,700.00	\$ 2,700	Remove piping, heads misc. demo	1	LS	\$ 5,000	\$ 5,000	\$ 11,500	\$ 11,500	\$ 16,500	\$ 13,800	511.11%	
Preaction system, complete, including compressor	1	ls	118,185.00	\$ 118,185	Pre Action system complete including compressor	1	LS	\$ 17,500	\$ 17,500	\$ 17,500	\$ 17,500	\$ 35,000	\$ (83,185)	-70.39%	
Sprinkler heads and branch piping & connect to riser one location	12	ea	500.00	\$ 8,600	Sprinkler heads and branch piping and connect to riser one location	14	EA	\$ 400	\$ 5,600	\$ 1,000	\$ 14,000	\$ 19,600	\$ 11,000	127.91%	
Subtotal Fire Protection - Carried Forward to Summary				\$ 129,485					Fire Protection Subtotal:				\$ 71,100	\$ (58,385)	-45.09%
15200 HVAC				HVAC											
Chiller	1	ls	90,334.00	\$ 90,334	Chiller	1	EA	\$ 50,000	\$ 50,000	\$ 20,000	\$ 20,000	\$ 70,000	\$ (20,334)	-22.51%	
CAV boxes	3	ea	20,000.00	\$ 60,000	CAV boxes	2	EA	\$ 3,000	\$ 6,000	\$ 2,000	\$ 4,000	\$ 10,000	\$ (50,000)	-83.33%	
Piping and ductwork	1	ls	162,000.00	\$ 162,000	Piping	600	LF	\$ 50	\$ 30,000	\$ 15	\$ 9,000	\$ 39,000	\$ (123,000)	-75.93%	
Controls					Duct work (remove & install)	300	LF	\$ 30	\$ 9,000	\$ 35	\$ 10,500	\$ 19,500	\$ 19,500		
					CONTROL	1	LS	\$ 30,000	\$ 30,000	\$ 30,500	\$ 30,500	\$ 60,500	\$ 60,500		
Subtotal HVAC - Carried forward to Summary				\$ 312,334					HVAC Subtotal:				\$ 199,000	\$ (113,334)	-36.29%
16000 ELECTRICAL / FIRE ALARM				ELECTRICAL WORK / FIRE ALARM											
Wiring	1	ls	50,000.00	\$ 50,000	Wiring	11000	LF	\$ 6	\$ 60,500	\$ 8	\$ 88,000	\$ 148,500	\$ 98,500	197.00%	
Devices	1	ls	36,000.00	\$ 36,000	Devices	70	EA	\$ 100	\$ 7,000	\$ 200	\$ 14,000	\$ 21,000	\$ (15,000)	-41.67%	
Equipment	1	ls	60,000.00	\$ 60,000	Equipmet	42	EA	\$ 290	\$ 12,180	\$ 300	\$ 12,600	\$ 24,780	\$ (35,220)	-58.70%	
Connections	1	ls	30,000.00	\$ 30,000	Connections	52	EA	\$ 300	\$ 15,600	\$ 265	\$ 13,780	\$ 29,380	\$ (620)	-2.07%	
Lighting fixtures & Circuitry	1	ls	25,000.00	\$ 25,000	Lighting Fixtures & Circuitry	30	EA	\$ 356	\$ 10,680	\$ 150	\$ 4,500	\$ 15,180	\$ (9,820)	-39.28%	
Luminous Ceiling	1	ls	37,450.00	\$ 37,450	Luminous Ceiling	75	SF	\$ 98	\$ 7,350	\$ 80	\$ 6,000	\$ 13,360	\$ (24,090)	-64.33%	
Subtotal Fire Alarm - Carried Forward to Summary				\$ 238,450					Electrical/Fire Alarm Subtotal:				\$ 252,200	\$ 13,750	5.77%
Total 11000 through 16000				\$ 2,528,210					Total Bid Price:				\$ 2,228,650	(\$299,560.28)	-11.85%

General Contractor's Overhead @10% *In Division 1*
 SUBTOTAL \$ 2,528,210
 General Contractor Overhead Profit @10% *In Unit Prices*
 TOTAL \$ 2,528,210

Variance Justified: Yes / No
 List All Attachments:
 Prepared By: _____
 Name Title Date Signature
 Reviewed By: _____
 Name Title Date Signature

EXHIBIT 3

Project Implementation Guide (P.I.G.)



Project Initiation Guide

Operation:	Feasibility & Space Program Tasks 1.2 & 1.3	Process:	Capital Projects Planning Phase I
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Step	Description/Trigger	Image/Key Point/Reason	Who	Yes	No	N/A	Comments
	Preliminary Business Plan Tasks						
1	Overview	Includes, Reason for Action from A-3, Description of Program and Type of Projects.					
2	Planning	Cost of Consultants (A/E, Safety, HAZMAT, acoustical, estimating, etc.). Including 2P					
3	Planning	Cost of HHC FTEs, OTPS expenses and all other ancillary costs.					
4	Planning	Certificate of Need (CON)- Identify type of CON, projected submission date and projected project approval.					
5	Planning	Identify time sensitive funding (e.g. HEAL Grants).					
6	Strategic Considerations	Consider; Target Service Area. Review demographics, healthcare trends, community needs, market share, market potential, etc..					
7	Strategic Considerations	Service Lines / Hospitals/ Business Units Impacted/Competition					
8	Strategic Considerations	Productivity Efficiency Enhancements					
9	Strategic Considerations	Physician / Nurse Recruitment					
10	Capital FEC	Review/Evaluate including analysis					
11	Strategic Considerations	Master Plan Impact, Parking, Information Technology, Other Special Equipment, Savings					
12	Projected Operating Expenses	Personnel Service (Doctors, Nurses), OTPS (Utilities, Maintenance), Debt Service					
13	Projected Operating Revenue	Medicaid / Medicare, Third Party, Self -Pay, Other - For years 1 through 5					
14	Profit / Loss	(Projected Revenues - Projected Expense) For Year 1 through 5					
15	Identify Project Funding	Debt, Expense, Grants, Philanthropic Gifts, FEMA Reimbursement					
16	Sales and Marketing	Advertising Requirements for the Program					
17	Finalize business plan	Inclusive of project fee and scope as described on page 4					
18	Recommendation	Determine if Project should be implemented, if Yes; FED to send letter of recommendation to AVP at OFD.					
19	Final Report Submission	FM to assemble and submit complete package to ED for Approval/Action					



Project Initiation Guide

Operation:	Feasibility & Space Program Tasks 1.2 & 1.3	Process:	Capital Projects Planning Phase I
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Step	Description/Trigger	Image/Key Point/Reason	Who	Yes	No	N/A	Comments
	Facility Tasks						
1	Program Project	Identify the category of the project					
2	Medical Equipment Project	Identify the category of the project					
3	Regulatory Project	Identify the category of the project					
4	Infrastructure Project	Identify the category of the project					
5	Emergency Project	Identify the category of the project					
6	Architectural Firm	Does the project require a architectural firm					
7	In-House Architect	Does the project require a in-house architect					
8	Engineering Firm	Does the project require a engineering firm					
9	In-House Engineer	Does the project require a in-house engineer					
10	Construction Management Firm	Does the project require a CM firm					
11	In-House Construction Management	Dose the project require a in-house CM					
12	Write an RFP for A/E	Request proposals from a minimum of (2) HHC requirement consultants if project requires external support services					
13	Write an RFP for CM	Request proposals from a minimum of (2) HHC requirement consultants if project requires external support services					
14	Receive Proposals for A/E	Evaluate proposals, forward work order to OFD with selected consultant					
15	Receive Proposals for CM	Evaluate proposals, forward work order to OFD with selected consultant					
16	Purchase Order	Process requisition to obtain a PO for the selected consultant					
17	Engage with Consultants	Set up a kick off meeting with project team members					



Project Initiation Guide

Operation:

Feasibility & Space
Program Tasks 1.2 & 1.3

Process:

Capital Projects
Planning Phase I

Step	Description/Trigger	Image/Key Point/Reason	Who	Yes	No	N/A	Comments
	Introduction overall description of goals and context						
	Space Program						
1	Secure existing documentation and statistical data	Identify and turnover as-built plans & utilization statistics for past 5 years and all historic and on going project data	HHC				
2	Field survey by consultants	A/E & CM Survey	HHC				
3	Inventory of Existing Space	Inventory of existing space for proposed function. Compare existing and proposed space	HHC/ Arch				
4	Site Analysis/Analysis of Existing Conditions	Assess existing conditions for proposed site. List issues to be resolved.	HHC/ Arch				
5	Anticipated Growth or Diminishment	Analyze space requirements based upon anticipated growth	HHC/ Arch				
6	Is Swing Space needed	Analyze the need to move staffing in order to keep services flowing	HHC/ Arch/ CM				
7	Is Relocation / Make Ready Work needed?	Does any work need to occur prior to the start of this project	HHC/ Arch/ CM				
8	Space Programing	Prepare room by room, consider alternate operations, and staffing	HHC/ Arch				
9	Work Space Standards	Establish a standard for individual room spaces	HHC/ Arch				
10	Adjacency and Work Flow	Determine/illustrate adjacency requirements	HHC/ Arch				
11	Special Purpose Areas	Provide space requirements for special purpose functions	HHC/ Arch				
12	Building Service Areas	Develop requirements for building services (Materials Management)	HHC/ Arch				
13	Service Requirements	Provide narrative for communications, acoustics, and other special conditions	HHC/ Arch				
14	Mechanical Requirements	Provide space MEP / FP Systems for required capacity and coordination with existing systems	HHC/ Arch				
15	Power Requirements	Provide space for electric Systems for required (normal & Emergency) capacity and coordination with existing systems including separation of powers	HHC/ Arch				



Project Initiation Guide

Operation:	Feasibility & Space Program Tasks 1.2 & 1.3	Process:	Capital Projects Planning Phase I
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Step	Description/Trigger	Image/Key Point/Reason	Who	Yes	No	N/A	Time/Duration Comments
	Feasibility Planning						
1	Priority Identification and Development of Alternative Schemes	Develop project scope schemes for evaluation. Select an optimal for continuing development	HHC/ Arch/ CM				
2	Zoning Analysis	Provide a zoning analysis	HHC/ Arch				
3	Identification of Regulatory Requirements / Building Code Compliance	Insure compliance with NYCDOB	HHC/ Arch				
4	Fire Safety	Prepare Life Safety Plan	HHC/ Arch				
5	Communications and Data	Prepare narrative description of proposed services, assure that MEP is adequate	HHC/ Arch				
6	Environmental Goals	List/Describe environmental design features	HHC/ Arch				
7	Risk Assessment	Identify / List potential Risks that may impact cost and/or schedule	HHC/ Arch/ CM				
8	Security Analysis	Prepare narrative description of proposed services	HHC/ Arch				
9	Elemental Cost Estimate	Prepare construction and project cost estimates for each scheme. Including swing space / relocation costs. Review and modify estimates as required. Provide phased appropriate contingencies	HHC/ Arch/ CM				
10	Project Schedule	Prepare a Draft Schedule including deliverables	HHC/ Arch/ CM				
11	Master Plan if Needed	Prepare master plan for long-term development and multi year funding. Plan to include known and potential needs of the institution. Select an optimal approach for continuing development.	HHC/ Arch/ CM				
12	Coordinate Information for Business Plan	Meet with Facilities Management and supply all information necessary for Business Plan					

Upon submission to OFD with supporting documentation; OFD will provide a written recommendation or rejection for project advancement within 10 business days.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an Affiliation Agreement with the State University of New York/Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at Kings County Hospital Center ("KCHC") for a period of three years, commencing July 1, 2013 and terminating on June 30, 2016, consistent with the general terms and conditions and for the amounts as indicated in Attachment A;

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

WHEREAS, the Corporation has entered into affiliation agreements pursuant to which various medical schools, voluntary hospitals and professional corporations provided General Care and Behavioral Health Services at Corporation facilities; and

WHEREAS, it is necessary for the President to have the managerial flexibility to insure that the rights of the Corporation remain protected during the negotiation process; and

WHEREAS, a summary of the proposed general terms and amounts of a new Affiliation Agreement with SUNY/HSCB is set forth in Attachment A, and

WHEREAS, the Community Advisory Board of KCHC has been consulted and apprised of such proposed general terms and conditions; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, now desires that SUNY/HSCB continue to provide General Care and Behavioral Health Services at KCHC.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation is hereby authorized to negotiate and execute an Affiliation Agreement with State University of New York/Health Science Center at Brooklyn, for the provision of General Care and Behavioral Health Services at Kings County Hospital Center, for a period of three years, commencing July 1, 2013 and terminating on June 30, 2016, consistent with the general terms and conditions and for the amounts as indicated in Attachment A; and

BE IT FURTHER RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

Attachment A

Summary of the Proposed Affiliation Agreement Between the New York City Health and Hospitals Corporation ("the Corporation") and the State University of New York/Health Science Center at Brooklyn ("SUNY/HSCB") for the provision of General Care and Behavioral Health Services at Kings County Hospital Center ("KCHC")

General Terms and Synopsis

The proposed agreement allows for the continued provision of some services at KCHC, notably in Psychiatry, Radiology, Ophthalmology, Radiation Oncology, and Emergency Medicine. The agreement calls for a three-year term commencing July 1, 2013 and HHC will compensate SUNY/HSCB on costs. SUNY/HSCB will maintain all appropriate attending supervision coverage as required by state regulations and national accreditation standards. The agreement also proposes a series of pay-for-performance indicators to align business goals and improve performance.

Key Achievements

- ❖ Half century partnership between Kings County Hospital Center and State University of New York/Health Science Center at Brooklyn
- ❖ Continued oversight by Joint Coordinating Committee (JCC) to promote collaboration and timely communication
- ❖ Re-establishment of advanced Hepatobiliary surgery with outstanding outcomes
- ❖ Joint research projects in Endocrinology, Emergency Medicine, Oncology and Radiation Oncology
- ❖ Major improvements in reducing hospital acquired conditions – KCHC received the President's Safety Award for no Central Line Acquired Blood Stream Infection (CLABSI) in Medical Intensive Care Unit (MICU) over an 18-month period.

Key Initiatives

- ❖ Reduce average length of stay in Behavioral Health by 50% over the next 6 months
- ❖ Restructure Behavioral Health outpatient services to ensure increased access and increased patient engagement.

Financial Terms

**Proposed Contract Costs
FY 2014 - 2016
Kings County Hospital Center**

CONTRACT YEAR	ANNUAL COSTS
FY 2014	\$17,085,818
FY 2015	\$17,381,996
FY 2016	\$17,692,709
FY 2014 - 2016	\$52,160,523

- ❖ Payments are subject to adjustment due to new initiatives for expanded programs or services, elimination or downsizing of programs, services or other reductions, market recruitment, retention-based salary adjustments, service grants and/or other designated programs consistent with the terms of the agreement.
- ❖ All changes to the budget must have KCHC and Central Office approval as per Corporate policy.
- ❖ The Affiliation contract will continue the current cost based compensation reimbursement methodology, not to exceed departmental spending limits.
- ❖ The FY 2014 budget is based on the final FY 2013 budget, adjusted for approved modifications.
- ❖ The figures reported assume no material change in patient volume or services provided and no additional impact from managed care programs or other third-party payer developments.

Pay-for-Performance Corporate Quality Indicators

- ❖ The Corporation will continue to monitor the Affiliate's efforts to maintain the highest quality of patient care with a pay-for-performance program by linking provider performance to some indicators
- ❖ Payment may be reduced annually up to \$100,000 if the Affiliate does not reach thresholds regarding SDOH citations, sentinel events, and malpractice claims
- ❖ Payment may be increased annually up to \$100,000 if the Affiliate reaches thresholds regarding mammography readings, dictation of radiology reports, and reducing length of stay and readmissions in behavioral health.

Transfers and Referrals

- Patients will be transferred and referred to other facilities if the required services are not available at KCHC, a third-party payer does not authorize reimbursement or the patient requests it.
- If a service is not available at the facility, such transfers and referrals will be made to other HHC facilities.
- If the service is not available at a HHC facility, transfers and referrals to non-HHC facilities will only be made with the approval of the Executive Director of his/her designee and if an agreement with the receiving facility is in place.
- Transfer and referral activity will be monitored monthly.
- Failure to comply results in a penalty for each event of 50% expected reimbursement.

Other Significant Relevant Terms and Conditions

- Physician providers must participate in required training including customer relations and cultural and linguistic competency.
- The Affiliate will provide support to the Network in all efforts to meet regulatory and legislative state and federal requirements.
- Physician Providers will participate in and support quality and safety practices at KCHC.
- There shall be no change in the number of residents without prior discussion and approval of the Joint Coordinating Committee.
- The Affiliate will ensure supervision of residents, per state regulations and national accreditation standards, for compliance with both work hour coverage and attending supervision requirements.
- The Affiliate shall be represented on KCHC search committees when considering the appointment of new chiefs of service.
- The Affiliate will ensure compliance with all Health Insurance Portability and Accountability Act (HIPAA) regulations and amendments in effect during the term of the contract.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and execute an Affiliation Agreement with the Staten Island University Hospital ("SIUH"), for the provision of General Care and Behavioral Health Services at Sea View Hospital Rehabilitation Center and Home ("Sea View"), for a period of three years, commencing July 1, 2013 and terminating on June 30, 2016, consistent with the general terms and conditions and for the amounts as indicated in Attachment A;

AND

Further authorizing the President to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

WHEREAS, the Corporation has for some years entered into affiliation agreements pursuant to which various medical schools, voluntary hospitals and professional corporations ("the Affiliates") provided General Care and Behavioral Health Services at Corporation facilities; and

WHEREAS, the current Affiliation Agreement with SIUH, to provide General Care and Behavioral Health Services at Sea View, expires on June 30, 2013; and

WHEREAS, a summary of the proposed general terms and amounts of a new Affiliation Agreement with SIUH is set forth in Attachment A; and

WHEREAS, the Community Advisory Board of Sea View has been consulted and apprised of such proposed general terms and conditions; and

WHEREAS, the Corporation, in the exercise of its powers and fulfillment of its corporate purposes, now desires that SIUH continue to provide General Care and Behavioral Health Services at Sea View.

NOW, THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation is hereby authorized to negotiate and execute an Affiliation Agreement with Staten Island University Hospital for the provision of General Care and Behavioral Health Services at Sea View Hospital Rehabilitation Center and Home, for a period of three years, commencing July 1, 2013 and terminating on June 30, 2016, consistent with the general terms and conditions and for the amounts as indicated in Attachment A; and

BE IT FURTHER RESOLVED, that the President is hereby authorized to make adjustments to the contract amounts, providing such adjustments are consistent with the Corporation's financial plan, professional standards of care and equal employment opportunity policy except that the President will seek approval from the Corporation's Board of Directors for any increases in costs in any fiscal year exceeding twenty-five percent (25%) of the amounts set forth in Attachment A.

ATTACHMENT A

Summary of the Proposed Affiliation Agreement Between the New York City Health and Hospitals Corporation ("the Corporation") and the Staten Island University Hospital ("SIUH") for the provision of General Care and Behavioral Health Services at Sea View Hospital Rehabilitation Center and Home ("Sea View")

Synopsis and General Terms

Sea View, a long-term care facility, has depended on local physicians to provide specialty services to our patients because of the difficulty of recruiting physicians to work at the Corporation's pay scale. Sea View previously contracted with SIUH to provide the needed specialty services because patients and their families prefer that they not leave Staten Island for care. Transportation for care off the island is costly and disruptive to the patients. Further, it is difficult for the elderly and infirm to make these trips, especially for those with dementia. Finally, it is important to establish a relationship with a hospital in the borough that can provide timely emergent care and whose doctors are knowledgeable about the patients' health condition.

We seek to renew our agreement with the SIUH because it is the only health care organization on Staten Island capable of meeting the needs of our patients at Sea View. The proposed agreement continues to require that SIUH assess our patients at our facility, eliminating the need to send Sea View residents off site for specialty services. Back-up providers are quickly available in the event that scheduled providers are unavailable. This agreement continues to ensure that Sea View patients do not receive fragmented care and enhances the continuity of care received as patients have access to the same physicians following them both at Sea View and when admitted on an emergent basis to SIUH.

The term of the proposed agreement for the provision of general care and behavioral health services at Sea View is for three years commencing July 1, 2013 and expiring on June 30, 2016. The proposed agreement, like the prior agreement, will compensate SIUH based on payments for services provided by the hour. Because of the small size of this contract and since SIUH will only provide services on a part time basis, additional performance indicators beyond those already being tracked as part of the corporate quality assurance program are not included.

Financial Terms

- The Corporation retains the right to bill all patients and third-party payers for services rendered.
- The total cost of the contract will be \$331,488 per year (\$994,464 for the contract term) to provide physician services as follows:

**Proposed Annual Contract Costs
FY 2014 - FY 2016
SIUH**

Service	Projected Annual Contract Costs
Gastroenterology	\$18,096
Endocrine	\$4,176
Neurology	\$41,496
Psychiatry	\$226,720
Laboratory	\$6,000
Miscellaneous Specialties	\$35,000
TOTAL	\$331,488

Other Relevant Terms and Conditions

- All physicians will be Board certified or exam-admissible.
- The Affiliate will ensure that all medical providers are culturally and linguistically sensitive to our resident population.
- Either party may terminate this Agreement, without cause, at any time during its term by giving twelve months written notice to the other party.
- Transfers and referrals will be in accordance with Corporate Policies and Procedures.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to purchase Cisco SMARTnet maintenance through a NYS Office of General Services (OGS) contract from Cisco’s authorized reseller, Dimension Data North America, Inc. in an amount not to exceed \$22,080,000, including a 15% contingency, over the term of three years.

WHEREAS, the Corporation has an immense inventory of routers, switches, firewalls, UCS servers and wireless controllers, which are utilized to link various computers and data systems throughout the Corporation together to share business and clinical applications used for patient care;
and

WHEREAS, the Cisco SMARTnet Services and Maintenance is required in order to avoid any outages associated with equipment/part failures, software glitches and operating system software issues; and

WHEREAS, failure to obtain services and maintenance for the Corporation’s network infrastructure can result in system unavailability, which may have an impact on patient care; and

WHEREAS, the Corporation solicited proposals from Cisco resellers who offer their services via the New York State OGS contract, including Dimension Data North America, Inc.; and

WHEREAS, Dimension Data North America, Inc. offered the lowest price for the requested services; and

WHEREAS, the overall responsibility for managing and monitoring the agreement shall be under the Senior Vice President/Corporate Chief Information Officer.

NOW THEREFORE, be it:

RESOLVED, THAT THE President of the New York City Health and Hospitals Corporation be and hereby is authorized to purchase Cisco SMARTnet maintenance through a NYS Office of General Services (OGS) contract from Cisco’s authorized reseller, Dimension Data North America, Inc. in an amount not to exceed \$22,080,000, including a 15% contingency, over the term of three years.

Resolution

Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to negotiate and execute a contract with IBM Corporation for the procurement of a performance analytics/business intelligence platform. The contract will be for an amount not to exceed \$10,054,721 for an initial term of one year, with three (1) one year renewal options, exercisable solely by the Corporation.

WHEREAS, the Corporation desires to improve decision support across the continuum of care, integrate disparate information from a broad array of data source systems, across multiple facilities and for aggregation at the corporate level; deliver high quality data to ensure that the information solution is timely, incremental, automatic and accurate; deploy meaningful and timely reports, dashboards and alerts for various user levels that track and monitor key performance indicators for better evidence-based decision-making; and

WHEREAS, a qualified systems vendor is required to assist the Corporation to implement an enterprise data warehouse, provide relevant tools, and deploy a reporting solution; and

WHEREAS, a selection committee composed of the members from the Corporation’s Central Office and Facilities considered proposals from various vendors and recommended that the Corporation enter into a contract with IBM Corporation; and

WHEREAS, the contract with IBM includes professional services procured via Federal GSA contract, hardware procured via NYS OGS contract and software procured via a direct agreement with IBM based on Federal GSA pricing for IBM software; and

WHEREAS, the overall responsibility for monitoring the contract with IBM shall be under the direction of the Senior Vice President/Chief Information Officer, Division of Enterprise Information Technology Services.

NOW THEREFORE, BE IT

RESOLVED, that the President of the New York City Health and Hospitals Corporation is hereby authorized to negotiate and execute a contract with IBM Corporation for the procurement of a performance analytics/business intelligence platform. The contract will be for an amount not to exceed \$10,054,721 for an initial term of one year, with three (1) one year renewal options, exercisable solely by the Corporation.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (“the Corporation”) to negotiate and execute a contract with Allscripts Healthcare LLC. (“Allscripts”) for a web-based case management, and denials management and discharge planning software solution accessible throughout the Corporation’s acute-care and long-term care facilities for a three (3) year term with two (2) one year renewal options, exercisable solely by the Corporation, in an amount not to exceed \$5,201,225.

WHEREAS, the Corporation must maintain a strong case management and discharge planning function to serve its patients effectively; and

WHEREAS, the Corporation must receive appropriate third party revenues for the services that it provides to its patients, from the payer mix that includes numerous Medicaid managed care, Medicare Advantage, and commercial managed care and insurance plans; and

WHEREAS, the facilities’ case management and discharge planning staff require assistance to manage patients more efficiently and navigate obtaining authorization and other approvals required by the managed care and insurance companies as a condition of reimbursement; and

WHEREAS, a Request for Proposals (“RFP”) was issued on December 21, 2012 in accordance with the Corporation’s operating procedures; and

WHEREAS, the selection committee rated the proposals using criteria specified in the RFP, and the committee determined that Allscripts best met the requirements of the RFP and recommended that Allscripts be awarded the contract; and

WHEREAS, under this contract, Allscripts will provide 1) a web-based case management, and denials management, and discharge planning software solution for the Corporation; 2) reporting capabilities for local and Corporate-wide reports; 3) interface capabilities between the web-based product and the Corporation’s electronic medical record, registration, and financial systems; and 4) training and technical support services, and

WHEREAS, the overall responsibility for managing and monitoring the contract shall be under the Senior Vice President/Chief Information Officer, and the Senior Vice President for Finance.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and is hereby authorized to negotiate and execute a contract with Allscripts to provide a web-based case management, and denials management, and discharge planning software solution to the Corporation’s facilities for a three (3) year term with two (2) one year renewal options, exercisable solely by the Corporation, in an amount not to exceed \$5,201,225.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute construction requirements contracts with six (6) firms: Gridspan Corporation; Vastech Contracting Corporation; Volmar Construction, Inc.; Sierra Mechanical Contracting, Inc.; Jemco Electrical Contractors, Inc.; and Charan Electrical Enterprises, Inc. (the "Contractors"), to provide construction services on an as-needed basis at various facilities throughout the Corporation. 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 \$36 Million.

WHEREAS, the facilities of the Corporation may require professional construction services, such as, General Contracting (GC) services, Heating, Ventilation, and Air Conditioning (HVAC) services, and Electrical services; and

WHEREAS, the Corporation has determined that such needs can best be met by utilizing outside firms, on an as-needed basis, through a requirements contracts; and

WHEREAS, the Corporation's Operating Procedure No. 100-5 requires approval by the Board of Directors contracts of \$3,000,000 and above; and

WHEREAS, the Corporation published a request for bids for professional GC, HVAC, and electrical services, bids received were publicly opened on March 18, 2013, and March 21, 2013, and the Corporation determined that the Contractors are the lowest responsible bidders for these contracts; and

WHEREAS, the Contractors have met all, legal, business and technical requirements and are qualified to perform the services as required in the contract documents.

NOW, THEREFORE, be it

RESOLVED, the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute requirements contracts with six firms; Gridspan Corporation; Vastech Contracting Corporation; Volmar Construction, Inc.; Sierra Mechanical Contracting, Inc.; Jemco Electrical Contractors, Inc.; and Charan Electrical Enterprises, Inc., to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$6,000,000. The total authorized to be spent under these contracts is \$36 Million.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute construction requirements contracts with four (4) firms: Par Plumbing; Richard Plumbing and Heating; Empire Control Abatement, Inc.; and New York Environmental Systems, Inc. (the "Contractors"), to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$2,000,000. The total authorized value of these contracts is \$8 Million.

WHEREAS, the facilities of the Corporation may require professional construction services, such as, Hazardous Material (HazMat) services, and Plumbing services; and

WHEREAS, the Corporation has determined that such needs can best be met by utilizing outside firms, on an as-needed basis, through a requirements contracts; and

WHEREAS, the Corporation's Operating Procedure No. 100-5 requires approval by the Board of Directors contracts of \$3,000,000 and above; and

WHEREAS, the Corporation published a request for bids for professional HazMat, and plumbing services, bids received were publicly opened on March 18, 2013, and March 21, 2013, and the Corporation determined that the Contractors are the lowest responsible bidders for these contracts; and

WHEREAS, the Contractors have met all, legal, business and technical requirements and are qualified to perform the services as required in the contract documents.

NOW, THEREFORE, be it

RESOLVED, the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute requirements contracts with four firms; Par Plumbing; Richard Plumbing and Heating; Empire Control Abatement, Inc.; and New York Environmental, to provide construction services on an as-needed basis at various facilities throughout the Corporation. Each individual contract shall be for a term of two (2) years, for an amount not to exceed \$2,000,000. The total authorized to be spent under these contracts is \$8 Million.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to modify the scope and budget for the existing Boiler Plant project at Coney Island Hospital (the "Facility") to add an additional \$2,935,845, increasing the total project budget to an amount not-to-exceed \$9.94 million.

WHEREAS, the Board of Directors approved a resolution on May 24, 2012, which authorized the New York Power Authority ("NYPA") to provide the planning, pre-construction, design services, construction, procurement, construction management and project management services necessary to replace the existing boiler plant at the Facility; and

WHEREAS, scope changes and other revisions to the project budget have been proposed to address structural damages incurred by the existing Facility Boiler House resulting from Hurricane Sandy, requiring boilers to be raised above the Federal Emergency Management Agency ("FEMA") designated 100-year flood line; and

WHEREAS, the additional work proposed to be performed will require an additional \$2,935,845 to the current project budget of \$6,997,980 to address these issues; and

WHEREAS, additional proposed work may be eligible for FEMA reimbursement as an element of broader remedial measures taken by the facility in response to hazard mitigation; and

WHEREAS, the overall management of the construction contract will be under the direction of the Facility's Senior Associate Director - Facilities and the Assistant Vice President – Facilities Development.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and is hereby authorized to modify the scope and budget for the existing Boiler Plant project at Coney Island Hospital (the "Facility") to add an additional \$2,935,845, increasing the total project budget of an amount not-to-exceed \$9.94 million.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation or "Licensor") to execute a revocable license agreement with the American Academy McAllister Institute of Funeral Service (the "Licensee") for its use and occupancy of space to provide instruction in the techniques of mortuary science on the campus of Harlem Hospital Center (the "Facility").

WHEREAS, the space the Licensee occupied in the basement of Bellevue Hospital Center suffered storm damage as a result of Sandy and is no longer suitable for the Licensee's use; and

WHEREAS, the Licensee provides practical instruction in the techniques of mortuary science including embalming, anatomical science, and the preparation of bodies for burial; and

WHEREAS, the Facility has appropriate space available on its campus to house the Licensee's educational program.

NOW, THEREFORE, be it

RESOLVED, that the President of the Corporation be and hereby is authorized to execute a revocable license agreement with the American Academy McAllister Institute of Funeral Service (the "Licensee"), for its use and occupancy of space to provide instruction in the techniques of mortuary science on the campus of Harlem Hospital Center (the "Facility").

The Licensee shall have the use and occupancy of approximately 650 square feet of space on the first floor of the Martin Luther King Building (the "Licensed Space"). The annual occupancy fee shall be \$7,779. The occupancy fee is the fair market value prorated to account for the Licensee's use of the space. The occupancy fee shall be escalated by 2.5% per year. The Facility shall provide all utilities, housekeeping, red bag waste disposal, security and maintenance during the term of the agreement.

The Licensee shall indemnify and hold harmless the Corporation and the City of New York for all personal injury or property damage claims arising from their activities with regard to the Licensed Space. In addition, the Licensee shall purchase general liability insurance within the limits prescribed by the Corporation naming the Corporation and the City of New York as additional insureds.

The term of this license agreement shall not exceed five (5) years without further approval of the Board of Directors of the Health and Hospitals Corporation, and shall be revocable by any of the parties on sixty (60) days prior written notice.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a revocable license agreement with the American Cancer Society, Eastern Division, Inc. ("ACS" or the "Licensee"), for its continued use and occupancy of space to provide non-clinical patient support services on the campuses of Elmhurst Hospital and Queens Hospital Centers (the "Facilities").

WHEREAS, in June 2010, the Board of Directors authorized the President to enter into a license agreement with the Licensee which by its terms expires September 19, 2013; and

WHEREAS, the annual cancer incidence in the Borough of Queens is over 9,000 cases, and cancer is among the leading causes of death for adults aged 25 to 64 in nearly all Queens neighborhoods; and

WHEREAS, the Licensee will make its Patient Navigation Program available to patients and staff at the Facilities; and

WHEREAS, the goal of the Licensee's Patient Navigation Program is to provide access to quality educational materials, support service referrals, and other resources for the medically underserved cancer patient population and their caregivers; and

WHEREAS, the Licensee's program shall enhance the continuum of care and treatment provided by the Facilities to patients diagnosed with cancer.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") be and hereby is authorized to execute a revocable license agreement with the American Cancer Society, Eastern Division, Inc. ("ACS" or the "Licensee"), for its continued use and occupancy of space to provide non-clinical patient support services on the campuses of Elmhurst Hospital and Queens Hospital Centers (the "Facilities").

The Licensee shall be granted the continued use of approximately 120 square feet of space in room A-520 of the Main Hospital building on the Queens Hospital Center campus and approximately 120 square feet of space in room 203 of the Hope Pavilion on the Elmhurst Hospital Center campus (the "Licensed Space"). In lieu of an occupancy fee, the Licensee shall provide patient support services at the Facilities. The Facilities shall provide electricity, maintenance, and housekeeping to the Licensed Space.

The Licensee shall indemnify and hold harmless the Corporation and the City of New York from any and all claims arising by virtue of its use of the Licensed Space and shall also provide appropriate insurance naming each as additional insured parties.

The license agreement shall not exceed three (3) years without further authorization by the Board of Directors of the Corporation and shall be revocable by either party on sixty (60) days written notice.

A RESOLUTION AUTHORIZING ONE OR MORE
BORROWINGS IN AN AGGREGATE
AMOUNT NOT TO EXCEED \$40,000,000

WHEREAS, the President of New York City Health and Hospitals Corporation (the "Corporation") has issued certain Operating Procedures (40-58 Debt Finance and Treasury) (the "Operating Procedures") relating to the delegation of certain powers for the incurrence of debt for equipment financing to the Corporation's Chief Financial Officer by resolution to be adopted by the Board of Directors of the Corporation; and

WHEREAS, the Board of Directors of the Corporation, and the Finance Committee of such Board, pursuant to Section 4(f)(i) of such Operating Procedures, have determined that it is necessary and desirable to authorize the incurrence of debt for equipment financing, in an aggregate amount from time to time not exceeding \$40,000,000, in the form of tax-exempt or taxable loans borrowed by the Corporation from time to time from one or more lenders (the "Lenders"), to provide funds to finance, refinance and reimburse the Corporation for the costs of equipment and various related capital projects and expenditures at the Corporation's facilities, and to carry out the purposes permitted by law and set forth herein and consistent with the Operating Procedures; now, therefore,

NOW, THEREFORE, BE IT RESOLVED, AS FOLLOWS:

Section 101. Authority. This Resolution is adopted pursuant to the authority contained in the New York City Health and Hospitals Corporation Act and in the Operating Procedures.

Section 102. Principal Amount. The incurrence of debt is hereby authorized in the aggregate principal amount of not exceeding \$40,000,000, from time to time, for the purpose of financing equipment and various related capital projects and expenditures at the Corporation's facilities. Such debt may take the form of borrowings, loan agreements, installment purchase agreements or lease agreements, all as contemplated by the Operating Procedures.

Section 103. Interest. Such debt shall bear interest as determined by the Chief Financial Officer of the Corporation as authorized in the Operating Procedures.

Section 104. Authorization of Related Documents. The Corporation is authorized to enter into one or more debt contracts, such as loan agreements, notes, bonds, installment purchase agreements, rental arrangements or lease agreements. The form, terms and provisions of the debt contracts, between the Corporation and a Lender, providing for the incurrence of such debt, shall be approved by an Authorized Officer (defined below) of the Corporation, as evidenced by his or her signature thereon. The Chairman, Vice Chairman, President, Senior Vice President, Finance and Chief Financial Officer, or any other authorized officer of the Corporation (each an "Authorized Officer") is authorized and empowered for and on behalf of the Corporation to execute, acknowledge and deliver the debt contracts, and the

Secretary or any other Authorized Officer of the Corporation is hereby authorized and empowered to affix the seal of the Corporation and to attest to the same for and on behalf of the Corporation.

The Chairman, Vice Chairman, President, Senior Vice President, Finance and Chief Financial Officer, or any other Authorized Officer of the Corporation are each hereby authorized to take any action, execute any document, or give any consent which may from time to time be required by the Corporation under this Resolution or any such debt contracts. Any such action taken or document executed or consent given by such officer in his or her capacity of an officer of the Corporation shall be deemed to be an act by the Corporation.

Section 105. Effective Date. This Resolution shall take effect immediately upon its adoption by the Board of Directors of the Corporation, subsequent to its adoption by the Finance Committee of such Board.

Adopted: July 25, 2013 Board of Directors of the Corporation

July 9, 2013 Finance Committee of the Board of Directors

EXECUTIVE SUMMARY

Authorizing One or More Borrowings in an Aggregate Amount not-to-exceed \$40,000,000

The resolution authorizes the Corporation to borrow from one or more lenders, from time to time incur, for an aggregate outstanding principal amount not exceeding \$40 million. The overall negotiation, execution, and management of the borrowing under this resolution are delegated to the Corporation's Chief Financial Officer (CFO). Any borrowing under this resolution will be reported quarterly by the CFO to the Finance Committee as described in Operating Procedures 40-58 (Debt Finance & Treasury), Section 4. F. (Equipment Financing)

The Corporation funds the vast majority of its major capital expenditures with the proceeds of tax-exempt bonds issued by the Corporation or the City of New York. Since bonds proceeds are best suited to finance longer useful life projects, the Corporation has determined that it is more suitable to finance shorter useful life projects such as equipment with loans provided by banks and/or leasing providers. This type of borrowing allows the Corporation to borrow in smaller amount, as the need arises, incur minimal cost of issuance and minimizes investment risk on borrowed proceeds.

From FY 2001 to FY 2012, the average annual capital equipment expenditures are approximately \$40 million, with useful life typically ranging from 5 to 10 years. Of the \$40 million, approximately \$15 million were related to information technology (IT) purchases (including but not limited to network switches, computer servers, etc.) and approximately \$25 million were medical equipment purchases (including but not limited to anesthesia machines, adult/neonatal ventilators, blood pressure monitors, blood culture system, bone densitometry machine, breast biopsy system, chemistry analyzers, CT scanner, digital mammography machine, digital X-ray machine, EKG/EEG machines, feeding/infusion/IV pumps, fetal monitors, gamma camera, MRI machine, urine analyzers, etc.)



NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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Alan D. Aviles
President

OPERATING PROCEDURE 40-58

DEBT FINANCE & TREASURY

TO: Distribution "D"
FROM: Alan D. Aviles *ADA*
DATE: June 18, 2012

1. PURPOSE: To establish responsibilities, authorizations and procedures for Debt Finance and Treasury functions including:

- a. Responsibilities
 - i. Board of Directors
 - ii. Chief Financial Officer
 - iii. General Counsel
 - iv. Office of Facilities Development
 - v. Chief Information Officer
- b. Procedures
 - i. bond issuance,
 - ii. selection of the bond finance team,
 - iii. drawdown of bond proceeds,
 - iv. equipment financing
- c. Policies
 - i. use of swaps and derivatives,

- ii. determination of capital eligibility,
- iii. investment and/or deposit of corporate funds.

2. **SCOPE:** This procedure applies to all Corporate facilities and Central Office.

3. **RESPONSIBILITIES:**

a. Board of Directors

The Board of Directors shall approve each series resolution. Series resolutions shall limit the size of the borrowing and set parameters. The Board shall also approve the selection of bond financing team - underwriters, bond counsel and financial advisors (see Section 4b). The Board shall approve a limit on total aggregate outstanding principal to be used for equipment financing. The Board shall maintain policies on the use of SWAPs and other derivatives.

b. Chief Financial Officer

The Corporate Chief Financial Officer shall provide the Finance Committee of the Board information on possible debt structure prior to the approval of each series resolution; moreover the CFO shall provide periodic updates from the time a transaction is being considered including a full report post- closing. The Chief Financial Officer is authorized to obtain credit ratings, prepare official statement, execute a Bond Purchase Agreement and, if the CFO deems appropriate, obtain and maintain credit enhancement including bond insurance, letter of credits, liquidity banks and/or other vehicles. The Chief Financial Officer shall report to the Board of the Capital Corporation every six months on the status of all indebtedness. Under the direction of the Chief Financial Officer the Corporate Debt Finance Office shall conduct the selection process for the financing team (See Section 4b), report to investors, process Electronic Municipal Market Access (EMMA) disclosures, review and approve equipment financing (see Section 4f), maintain relationships with lenders, and process drawdowns from bond proceed accounts (see Section 4e). Under the direction of the Chief Financial Officer the Corporate Comptroller shall ensure proper accounting of all debt, report indebtedness to the Audit Committee of the Board, implement Board investment and deposit policies for cash management and work with the trustee to service debt. The CFO is responsible for post-issuance tax compliance.

c. General Counsel

In consultation with Bond Counsel, the General Counsel shall review and provide opinion on all aspect of the Corporation's financing arrangements.

d. Office of Facilities Development

The Office of Facilities Development shall maintain a schedule of active and planned capital projects and equipment purchases. In consultation with the

Corporate Debt Finance Office, the Office of Facilities Development shall require that bond proceeds and equipment financing shall only be used for items that meet the tests of capital eligibility.

e. Chief Information Officer

The Chief Information Officer shall maintain a schedule of active and planned capital projects for information technology purposes. The Chief Information Officer shall confirm capital eligibility with the Office of Facilities Development.

4. PROCEDURES

a. Bond Issuance

Issuances of bond debt are governed by the New York City Health and Hospitals Act ("the Act"), provisions established in the General Resolution adopted by the Board on November 19, 1992 pursuant to the Act, and Series Resolutions approved by the Board prior to each issuance of new or refunding debt. In accordance with the Act, each new issuance shall be approved by the New York City Mayor and the New York City Comptroller.

b. Selection of Bond Financing Team

Process for selection shall follow Section 4d of this operating procedure and is not subject to Operating Procedure 100-05. Accordingly, upon completion of steps in Section 4d the matter shall be presented to the Finance Committee of the Board and the Board of Directors for approval without review by the Contract Review Committee (CRC).

- i. Financial Advisor The Corporate Debt Finance Office shall periodically present a Board resolution authorizing a contract for Financial Advisory services. The Financial Advisor contract shall be procured by a Request for Proposals conducted as described below in Section 4d.
- ii. Underwriters The Corporate Debt Finance Office shall periodically present a Board resolution approving a team of investment banking firms to serve as underwriters, including senior and co-managers, in the event of a bond debt issuance. The underwriting team recommended for Board approval shall be selected by a Request for Proposal (RFP) process conducted by the Corporate Debt Finance Office as described in Section 4d.
- iii. Bond Counsel The Corporate Debt Finance Office shall periodically present a Board resolution authorizing a contract for Bond Counsel services. The bond counsel recommended for Board approval shall be selected by a Request for Proposal (RFP) process conducted by the Corporate Debt Finance Office as described in Section 4d.

- c. Choosing Senior and Co-Managers from the Underwriting Team for Issuance
- i. Subsequent to Board approval of a Series Resolution authorizing a bond financing, the Corporate Debt Finance Office shall conduct a process to select one or more of the approved Senior Manager firms to serve as Senior and Co-Manager for the authorized financing.
 - ii. The selection process may include a review of plan of finance proposals from each eligible firm and such additional information as may be determined necessary.
 - iii. Selection shall be made in consultation with the NYC Office of Management and Budget, NYC Comptroller's Office and the Financial Advisor, and approved by the Chief Financial Officer.
- d. Request for Proposal Process (RFP). The form of the RFP, including scope of services, required proposal elements, list of invitees and evaluation criteria will be developed in consultation with the NYC Office of Management and Budget, NYC Comptroller's Office and the Financial Advisor (if needed), and approved by the Chief Financial Officer.
- i. Advertisement. The RFP shall be advertised in the City Record, appropriate finance industry publications (such as The Bond Buyer) and on the HHC website, nyc.gov/hhc, under the link "Contracting Opportunities" for a minimum of 10 business days.
 - ii. Selection Committee.
 1. The Corporate Debt Finance Office shall convene a Selection Committee including at least one representative from each of the following: New York City Office of Management & Budget, New York City Office of the Comptroller, HHC Corporate Finance Division and for Bond Counsel Contract only include HHC Corporate Legal Affairs. Additional representatives may be requested from Facilities and other Corporate Offices.
 2. The Selection Committee shall review and evaluate proposals submitted by the proposal due date, and separately identify the top ranked proposers for Senior Manager and Co-Manager roles.
 3. The Corporate Debt Finance Office shall maintain minutes of selection committee deliberations including the evaluation criteria and weights.
 4. Confidentiality. No personnel or contractors involved in the RFP process shall discuss the evaluation with any other proposer responding to the RFP.

- iii. Consistent with New York City policy, underwriting firms are not subject to VENDEX or EEO submission requirements. Bond Counsel and Financial Advisor are subject to VENDEX and EEO submission requirements.

e. Bond Proceed Drawdown

This section covers the process for drawing down bond proceeds to reimburse the Corporation for capital eligible expenditures.

- i. Not less than every three months, the Corporate Debt Finance Office shall prepare a request to drawdown bond proceeds to reimburse expenditures designated by the Office of Facilities Development as meeting capital eligibility and budgeted for HHC bond financing.
- ii. The drawdown request shall include:
 - 1. A list of capital expenditures not previously reimbursed; and a drawdown request form with wire transfer instruction and authorized signature.
 - 2. The original request shall be given to the Corporate Cash Management Office to be sent to Bond Trustee.
 - 3. Upon approval from the Bond Trustee, the requested drawdown amount will be transfer via wire transfer to the Corporation.
 - 4. The Corporate Debt Office shall retain a copy of every draw down request submitted to the Bond Trustee, and maintain a database of all capital expenditures, by project and facility for each bond issuance, consistent with Internal Review Service record retention rules.

f. Equipment Financing

This section covers taxable and tax-exempt financing of equipment, including rentals, leases, reagent rentals, or any other time based payments.

i. Board Approval of Indebtedness

- 1. Corporate Debt Finance shall present a resolution for the Finance Committee and the Board authorizing the CFO to borrow up to an identified dollar amount on an as needed basis at competitive rates to finance the purchase of equipment. The CFO shall report to the Finance Committee on a quarterly basis indicating any activity, including information on dollar amounts, rates of interest, term and general structure.

2. Corporate Comptroller's office will maintain records on interest and outstanding principal related to the finance of equipment.
3. Corporate Comptroller's office will report annually to the Audit Committee on the level of interest and outstanding principal.
4. In the event that equipment needs necessitate the increase in total outstanding principal be increased beyond the resolution amount, Corporate Debt Finance will seek an approval from the Finance Committee and the Board for an increase to the original approved amount.

ii. Process for Seeking Financing

1. Corporate Debt Finance shall with the assistance of the Financial Advisor maintain up to date understanding of competitive structures and rates for obtaining equipment financing. This may include maintaining lists of banks with lending capacity.
2. Corporate Debt Finance shall survey other hospitals and other government institutions to validate market conditions.
3. Corporate Debt Finance shall work with Office of Facilities Development and Corporate Information Technology to anticipate future equipment borrowing needs.
4. Facilities and other Corporate Officers shall not seek financing or accept any vendor related financing including implied financing arrangements such as but not limited to operating leases or rentals for capially eligible items.
5. All relationships and negotiations with lenders shall be conducted by Corporate Debt Finance and when appropriate in consultation with bond counsel.
6. Corporate Debt Finance shall review and approve all documents related to any vendor offered debt and seek alternative more efficient bank tax-exempt debt when available and preferable.
7. Corporate Debt Finance shall review documents with the Office of Legal Affairs before seeking written approval from the General Counsel and the Chief Financial Officer.

- iii. Corporate Debt Finance shall inform the Corporate Comptroller of all transactions.

5. POLICIES:

- a. Use of Interest Rate Swaps and other Derivatives

- i. Policy on the use of interest rate swaps and derivatives is governed by the Board Resolution adopted on December 19, 2002, which establishes procedures and guidelines for approval, execution, monitoring and reporting of derivative agreements. The resolution provides that:
 1. The Corporation shall not enter into any derivative agreement for speculative purposes.
 2. Subject to requirements outlined in the resolution, the Board may approve the use of derivatives within prudent risk guidelines to achieve significant savings or to enhance investment returns.
- b. **Eligible Uses of Debt Financing** HHC capital eligibility is governed by provisions of the General Resolution and this procedure. This procedure requires HHC to follow New York City Comptroller's Directive #10 governing eligibility for capital projects funded by the City, with some exceptions.
 - i. **General Resolution** Bond proceeds are to be used for Capital Expenditures, which include:
 1. acquisition of title to real property;
 2. labor, materials and compensation to HHC's contractors for the construction, renovation and improvement;
 3. cost of design, surveys, feasibility studies, plans, and other pre-construction requirements;
 4. costs required for the acquisition and installation of equipment, equipment systems or machinery;
 5. all other costs which the Corporation is required to pay or capitalize for the acquisition, construction, installation, repair, improvement and furnishing of a Capital Expenditure.
 - ii. **Directive # 10** The City's Directive #10 details the criteria for using bond proceeds for capital. This Operating Procedure incorporates the Directive by reference. Directive #10 adopts all government accounting standards which require that the asset being financed either be owned by the Corporation or available for the Corporation's sole use. There are many other requirements, highlights include:
 1. **A minimum cost requirement:** The minimum requirement for a capital project or unit of equipment to be a Capital Expenditure eligible for debt financing must be \$35,000 or more.
 2. **Useful Life Requirement:** A project's useful life (and/or equipment useful life) must be at least five (5) years for the Capital Expenditure to be eligible for debt financing.

3. Leasehold Betterments: Capital funds may only be used to better a leased property if the term of the lease, which may only be cancellable by the landlord for non-payment, is longer than the probable useful life of the improvement and both are longer than five (5) years. Prior to the termination of a lease by the Corporation the CFO shall be consulted. Under such circumstances the CFO, in consultation with Bond Counsel and General Counsel, shall ensure that compliance with related Internal Revenue Service requirements is met.

iii. Exceptions to Directive #10 The Corporation will allow bond proceeds to be used for "in-house" renovation. The Corporation will allow the calculation of the \$35,000 minimum threshold to be based on overall purchase rather than individual project or unit for beds, infusion pumps, and laboratory equipment with a useful life of at least five (5) years.

c. The Corporate Debt Finance Office shall regularly compare the weighted average maturity of each debt instrument with the aggregate weighted useful life of debt financed Capital Expenditures to ensure that in the aggregate, the weighted average maturity of each of HHC's tax-exempt debt issuances (i.e., bond issues, capital leases) does not exceed 120% of the weighted economic life of the assets financed or refinanced with the proceeds of such debt.

d. Investment and Deposits

Pursuant to its authority under the Act, the Board has adopted resolutions creating Corporate investment and deposit policies. Consistent with the limits created by the Act, the Board Resolution adopted on September 14, 1972 requires all deposits to be collateralized by government-backed securities. The Board Resolution adopted on May 9, 1983 provides for the use of broker dealers to place investments. Parameters for routine banking deposits are established in the Board Resolution on Execution of Routine Banking Documents adopted on April 21, 2005.

Procedures for opening, closing and managing deposits are included in Operating Procedure 40-17 (July 12, 2006).

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NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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212-788-3321 Fax: 212-788-0040 E-mail: AVILESA@NYCHHC.ORG

Alan D. Aviles
President

OPERATING PROCEDURE 40-58

Change No. 1

DEBT FINANCE & TREASURY

TO: Distribution "D"
FROM: Alan D. Aviles *ADA*
DATE: May 10, 2013
SUBJECT: **Addition of Post-Issuance Tax Compliance for Tax-Exempt Bonds**

1. Subsection 4.a. Procedures to replace by the following:

a. (1) Bond Issuance

Issuances of bond debt are governed by the New York City Health and Hospitals Act (the "Act"), provisions established in the General Resolution adopted by the Board on November 19, 1992 pursuant to the Act, and Series Resolutions approved by the Board prior to each issuance of new or refunding debt. In accordance with the Act, each new issuance shall be approved by the New York City Mayor and the New York City Comptroller.

(2) Post-Issuance Tax Compliance for Tax-Exempt Bonds ("Bonds")

Corporate Debt Finance will be charged with understanding and implementing the requirements of these procedures and overseeing the collection of the information needed to comply with these procedures and maintaining such information for the designated time period.

The Corporation will ensure the designated staff in Corporate Debt Finance is afforded the support needed to perform the tasks, which includes access to professionals, education and personnel, as appropriate.

- i. **Rebate:** The Corporation shall retain a rebate consultant to perform the required rebate calculations for all Bond issues. The Corporation will retain information relative to the investment of the Bond proceeds, the rebate calculations and documentation of the payment of any liability, for the period commencing with the issue date of each Bond issue and ending on the date that is six (6) years after the retirement date of the last Bond of that issue of Bonds, including refunding issues.
- ii. **Use of Proceeds:** Individual project expenditures from amounts received from the sale of Bonds are tied back to specific Bond issues.
- iii. **Record Retention:** The Corporation will compile a list of each improvement financed or refinanced with the proceeds of each issue of Bonds. The list will identify:
 1. the amount received,
 2. the actual improvement financed or refinanced, and
 3. the amount and source of any other monies that were or will be applied to the payment of the cost of the improvement.

To the extent that an improvement may have been financed or refinanced with proceeds of several Bond issues, the information will reflect such fact and will be maintained for each Bond issue. The Corporation will maintain such list, along with the information to be collected, at least annually, for a period commencing on the issue date of each Bond issue and ending on the date that is six (6) years after the final redemption or maturity date of such Bond issue or the bond issue refinancing such Bond issue. This information will be maintained on an issue-by-issue basis.

The list will also serve to record the final allocation of proceeds received from the sale of an issue of Bonds. Such final allocation is required to be made not later than the date which is 18 months after the later of (1) the date of expenditure was paid or (2) the date the facility to which the expenditure relates was placed in service, but in no event later than the 60th day after the five-year anniversary of the date of issuance of the issue of Bonds or, in the case of short-term obligations, no later than 60th day after the redemption or maturity date of the short-term obligations.

The information collected relative to the improvements financed or refinanced with the proceeds of the Bond issue in question is intended to assist in the review of any subsequent use of the improvement. For example, if the improvement financed or refinanced affects only a specific area within a HHC facility, only uses of the area financed will be required to be reported. If, however, the improvement financed is to an entire HHC facility, information relative to the entirety of the facility may be necessary.

- iv. **Annual Questionnaire:** To ensure tax compliance, the Corporation will review annually, the use and operation of facilities that have been financed with the proceeds of a Bond issue.

The Corporation shall annually review (and compile responses to the attached Tax-Exempt Bond Annual Questionnaire) information documenting any change in the use or operation of facilities financed or refinanced with Bond proceeds.

If the Corporation or any of the HHC Facilities has responded "Yes" to any of the questions in the Tax-Exempt Bond Annual Questionnaire, Bond Counsel should be consulted for proper advice on how to proceed in order to safeguard the tax-exempt status of interest of the Bonds.

- v. **Requirements of the Internal Revenue Codes:** The Internal Revenue Code of 1986, as amended (the "Code"), limit the amount of a Bond issue that may be used in a "private business use" to an amount not-to-exceed 10% of the proceeds of the Bond issue. In situations involving "unrelated or disproportionate private use", this amount is limited to 5%. Certain exceptions specified in the Internal Revenue Code, Treasury Regulations or IRS promulgations apply to the 10%/5% limitation.

The private business use inquiry examines any direct and indirect use of any facility financed or refinanced with Bond proceeds. Private business use includes ownership, a leasehold interest, a management or service contract, a research agreement, a naming rights agreement, or any other arrangement that conveys special legal entitlements or a special economic benefit.

- vi. **Excess Private Business Use:** Where the procedures describing above result in the identification of private business use in excess of the allowable 10%/5% limitation under the Code, the Corporation will undertake, as appropriate, remedial action measures, if permitted under the provisions of Section 1.141-12 of the Treasury regulations or, to the extent a remedial action is not available, proceed to the IRS's Voluntary Closing Agreement Program.

2. **All other provisions of Operating Procedure 40-58 shall remain in full force and effect.**

3. **These changes are effective immediately.**

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New York City Health and Hospitals Corporation (the "Corporation")

FY _____

Health System Bonds, _____ Series _____

TAX_EXEMPT BOND ANNUAL QUESTIONNAIRE

Please have this questionnaire completed by the individual healthcare facilities (each, a "HHC Facility") operated by the Corporation. Please note that any questions relating to the healthcare facilities are applicable to capital expenditures to be made and/or made at various facilities with the proceeds of the Corporation Health System Bonds, this includes any facilities or portion of the facilities that were originally financed or refinanced with proceeds of the tax-exempt bonds ("Bonds").

As used in this Annual Questionnaire, the terms "Project" or "Projects" mean the project(s), the costs of which were financed or refinanced with proceeds of the Bonds.

Any questions regarding the information requested herein should be directed to Paulene Lok, Director of Debt Finance, at 646-458-7723.

ANNUAL QUESTIONNAIRE	
Name of HHC Facility:	
(A) (i) Has the Corporation or the HHC Facility entered into an arrangement to sell (including an installment sale) any portion of a the facility to a person that is not a State or local government entity?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ii) Is the Corporation or the HHC Facility contemplating such a sale, including an installment sale?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
(B) (i) Has the Corporation or the HHC Facility entered into a lease or any portion of the facility with a person that is not a State or local government entity?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
(ii) Is the Corporation or the HHC Facility contemplating entering into such a lease agreement?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p>(C) (i) Has the Corporation or the HHC Facility entered into a management, administrative services, or joint operating agreement or contract with respect to any portion of the facility with a person that is not a State or local government entity?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>(ii) Is the Corporation or the HHC Facility contemplating entering into such a management, administrative services or joint operating agreement or contract?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>(D) (i) Has the Corporation or the HHC Facility entered into an agreement whereby an entity that is not a State or local governmental entity will occupy, operate or otherwise use or direct the use of any portion of the facility, including by reason of selling naming rights or conducting research?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>(ii) Is the Corporation or the HHC Facility contemplating entering into an agreement whereby an entity that is not a State or local governmental unit will occupy, operate or otherwise use or direct the use of any portion of the facility, including by reason of selling naming rights or conducting research?</p> <p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>

ACKNOWLEDGEMENT AND SIGNATURE		
I certify that I am familiar with each of the Projects and that all information contained herein is true, correct, and complete to the best of my knowledge.		
SIGNATURE	PRINT NAME AND TITLE	DATE

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract with Surgical Solutions, LLC to provide laparoscopic/endoscopic video equipment and other instruments, repair services, disposable supplies and preoperative, postoperative support services to Bellevue Hospital Center, Elmhurst Hospital Center and Kings County Hospital Center for a term of 2 years with two additional 2 year options solely exercisable by the Corporation in an amount not to exceed \$31,484,013 including an 8% contingency of \$2,332,149.

WHEREAS, Operating Procedure 100-5 authorizes the Supply Chain Council to standardize products, services and methods of providing products and services that will produce savings for the Corporation without sacrificing quality or safety; and

WHEREAS, the Supply Chain Council identified laparoscopic and endoscopic instruments, and the management of the preoperative and postoperative scope procedures as a source of potential savings if the methodology of delivering the products and services was standardized; and

WHEREAS, the Vendor has the proven clinical and technical resources to furnish the Corporation's physicians their preferred scope manufacturer and to provide expertise and technical support in pre-operative set-up, inter-operative equipment troubleshooting, post-procedure room turnover, equipment maintenance and repair, decontamination and disinfection of equipment; and

WHEREAS, the Corporation's Supply Chain Council has reviewed Surgical Solutions and concluded that the Vendor's scope management model will improve patient care and patient safety and provide a projected savings for the three hospitals of \$6,979,253 to the Corporation; and

WHEREAS, a Request for Expression of Interest was issued on April 1, 2013 seeking vendors that would have an interest in managing the Corporation's instrument and scope operations, and Surgical Solutions was the only vendor that responded; and

WHEREAS, the Executive Vice President/COO shall be responsible for the management and enforcement of the proposed contract.

NOW, THEREFORE, BE IT RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") negotiate and execute a contract with Surgical Solutions, LLC to provide laparoscopic/endoscopic video equipment and other instruments, repair services, disposable supplies and preoperative, postoperative support services to Bellevue Hospital Center, Elmhurst Hospital Center and Kings County Hospital Center for a term of 2 years with two additional 2 year options solely exercisable by the Corporation in an amount not to exceed \$31,484,013 including an 8% contingency of \$2,332,149.

EXECUTIVE SUMMARY

The Supply Chain Council has identified a company that will improve patient care, patient safety and saves the Corporation money in its scope procedure operation. The Corporation has encountered in its endoscopic and laparoscopic procedure operations challenges such as a chronic shortage of scope equipment and instrumentation; low levels of standardization and accuracy; no defined or quantitative process for repairs versus replacements; consistently high levels of overtime; need for continuing education of staff; and a continuing need to engage in process review and improvement.

Elmhurst Hospital Center and Kings County Hospital Center presently have agreements with multiple manufacturers of endoscopes and laparoscopes equipment and instruments. The various agreements have proved to be a challenge to manage because of equipment cost, repair and storage. Bellevue Hospital presented to the Supply Chain Committee a program they currently have with Surgical Solutions for instrument and scope management. Consequently, the Supply Chain Committee authorized Surgical Solutions to conduct an evaluation of interested HHC acute care centers to ascertain the costs and benefits of an instrument and scope management program. The findings were presented to Supply Chain Committee on May 30, 2012 and the Supply Chain Council voted to approve the facility's evaluation and potential standardization to Surgical Solutions, LLC for instrument and scope management throughout the Corporation. The Bellevue Hospital Center program is being expanded to King County Hospital and Elmhurst Hospital to assure that the vendor can successfully replicate the program. A review of the program will be conducted by the Supply Chain Committee after a full year of implementation to determine whether the program should be expanded to the remaining eight acute care hospitals. HHC Facility's CFOs at Bellevue Hospital Center, Elmhurst Hospital Center and Kings County Hospital Center reviewed and approved the cost and savings projections. Consequently, a Request for Expression of Interest was issued on April 1, 2013 and Surgical Solutions was the only respondent.

The contract term is 2 years with two additional 2 year options solely exercisable by the Corporation for an amount not to exceed \$31,484,013 including an 8% contingency of \$2,332,149. The contract is based upon the number of procedures performed and the level of service and amount of capital requested. The projected savings is \$6,979,253.

Surgical Solutions

	Bellevue*	Elmhurst	Kings	Total
Total Volume of Rigid	15,832	9,726	9,400	34,958
Total Volume of Flexible	36,324	15,942	29,375	81,641
Total Procedures	52,156	25,668	38,775	116,599
Total number of months using contract	72	72	70.5	

Baseline Costs Without Contract

Capital	\$2,500,000	\$1,800,000	\$3,987,000	\$8,287,000
Repair	N/A	\$2,115,230	\$2,711,250	\$4,826,480
Disposables	N/A	\$4,497,983	\$6,989,000	\$11,486,983
Total Baseline Costs	\$14,030,654	\$8,413,213	\$13,687,250	\$36,131,117

Total Contract Costs

Total Cost for Rigid Procedures	\$5,766,119	\$3,623,030	\$4,355,200	\$13,744,349
Total Cost for Flexible Procedures	\$7,194,780	\$2,869,560	\$5,434,375	\$15,498,715
Total Contract Cost	\$12,960,899	\$6,492,590	\$9,698,375	\$29,151,864

Variance better/(worse)	\$1,069,755	\$1,920,623	\$3,988,875	\$6,979,253
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***Bellevue is transitioning from existing per procedure contract to a new per procedure contract.**

Surgical Solutions will provide \$2.5MM in new equipment.

Surgical Solutions is reducing current per procedure cost for flexible by \$25.

**** Total principal and interest**

CONTRACT FACT SHEET
New York City Health and Hospitals Corporation

Contract Title: Instrument and Scope Management
Project Title & Number: Instrument and Scope Management
Project Location: Bellevue, Elmhurst, King's County
Requesting Dept.: Central Office Operations

Successful Respondent: Surgical Solutions, LLC.

Contract Amount: \$31,484,013 including an 8% contingency of \$2,332,149

Contract Term: 2 Years with two additional 2 year options solely excisable by the Corporation.

Number of Respondents: One
(If Sole Source, explain in Background section)

Range of Proposals: \$ 31,484,013

Minority Business Enterprise Invited: If no, please explain: Only One Respondent

Funding Source: General Care

Method of Payment: Other: explain, Invoiced, Net 90, based upon facility's purchase order.

EEO Analysis: Approved November 30, 2012

Compliance with HHC's McBride Principles? Yes

Vendex Clearance Yes

(Required for contracts in the amount of \$100,000 or more awarded pursuant to an RFP, NA or as a Sole Source, or \$100,000 or more if awarded pursuant to an RFB.)

CONTRACT FACT SHEET(continued)

Background (include description and history of problem; previous attempts, if any, to solve it; and how this contract will solve it):

HHC facilities presently have agreements with multiple manufacturers of endoscopes and laparoscopes equipment and instruments. The various agreements have proved to be a challenge to manage because of equipment cost, repair and shortages of equipment.

Elmhurst Hospital and Kings County Hospital has identified challenges to our Endoscopic and MIS Rigid Scope processes in the following areas:

- Chronic shortage of surgical equipment and instrumentation
- Low levels of disposable standardization and multiple vendors
- No defined or quantitative process for repairs vs. replacements
- Consistent levels of high staff overtime
- Need for continuing education of the CSPD staff
- Continuing need for a process review and improvement in CSPD

Surgical Solutions' offers:

- Vendor-Neutrality
- State-of-the-Art equipment based on surgeons' preferences
- 24-hour / 7-day case coverage
- In-House reprocessing
- Specialized Endoscopy services
- CRCST or CST certified technologists
- Use of supplies when needed supplied by vendor. No inventory needed by HHC for trocars, obturators, veres needles, clip appliers, and shears

CONTRACT FACT SHEET(continued)

Contract Review Committee

Was the proposed contract presented at the Contract Review Committee (CRC)? (include date):

Yes, June 5, 2013

Has the proposed contract's scope of work, timetable, budget, contract deliverables or accountable person changed since presentation to the CRC? If so, please indicate how the proposed contract differs since presentation to the CRC:

The scope of work and contract deliverables have not changed since presentation to the CRC. The budget has been decreased due to a reduction in the number of facilities included in the resolution.

CONTRACT FACT SHEET (continued)

Selection Process (attach list of selection committee members, list of firms responding to RFP or NA, list of firms considered, describe here the process used to select the proposed contractor, the selection criteria, and the justification for the selection):

A Request For Expression of Interest (RFEI, issued April 1st – April 12th). Surgical Solutions was the sole respondent to the RFEI for a qualified supplier for Laparoscopic / Endoscopic Video Equipment, Instruments, Rigid Scopes, Flexible Scopes, Disposable Supplies and management and repair. In addition, ECRI and The Advisory Board were not aware of any competing companies.

Scope of work and timetable:

Pre-Operative Set Up

- Technicians set up the room with the required scope(s) for the procedure. The scope is tested for proper functioning of video, suction and air/water output so that it is ready for the physician without any further preparation.

Intra-Operative Support

- Our technicians are available for video and scope troubleshooting throughout the procedure, including printer and photo support and picture-in-picture set up for procedures such as Endoscopic Ultrasound. The technicians will also perform scope switches as necessary for multiple scope procedures such as EGD/Colonoscopy.

Post-Procedure Room Turnover

- Technicians work with facility housekeeping staff to expedite the room turnover process. Cart cleaning, endoscope pre-cleaning, removal of the soiled instrument(s) and returning any equipment configurations to the correct setting for the next procedure is done at this time. The technician will transport the instrument(s) to the decontamination area for processing.

Equipment Maintenance and Repair Management

- Technicians troubleshoot malfunctioning scopes and equipment and work with the repair vendor to arrange loaner instrumentation, repairs and repair record keeping.

Decontamination and Disinfection of Equipment

- Technicians decontaminate and disinfect the instrumentation, conforming to all facility, manufacturer and regulatory guidelines. Technicians maintain control of the instrument from the pre-cleaning and leak testing process all the way through to the storing the disinfected endoscope in the designated cabinets. This applies to all endoscopy related equipment, including, but not limited to re-usable biopsy forceps, retrieval devices and snares, re-usable bite blocks and spray catheters. Our technicians also work with the facility Sterile Processing Department to arrange for turnover of items requiring sterilization such as air/water bottles.

Off-Site and Bedside Procedures

- Technicians will transport traveling endoscopy carts to ICU, OR, ER and other patient units as requested. The cart, scopes and all applicable equipment will arrive and be set up and tested in the same manner as it would be in the endoscopy suite itself. Post procedure our technicians will perform all bedside pre-cleaning of the instruments and transport the equipment back to its designated storage area.

Physician Preference

- Technicians work closely with the physicians, endoscopy techs and nurses to ensure that each physician has available to them their preferred model scope and other instrumentation/equipment for all standard and specialty procedures. This allows for a smoother transition when the physician working in a room completes their cases and the next physician arrives.

Repair

- Pull defective endoscopes and send out for repair. Repairs billed to Surgical Solutions, LLC.

Loaner

- Provide loaners as needed in a timely fashion.

Equipment

- New Scopes
- Video Towers and Monitors

The contract term is 2 Years with two additional 2 year options by mutual agreement to allow for a co-terminous expiration of participating facilities.

Hospital	Projected Start Date
Elmhurst	August 1, 2013
King's County	September 15, 2013
Bellevue	October 1, 2013

CONTRACT FACT SHEET (continued)

Provide a brief costs/benefits analysis of the services to be purchased.

Surgical Solutions	Bellevue *	Elmhurst	Kings	Total
Total Volume of Rigid	15,832	9,726	9,400	34,958
Total Volume of Flexible	36,324	15,942	29,375	81,641
Total Procedures	52,156	25,668	38,775	116,599
Total number of months using contract	72	72	70.5	
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Capital	\$2,500,000	\$1,800,000	\$3,987,000	\$8,287,000
Repair	N/A	\$2,115,230	\$2,711,250	\$4,826,480
Disposables	N/A	\$4,497,983	\$6,989,000	\$11,486,983
Total Baseline Costs	\$14,030,654	\$8,413,213	\$13,687,250	\$36,131,117
Total Contract Costs				
Total Cost for Rigid Procedures	\$5,766,119	\$3,623,030	\$4,355,200	\$13,744,349
Total Cost for Flexible Procedures	\$7,194,780	\$2,869,560	\$5,434,375	\$15,498,715
Total Contract Cost	\$12,960,899	\$6,492,590	\$9,698,375	\$29,151,864
Variance better/(worse)	\$1,069,755	\$1,920,623	\$3,988,875	\$6,979,253

*Bellevue is transitioning from existing per procedure contract to a new per procedure contract. Sur Surgical Solutions is reducing current per procedure cost for flexible by \$25.

** Total principal and interest

CONTRACT FACT SHEET (continued)

Contract monitoring (include which Senior Vice President is responsible):

Antonio Martin, SVP, COO

Equal Employment Opportunity Analysis (include outreach efforts to MBE/WBE's, selection process, comparison of vendor/contractor EEO profile to EEO criteria. Indicate areas of under-representation and plan/timetable to address problem areas):

Received By E.E.O. _____
Date

Analysis Completed By E.E.O. _____
Date

Name

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO
manasses.williams@nychhc.org

TO: Richard Olah
Senior Director
Materials Management

FROM: Manasses Williams

DATE: November 30, 2012

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Surgical Solutions, LLC, has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): Central Office

Contract Number: _____

Project: Instrument and Scope Management

Submitted by: Materials Management Department

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

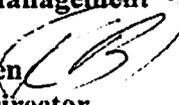
COMMENTS:

c: pt

Office of Legal Affairs

MEMORANDUM

To: David Larish
Materials Management

From: Karen Rosen 
Assistant Director

Date: July 22, 2013

Subject: VENDEX Approval

For your information, on July 22, 2013 VENDEX approval was granted by the Office of Legal Affairs for the following company:

Surgical Solutions, LLC.

cc: Norman M. Dion, Esq.



*Surgical Solutions
Instrument and Scope Management Contract*

Board of Directors Meeting: July 25, 2013

Contract Scope of Services

What Will Surgical Solutions Provide to Facilities:

Pre-Operative Set Up

- Surgical Solutions technicians set up the room with the doctor preference scope(s) for the procedure.

Post-Procedure Room Turnover

- Surgical Solutions technicians work with facility housekeeping staff to expedite the room turnover process.

Intra-Operative Support

- Surgical Solutions technicians are available for video and scope troubleshooting throughout the procedure and on call 24/7.

Decontamination and Disinfection of Equipment

- Surgical Solutions technicians decontaminate and disinfect the instrumentation, conforming to all facility, manufacturer and regulatory guidelines, and turnover trays/instrumentation to sterile processing department for terminal sterilization.

Equipment Maintenance and Repair Management

- Surgical Solutions technicians repair malfunctioning equipment to manufacturer's specifications and provide loaner instrumentation if required to assure all procedures are conducted on schedule.

Off-Site and Bedside Procedures

- Surgical Solutions technicians will transport endoscopy carts to ICU, OR, ER and other patient units as requested to conduct procedures.

Reason for Action

- **Costs**
 - Increasing cost of equipment
 - Increasing cost of disposables

- **Changing Technology**

- **Inability to manage repair cost, replacement cost, cleaning/sterilization cost and maintenance cost**

- **Administrative Challenges**
 - Managing multiple contacts
 - Continuous need to train staff for cleaning and handling of equipment
 - Delays and cancelations of procedures

Surgical Solutions Selection Process

- Bellevue Hospital engaged Surgical Solutions in 2008. Surgical Solutions has been able to provide improved patient care, improved patient safety and doctors are very satisfied with Surgical Solutions performance and ability to provide choice of scope.
- Bellevue Hospital has achieved \$3.5MM savings in 5 years.
- Bellevue Hospital presented to the Supply Chain Council (SCC) their experience with Surgical Solutions for instrument and scope management and recommended it for expansion to HHC acute care facilities.
- The SCC authorized a review of Surgical Solutions and whether the program could produce savings for other HHC Facilities.
- The findings of the review were presented to the SCC and two HHC facilities received approval to implement the Surgical Solutions model. Bellevue Hospital Center already has successfully implemented Surgical Solutions and would continue using Surgical Solutions.
- The two hospitals chosen were reviewed by the facilities' CFOs and approved the cost and savings projections presented by Surgical Solutions.
- Application to enter into a contract was presented to the Contract Review Committee (CRC) on February 27, 2013. The CRC required further review to confirm sole source status.
- A Request For Expression of Interest (RFEI) with an advertisement in a trade publication to confirm sole source status. Surgical Solutions was the sole entity to respond to the RFEI. ECRI and The Advisory Board were not aware of any competing companies

Business Model

Before

- ❖ Hospital staff manages pre-operative and post operative services.
- ❖ Recurring issues:
 - Delay in procedure start time
 - Cancellation of procedures
 - Equipment failure
- ❖ Hospitals' contracts separately increasing costs for:
 - Disposables
 - Equipment
 - Equipment Repair
- ❖ No technical support during procedure
- ❖ No off-site service to support patient units.

After

- ❖ Surgical Solutions manages pre-operative and post operative services.
- ❖ Hospitals pay a per procedure price for:
 - Rigid Procedures
 - Flexible Procedures
- ❖ Contract prices are firm for 72 months
 - New equipment is provided at the commencement of contract. Per procedure costs decrease in the 61st month once equipment is fully amortized.
- ❖ Contract prices are fixed and can only be increased if hospital requests new equipment.
- ❖ Surgical Solutions technicians troubleshoot equipment during procedure.
- ❖ Surgical Solutions technicians will transport carts to patient units as requested.

Savings

Total Savings of 6.9MM Over Six Years

1. Cost reduction for disposable supplies provided by Surgical Solutions, LLC including trocar/cannula systems, scissors, clip applicators, verres needles and hassons.
2. Cost reduction due to eliminating repair and maintenance costs for flexible scopes, rigid scopes and instruments.
3. Capital investment cost is deferred and paid on a per procedure cost.
4. Potential for increased revenue due to increased procedures.
5. Projected start dates:
 - Elmhurst Hospital – August 1, 2013
 - Kings County Hospital – September 15, 2013

Current State vs. Future State

Surgical Solutions

	Bellevue*	Elmhurst	Kings	Total
Total Volume of Rigid	15,832	9,726	9,400	34,958
Total Volume of Flexible	36,324	15,942	29,375	81,641
Total Procedures	52,156	25,668	38,775	116,599
Total number of months using contract	72	72	70.5	
Baseline Costs Without Contract				
Capital **	\$2,500,000	\$1,800,000	\$3,987,000	\$8,287,000
Repair	NA	\$2,115,230	\$2,711,250	\$4,826,480
Disposables	NA	\$4,497,983	\$6,989,000	\$11,486,983
Total Baseline Costs	\$14,030,654	\$8,413,213	\$13,687,250	\$36,131,117
Total Contract Costs				
Total Cost for Rigid Procedures	\$5,766,119	\$3,623,030	\$4,355,200	\$13,744,349
Total Cost for Flexible Procedures	\$7,194,780	\$2,869,560	\$5,434,375	\$15,498,715
Total Contract Cost	\$12,960,899	\$6,492,590	\$9,698,375	\$29,151,864
Variance better/(worse)	\$1,069,755	\$1,920,623	\$3,988,875	\$6,979,253

*Bellevue is transitioning from existing per procedure contract to a new per procedure contract. Surgical Solutions will provide \$2.5MM in new equipment.

Surgical Solutions is reducing current per procedure cost for flexible by \$25.

** Total principal and interest

Performance Bond Requirement

- ❖ HHC is recommending expanding existing successful Bellevue arrangement to Elmhurst Hospital and Kings County Hospital.
- ❖ The vendor's performance at all three hospitals will be monitored and reviewed by the Supply Chain Council to assure a seamless transition.
- ❖ A concern was raised regarding the vendor's capacity to expand the program to the remaining eight acute care facilities.
- ❖ Accordingly, Surgical Solutions will secure a \$2 million performance bond, for which they have received written confirmation from Liberty Mutual Surety.

Thank You

RESOLUTION

Ratifying the engagement by the President of the New York City Health and Hospitals Corporation (the "Corporation") of Parsons Brinkerhoff and ARCADIS (the "A&E Firms") to each provide specialized engineering services to assess storm damage, estimate replacement costs, assess hazard mitigation opportunities, propose and design such work, develop cost benefit analysis' for the projects and to advise the Corporation in its applications for reimbursement by the Federal Emergency Management ("FEMA"), The State of New York and from Community Development Block Grants ("CDBG") for Hurricane Sandy related repairs at a cost of not more than \$5 Million and authorizing the President to increase the funding for such engagements by an additional \$6 Million to make the total funding for the work \$11 Million.

WHEREAS, the Corporation has identified a need for specialized architecture and engineering firms to assess the Corporation's need to design and perform work to mitigate long term risks life and property from natural hazards similar to Hurricane Sandy;

WHEREAS, the Corporation issued a Request For Proposal ("RFP") to select a firm or firms with technical expertise to conduct an assessment of the Corporation's hazard exposure and to identify hazard mitigation strategies and projects;

WHEREAS, a selection committee of Corporate employees recommended for approval proposals presented by the A & E Firms based on their technical expertise and extensive New York experience;

WHEREAS, in March 2013 the President authorized a deviation from the Corporation's Operating Procedure 100-5 to engage without Board approval the A & E Firms at a cost of not more than \$5 Million to each provide specialized architecture and engineering services to assess the need for hazard mitigation construction and to design such work and to advise the Corporation in its applications for reimbursement by the FEMA and from CBGF for Hurricane Sandy the cost of related repairs; and

WHEREAS, such deviation was reported to the Corporation's Board of Directors at its March 2013 meeting; and

WHEREAS, the A & E Firms have provided valuable assistance to the Corporation in its FEMA and CBGF applications and have completed designs for important mitigation projects now being bid out;

WHEREAS, as a result of the A & E Firms' work, it became apparent that further work is required by the A & E Firms to fully assess the Corporation's need for hazard mitigation measures and to complete the design for the indicated projects; and

NOW THEREFORE, be it

RESOLVED, that the Board of Directors hereby ratifies and confirms the engagement of Parsons Brinkerhoff and ARCADIS to each provide specialized engineering services to assess the need for hazard

mitigation construction and to propose and design such work and to advise the Corporation in its applications for reimbursement by the Federal Emergency Management ("FEMA") and from Community Development Block Grants for Hurricane Sandy related repairs at a cost of not more than \$5 Million; and it is further;

. **RESOLVED**, that the Board of Directors hereby authorized the President of the Corporation to negotiate and execute an amendment to the contracts with Parsons Brinkerhoff and ARCADIS by an additional \$6 Million to bring the total funding for the work of such firms to \$11 Million.

EXECUTIVE SUMMARY

Most of the work the Corporation has performed to date to respond to Hurricane Sandy has been emergency repair work designed merely to repair the damage caused by the Storm and to enable the impacted facilities to resume providing services. The Corporation has performed only limited work so far to minimize the risk of damage from future storms. Good stewardship of these public assets, however, requires that the Corporation alter its facilities, where practicable, to guard against the impact of future storms. Further, FEMA will provide additional funding to harden damaged facilities from future storms if the Corporation properly proposes the hazard mitigation projects. The Corporation hired Parsons Brinkerhoff and ARCADIS (the "A & E Firms") to conduct a review of the Corporation's damaged facilities to identify alterations that might be performed at reasonable cost and that would substantially protect such facilities from the damage of future storms. The A & E Firms were also to design the alterations they proposed. Finally, the two firms were to assist HHC with claims for reimbursement for the cost of storm related repairs from FEMA and from Community Development Block Grants.

To date, the A & E firms have completed the work described below including having completed substantial parts of its review of the Corporation's facilities to determine where mitigation projects should be performed. Now that such review is substantially complete, the Corporation has the benefit of a list of projects in need of design and can budget for the design work remaining for the A & E Firms to complete also as indicated in the attached. To complete the design of such projects, the Corporation seeks to increase the funding for the work of the A & E Firms from \$5 Million initially authorized to \$11 Million – an increase of \$6 Million.

It is anticipated that a majority of the cost of these A & E services will be reimbursed by FEMA.

Task	Facility	Description	Date Authorized	HHC Work Order	Billed-to-Date	Progress-to-Date	Comments
1	Bellevue	Damage Assessment / Return to Pre-Storm Condition Estimate Reflecting Code Upgrades	5/30/2013	Interim Authorization	\$ -	10%	None
2	Bellevue	Benefit Cost Analysis in Support of 406 HMP	6/12/2013	Interim Authorization	\$ -	10%	None
3	Bellevue	Short-term Solutions / Mitigation MCA / 406 Hazard Mitigation Plan / 404 Grants	4/19/2013	DCN 641102	\$ -	40%	None
4	Coney Island	Damage Assessment / Return to Pre-Storm Condition Estimate Reflecting Code Upgrades	5/30/2013	Interim Authorization	\$ -	30%	None
5	Coney Island	Benefit Cost Analysis in Support of 406 HMP	6/12/2013	Interim Authorization	\$ -	10%	None
6	Coney Island	Short-term Solutions / Mitigation MCA / 406 Hazard Mitigation Plan / 404 Grants	5/8/2013	DCN 691400	\$ -	25%	None
7	Coler	Damage Assessment / Return to Pre-Storm Condition Estimate Reflecting Code Upgrades	5/30/2013	Interim Authorization	\$ -	0%	Activity to Start Week of July 1st
8	Coler	Benefit Cost Analysis in Support of 406 HMP	6/12/2013	Interim Authorization	\$ -	0%	None
9	Coler	Mitigation MCA / 406 Hazard Mitigation Plan / 404 Grants	6/12/2013	Interim Authorization	\$ -	0%	None
10	Metropolitan	Damage Assessment / Pre Storm Estimate / BCA / 406 hazard Mitigation Plan / 404 Grants			\$ -	0%	None
11	Draper Hall	Damage Assessment / Return to Pre-Storm Condition Estimate Reflecting Code Upgrades	5/31/2013	Interim Authorization	\$ -	30%	None
12	All	FEMA Additional Meeting Support			\$ -	0%	None

Item No.	Work Order / Project Name	Operative Summary / Description of Work	City	Requested By	Date Proposed	Date of Review	Est. Approved (in Dollars)	Date Authorized	Associated HHC PW #	Approved Deliverables (in Dollars)	Proposed Deliverables Construction Date	Anticipated (incentive) Award Date	Summary of Deliverables
1	Bellevue Hospital Task Order No. 1	Replacement of 1500KW Generator and Fuel Oil System Storage and Gallery Modifications (Refer to Attachment A for Scope of Work Document Provided by Bellevue Hospital)	Bellevue	M. Rowling	April 4, 2013	April 10, 2013	25%	April 18, 2013	111-5140-01	Condition/Damage Assessment Report	May 7, 2013	June 4, 2013	1. Condition/Damage Assessment Report (25%) 2. 50% Design Phase (25%) 3. 100% Design Phase (25%) 3. Construction Administration (15%)
2	Bellevue Hospital Task Order No. 2	Expansion of Emergency Power Distribution System to serve additional critical loads within the Hospital (Refer to Attachment A for Scope of Work Document Provided by Bellevue Hospital)	Bellevue	M. Rowling	April 4, 2013	April 10, 2013	25%	April 18, 2013	111-5140-01	Condition/Damage Assessment Report	May 7, 2013	June 4, 2013	1. Condition/Damage Assessment Report (25%) 2. 50% Design Phase (25%) 3. 100% Design Phase (25%) 3. Construction Administration (15%)
3	Bellevue Hospital Task Order No. 3	Vertical Transportation Mitigation Planning and Design (Refer to Attachment A for Scope of Work Document Provided by Bellevue Hospital)	Bellevue	M. Rowling	April 4, 2013	April 10, 2013	25%	April 18, 2013	111-5140-01	Condition/Damage Assessment Report	May 7, 2013	June 4, 2013	1. Condition/Damage Assessment Report (25%) 2. 50% Design Phase (25%) 3. 100% Design Phase (25%) 3. Construction Administration (15%)
4	Bellevue Hospital Task Order No. 4	Main Hospital Building Connect Wire System Redundancy (Refer to Attachment A for Scope of Work Document Provided by Bellevue Hospital)	Bellevue	M. Rowling	April 4, 2013	April 10, 2013	25%	April 18, 2013	111-5140-01	Condition/Damage Assessment Report	May 7, 2013	June 4, 2013	1. Condition/Damage Assessment Report (25%) 2. 50% Design Phase (25%) 3. 100% Design Phase (25%) 3. Construction Administration (15%)
5	Bellevue Hospital Task Order No. 5	Medical Gas System Mitigation Planning and Design (Refer to Attachment A for Scope of Work Document Provided by Bellevue Hospital)	Bellevue	M. Rowling	April 4, 2013	April 10, 2013	25%	April 18, 2013	111-5140-01	Condition/Damage Assessment Report	May 7, 2013	June 4, 2013	1. Condition/Damage Assessment Report (25%) 2. 50% Design Phase (25%) 3. 100% Design Phase (25%) 3. Construction Administration (15%)
6	Bellevue Hospital Task Order No. 6	Backup Steam Source and Distribution Project (Refer to Attachment A for Scope of Work Document Provided by Bellevue Hospital)	Bellevue	M. Rowling	April 4, 2013	April 10, 2013	25%	April 18, 2013	111-5140-01	Condition/Damage Assessment Report	May 7, 2013	June 4, 2013	1. Condition/Damage Assessment Report (25%) 2. 50% Design Phase (25%) 3. 100% Design Phase (25%) 3. Construction Administration (15%)
7	Colex Hospital Task Order No. 1	Design for Permanent Emergency Generator Installation Base Scope of Work (Refer to Attachment E for email request for meeting on subject matter.)	Colex	M. Buchheit	April 25, 2013	June 19, 2013	25%	Pending	411-5140-01	Condition/Damage Assessment Report	July 29, 2013	August 5, 2013	1. Condition/Damage Assessment Report (25%) 2. 50% Design Phase (25%) 3. 100% Design Phase (25%) 3. Construction Administration (15%)
8	Colex Hospital Task Order No. 2	Design for Basement and Crawl Space Lighting. (Refer to Attachment E for email request for meeting on subject matter.)	Colex	M. Buchheit	April 25, 2013	June 19, 2013	25%	Pending	411-5140-01	Condition/Damage Assessment Report	July 29, 2013	August 5, 2013	1. Condition/Damage Assessment Report (25%) 2. 50% Design Phase (25%) 3. 100% Design Phase (25%) 3. Construction Administration (15%)
9	Metropolitan Hospital Task Order No. 1	Provide A&E Damage Assessment Report, Associated Cost Estimates and Draft FEMA Project Worksheets for Damages occurred at Metropolitan Hospital as a result of Hurricane Sandy (Refer to Attachment G for Meeting Minutes requesting subject matter) 06/10/2013 Updates request from John Levy to re-eval proposed based on reduction of scope.	Metropolitan	J. Levy	May 13, 2013	June 19, 2013	100%	Pending	231-5140-01	Condition/Damage Assessment Report	July 17, 2013	July 24, 2013	1. DRAFT Assessment Report (50%) 2. Final Assessment Report (10%)
10	Jacobi Hospital Task Order No. 1	Provide Damage Assessment Report for Building 24 South Eastwing as a result of Hurricane Sandy. (Refer to Attachment H for email requesting subject matter.)	Jacobi	J. Levy	May 20, 2013	June 19, 2013	100%	May 29, 2013	131-5140-01	Condition/Damage Assessment Report	May 30, 2013	June 4, 2013	1. DRAFT Assessment Report (50%) 2. Final Assessment Report (10%)
11	Canary Island Hospital Task Order No. 1	Provide MEP, Architectural and Structural Design for the relocation of existing computer center from 3rd Floor of Harwood Bldg. to higher level within Main Bldg. (Refer to Attachment I for email and Meeting Minutes requesting subject matter.)	Canary Island	O. Collins	May 29, 2013	June 19, 2013	30%	Pending	231-5140-01	Condition/Damage Assessment Report	July 26, 2013	August 2, 2013	1. Condition/Damage Assessment Report & Schwartz Design (30%) 2. 50% Design Phase (40%) 3. 100% Design Phase (15%) 3. Construction Administration (15%)
12	Bellevue Hospital Task Order No. 7	Provide short term temporary mitigation designs for temporary fuel oil delivery, domestic water and temporary emergency generator connection. (Refer to Attachment N for Minutes of Meeting requesting subject matter.)	Bellevue	M. Rowling	June 3, 2013	June 17, 2013	N/A						
13	Colex Hospital Task Order No. 3	Expansion of Emergency Power Distribution System to serve additional critical loads within the Hospital (Refer to Attachment I for email requesting subject matter.)	Colex	M. Buchheit	June 4, 2013	June 6, 2013	N/A						
14	FEMA Additional Meeting Support	Prepare documents, participate in negotiations, attend meetings as directed by client	All HHC Facilities	J. Levy									
15	Spend to date	requesting per HHC request	All HHC Facilities										

Manasses C. Williams
Assistant Vice President
Affirmative Action/EEO

manasses.williams@nychhc.org

TO: Joseph Quinones
Senior Assistant Vice President
Operations Department

FROM: Manasses Williams 

DATE: April 9, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Parsons Brinckerhoff, Inc.** has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

Minority Business Enterprise Woman Business Enterprise Non-M/WBE

Project Location(s): HHC's Corporate Wide

Contract : _____

Project: Engineering Services

Submitted by: Operations Department

EEO STATUS:

1. Approved
2. Conditionally approved with follow-up review and monitoring-No EEO Committee Review
3. Not approved
4. Conditionally approved subject to EEO Committee Review

COMMENTS:

c: pt

The New York City
Health and Hospitals Corporation



Architectural & Engineering Services

July 2013

Federal & State Programs

- Public Assistance Grant Program
 - Category B: Emergency Work
 - Category E: Permanent Work
- 406 Mitigation
 - Public Assistance
- 404 Mitigation
 - Hazard Mitigation Grant Program
- CDBG
 - Community Development Block Grants

A&E Services

- Building assessments & mechanical estimates
- Flood assessment & mitigation opportunities
- BCA: Benefit-to-cost analysis
- FEMA submittals
- Design, drawings, bid packages

Estimated Funding Opportunity

- Emergency Work \$250M
- Restoration: \$250M-\$400M*
- 406 Mitigation: \$500M
- 404 Mitigation: \$ 50M

- Total Recovery & Mitigation Program:
Estimated \$1.05B

*Estimates still in progress

Architects & Engineers.... NTE Contract

• Mechanical, electrical, and plumbing (MEP)	\$2,500,000
• Short-term / Long-term Flood Assessment	\$2,800,000
• Damage / Asset Inventory	\$540,000
• Conceptual Designs	\$1,900,000
• PW & 406 Scopes of Work	\$550,000
• Facility Level BCA's	\$860,000
• FEMA Submittal and Negotiations	\$1,300,000
	<hr/>
	\$10,450,000

Timeline remainder of 2013

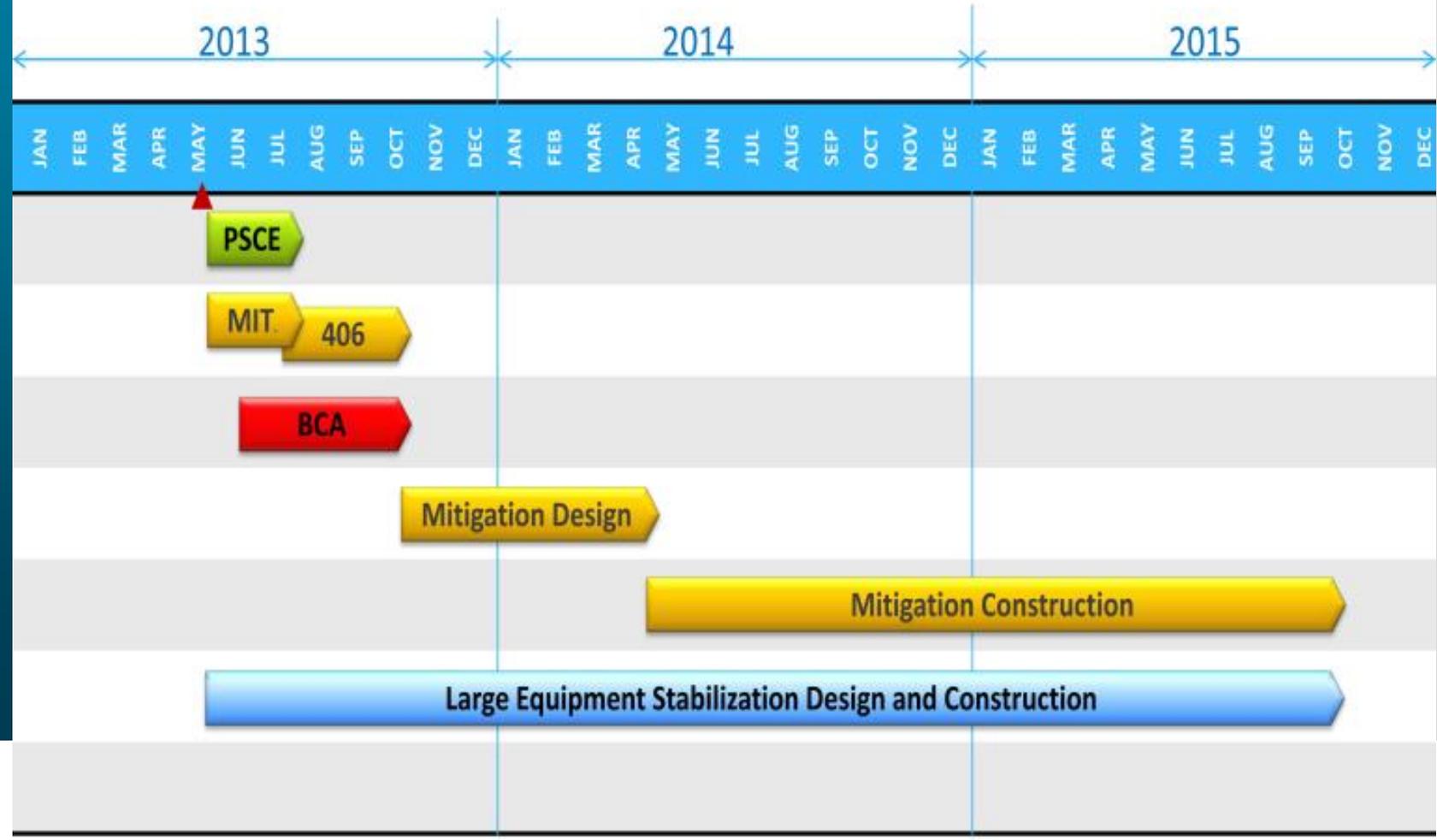
Timeline for Obtaining Hazard Mitigation Funding



Timeline

2013 – 2015

Longer-term Timeline of Mitigation Projects





The New York City Health and Hospitals Corporation



nyc.gov/hhc

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation" or "Licensor") to execute a license agreement with the New York Legal Assistance Group (the "Licensee" or "NYLAG") for its continued use and occupancy of space at Coler-Goldwater Specialty Hospital and Nursing Facility (the "Facility") to provide *pro bono* legal services to facility residents and patients, and training to Corporation staff.

WHEREAS, in March 2011, the Board of Directors authorized the President of the Corporation to enter into a license agreement to provide training and legal services at Bellevue Hospital Center, Elmhurst Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical & Mental Health Center, Woodhull Medical & Mental Health Center; and Harlem Hospital Center; and

WHEREAS, in June 2012 the Board of Directors authorized the President to enter into a six (6) month license agreement with the Licensee, which was extended for an additional six (6) months by the Board of Directors in January 2013, and the Corporation now desires to execute a new six (6) month agreement for its services at the Facility; and

WHEREAS, the Licensee is a not-for-profit provider of *pro bono* legal services to, among others, patients in need of attorney counseling in various areas of the law, including, but not limited to, immigration, domestic relations, child support and custody, and benefit entitlements; and

WHEREAS, the Licensee's program includes the training of Corporation staff to assist the Licensee in recognizing patients in need of legal services; and

WHEREAS, the Facility desires to continue to utilize the Licensee's services and has adequate space to accommodate its program needs.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation be and hereby is authorized to execute a license agreement with the New York Legal Assistance Group (the "Licensee" or "NYLAG") for its continued use and occupancy of space at Coler-Goldwater Specialty Hospital and Nursing Facility (the "Facility") to provide *pro bono* legal services to facility residents and patients, and training to Corporation staff.

The Licensee shall be granted the continued part-time use of approximately 150 square feet of office space on the Facility's Goldwater and Coler campuses (the "Licensed Space"). The Licensed Space shall be used by one of the Licensee's attorneys to train Facility staff and provide legal services to Facility residents and patients. The Facility shall provide utilities, housekeeping, maintenance, and reasonable security to the Licensed Space. The Corporation shall pay the Licensee the sum of \$37,186 for services provided over a six (6) month period.

The Licensee shall indemnify and hold harmless the Corporation and the City of New York from any claims arising by virtue of its use of the Licensed Space and its provision of services in such space. The Licensee shall also provide appropriate insurance, naming both parties to the license agreement and the City of New York as insureds.

The term of the license agreement shall not exceed six (6) months without further authorization of the Board of Directors of the Corporation. The license agreement shall be revocable by either party on fifteen (15) days notice.

EXECUTIVE SUMMARY

LICENSE AGREEMENT

NEW YORK LEGAL ASSISTANCE GROUP

The President seeks authorization of the Board of Directors of the Corporation to execute a revocable license agreement with the New York Legal Assistance Group ("NYLAG") for its continued use and occupancy of space at Coler-Goldwater Specialty Hospital and Nursing Facility (the "Facility") to provide *pro bono* legal services to residents and patients, and training to Corporation staff.

NYLAG is a not-for-profit organization whose purpose includes providing legal services to patients least able to afford private counsel. In June 2002, the Board of Directors authorized the President to enter into a revocable license agreement with NYLAG to provide training and legal services at Elmhurst Hospital Center. The success of this program underscored the need to expand the legal services program to other hospitals. In addition to Elmhurst Hospital, NYLAG provides training and legal services at Bellevue Hospital Center, Jacobi Medical Center, Kings County Hospital Center, Lincoln Medical & Mental Health Center, Woodhull Medical & Mental Health Center; and Harlem Hospital. In January 2013, the Board authorized the President to enter into a six (6) month agreement with NYLAG for its services at the Facility and the new agreement will allow the program to operate on campus for an additional six (6) months.

NYLAG will assign an attorney to conduct periodic training sessions to teach Corporation staff to recognize and identify patients requiring legal services. In addition, a NYLAG attorney will be on-site one half-day per week to counsel nursing home residents and patients in need of legal advice and representation on a *pro bono* basis. NYLAG will be present on the Coler campus and the Goldwater campus each twice per month. The services offered would be in areas of law, including, but not limited to, immigration, domestic relations, child support and custody, and benefit entitlements. This model of patient-focused legal services has been used successfully at safety-net hospitals elsewhere in the country to address legal problems common to low-income patient populations. It is anticipated that NYLAG will assist patients with approximately 60 matters during the half-year period. The Corporation will pay the Licensee the sum of \$37,186 for the services provided over the six month period.

The licensed space, utilities, housekeeping, maintenance, and reasonable security will be provided by the facilities at no charge to NYLAG. NYLAG will indemnify and hold harmless the Corporation and the City of New York from any claims arising by virtue of its use of the licensed space and its provision of services. NYLAG will also provide appropriate insurance, naming both parties to the license agreement and the City of New York as insureds.

The term of the license agreement shall not exceed six (6) months without further authorization of the Board of Directors of the Corporation. The license agreement shall be revocable by either party on fifteen (15) days notice.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to surrender to the City of New York a parcel of land and buildings, Block 1373, Lot 20, located on the campus of Goldwater Specialty Hospital and Nursing Facility, One Main Street, Roosevelt Island, New York ("the Facility").

WHEREAS, the subject parcel and improvements are currently under the jurisdiction of the Corporation, and are deemed surplus by the Corporation for its corporate purposes; and

WHEREAS, the Facility shall be decommissioned and the land and buildings surrendered to the City of New York for disposition to Cornell University and Technion – Israel Institute of Technology to develop the Applied Sciences NYC project;

WHEREAS, Section 7385.6 and Section 7387.4 of the Corporation's enabling act authorize the surrender of property to the City of New York, which is fee owner of the Facility, after a public hearing, which was held July 11, 2013.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to surrender to the City of New York a parcel of land and buildings, Block 1373, Lot 20, located on the campus of Goldwater Specialty Hospital and Nursing Facility, One Main Street, Roosevelt Island, New York (the "Facility")

EXECUTIVE SUMMARY

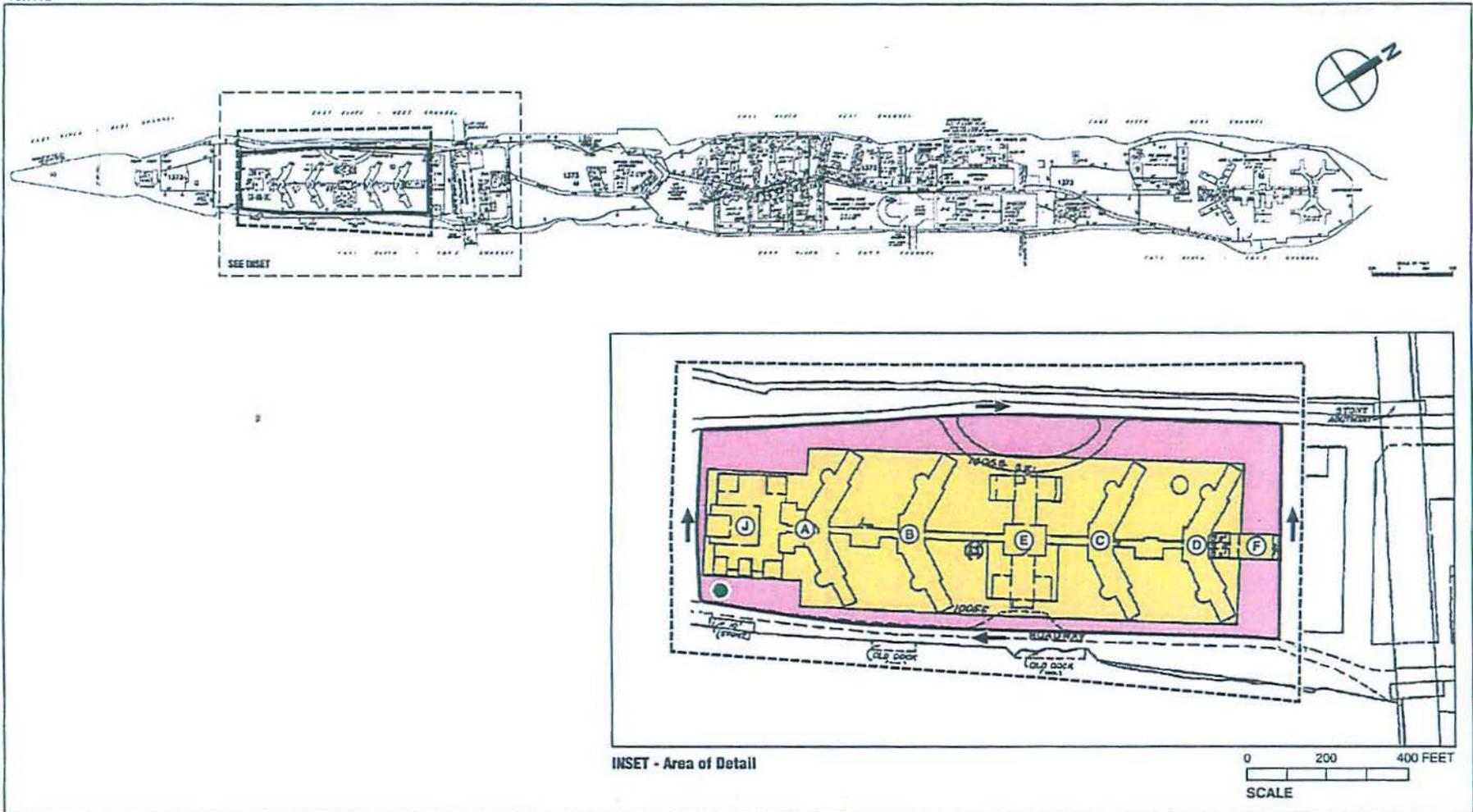
PROPERTY SURRENDER

GOLDWATER SPECIALTY HOSPITAL AND NURSING FACILITY THE GOLDWATER CAMPUS

The President seeks authorization from the Board of Directors of the Corporation to surrender to the City of New York a parcel of land and buildings, Block 1373, Lot 20, located on the campus of Goldwater Specialty Hospital and Nursing Facility, One Main Street, Roosevelt Island, New York (the "Facility")

The site measures approximately 9.8 acres and is located on the southern portion of Roosevelt Island south of the Ed Koch Queensboro Bridge. Goldwater Hospital opened on the island in 1939 as a chronic care and nursing facility. The Goldwater campus consists of the original six-building complex (Buildings A through F) and a circa 1971 addition (Building J). The Corporation will relocate activities from the Goldwater campus to other facilities and decommission the site. The land and buildings will be surrendered to the City of New York for disposition to Cornell University and Technion – Israel Institute of Technology to develop the Applied Sciences NYC project.

Section 7385.6 and Section 7387.4 of the Corporation's enabling act empower HHC to surrender real estate to the City of New York when such property is no longer utilized for its corporate purposes. The surrender process includes a public hearing, approval by the Board of Directors, and subsequent approval by the City Council. The public hearing was held July 11, 2013.



- Project Site
- Rezoning Area (Special Southern Roosevelt Island District)
- Ⓐ Goldwater Hospital Building Name
- DEP South Pump Station
- Traffic Direction

- Block 1373 Lot 20
Owned by: City of New York
Occupied by: Goldwater Memorial Hospital (NYCHHC)
- Block 1373 Lot 1 (portion)
Owned by: City of New York
Leased to: RIOC

Project Site: Current Ownership
Figure 1-2

METES & BOUNDS DESCRIPTION
LOT 20, BLOCK 1373
ROOSEVELT ISLAND
BOROUGH OF MANHATTAN
CITY, COUNTY & STATE OF NEW YORK

BEGINNING AT A POINT ON THE SOUTHWESTERLY MOST CORNER OF LOT 20, BLOCK 1373 HAVING A COORDINATE VALUE OF NORTH 10731.04, EAST 15442.79, SAID POINT BEING SOUTH 73 DEGREES - 32 MINUTES - 13 SECONDS EAST, A DISTANCE OF 215.59 FEET FROM A POINT ALONG THE NORTHEASTERLY LINE OF THE EAST RIVER WEST CHANNEL HAVING A COORDINATE VALUE OF NORTH 10792.14, EAST 15236.04 AND FROM SAID BEGINNING POINT, THE FOLLOWING TWELVE (12) COURSES ALONG THE PERIMETER OF LOT 20, BLOCK 1373:

1. NORTH 35 DEGREES - 27 MINUTES - 04 SECONDS EAST, A DISTANCE OF 228.61 FEET TO A POINT, THENCE;
2. NORTH 54 DEGREES - 32 MINUTES - 56 SECONDS WEST, A DISTANCE OF 65.25 FEET TO A POINT, THENCE;
3. NORTH 35 DEGREES - 27 MINUTES - 04 SECONDS EAST, A DISTANCE OF 1,005.50 FEET TO A POINT, THENCE;
4. SOUTH 54 DEGREES - 32 MINUTES - 56 SECONDS EAST, A DISTANCE OF 153.75 FEET TO A POINT, THENCE;
5. NORTH 35 DEGREES - 27 MINUTES - 04 SECONDS EAST, A DISTANCE OF 93.50 FEET TO A POINT, THENCE;
6. SOUTH 54 DEGREES - 32 MINUTES - 56 SECONDS EAST, A DISTANCE OF 61.00 FEET TO A POINT, THENCE;
7. SOUTH 35 DEGREES - 27 MINUTES - 04 SECONDS WEST, A DISTANCE OF 93.50 FEET TO A POINT, THENCE;
8. SOUTH 54 DEGREES - 32 MINUTES - 56 SECONDS EAST, A DISTANCE OF 153.75 FEET TO A POINT, THENCE;
9. SOUTH 35 DEGREES - 27 MINUTES - 04 SECONDS WEST, A DISTANCE OF 1,005.50 FEET TO A POINT, THENCE;
10. NORTH 54 DEGREES - 32 MINUTES - 56 SECONDS WEST, A DISTANCE OF 65.25 FEET TO A POINT, THENCE;
11. SOUTH 35 DEGREES - 27 MINUTES - 04 SECONDS WEST, A DISTANCE OF 228.61 FEET TO A POINT, THENCE;
12. NORTH 54 DEGREES - 32 MINUTES - 56 SECONDS WEST, A DISTANCE OF 238.00 FEET TO THE POINT AND PLACE OF BEGINNING.

CONTAINING 430,639 SQUARE FEET OR 9.8861 ACRES

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to execute a license agreement with the New York City Department of Housing Preservation and Development ("HPD") for the Corporation's use and occupancy of Block 7061, Lots 16, 39, 40, 41, 42, 43, 44 and 45 in the Coney Island area of Brooklyn for the Corporation's operation of a temporary primary medical clinic in a pre-fabricated structure under which the Corporation will not have to make any payments to HPD.

WHEREAS, Coney Island Hospital ("CIH") had operated the Ida G. Israel Community Health Center at 2201-2202 Neptune Avenue in the Coney Island area of Brooklyn (the "Center") until such clinic was destroyed by Hurricane Sandy; and

WHEREAS, the Coney Island neighborhood's need for primary health services is not being adequately met without the Center; and

WHEREAS, CIH will require more than a year to complete the selection of a new site for the Center and to complete the necessary alterations and construction once a site is selected; and

WHEREAS, HPD controls a number of vacant lots in the area and is willing to license them to the Corporation at no charge for the Corporation's use to site a pre-fabricated modular structure from which to operate a temporary version of the Center; and

WHEREAS, the Corporation is able to quickly erect a pre-fabricated modular structure from which to operate a temporary version of the Center.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be, and he hereby is, authorized to execute a license agreement with New York City Department of Housing Preservation and Development ("HPD") for the Corporation's use and occupancy of Block 7061, Lots 16, 39, 40, 41, 42, 43, 44 and 45 in the Coney Island area of Brooklyn for the Corporation's operation of a temporary primary medical clinic in a pre-fabricated, modular structure under which the Corporation will not have to make any payments to HPD.

EXECUTIVE SUMMARY

The President of the New York City Health and Hospitals Corporation (the "Corporation") seeks authorization to execute a terminable license agreement with the New York City Department of Housing Preservation and Development ("HPD") for the Corporation's use and occupancy of Block 7061, Lots 16, 39, 40, 41, 42, 43, 44 and 45 in the Coney Island area of Brooklyn for the Corporation's operation of a temporary primary medical clinic in a pre-fabricated structure. These are all vacant lots that are currently unused by HPD. Under the proposed license agreement, HPD will not charge the Corporation for its use and occupancy of the licensed property.

Hurricane Sandy destroyed the Ida G. Israel Community Health Center at 2201-2202 Neptune Avenue in the Coney Island area of Brooklyn (the "Center"). Since then, Coney Island Hospital ("CIH") has been working with the community, local elected officials and various agencies of the City of New York to find a suitable replacement site for the Center. Even once a location is found, it is likely that it will take from 6 to 18 months to complete all of the work at such location to enable the Center to begin its operations there. In the meantime, the Coney Island neighborhood's need for primary health services is not being adequately met. Thus, it is appropriate to quickly implement a temporary solution that can serve the community until a new home for the Center is found and renovated to meet the Center's needs.

CIH has identified a reputable manufacturer of modular, prefabricated structures. CIH, working with an architect, has developed plans for a structure of approximately 13,000 square feet that can be erected on the property to be licensed. Including the cost to establish utility connections, it is estimated that the structure can be erected for a cost of approximately \$5 Million and that the structure can be equipped at a further cost of approximately \$500,000. CIH anticipates that a substantial part of these costs will be reimbursed by the Federal Emergency Management Agency.

CIH will return to the Capital Committee of the Board for a separate authorization for the capital required for this project and will present a detailed budget for the expenses at that time.

CIH estimates that the structure can be erected, outfitted and ready for the treatment of patients on or about February 1, 2014.

When the structure is erected, outfitted and fully operational, CIH anticipates providing dental, pediatric, general primary medical care and chemical dependency services.