

AUDIT COMMITTEE
MEETING AGENDA

September 17th, 2015

12:30 P.M.

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

CALL TO ORDER

- Adoption of Minutes June 11, 2015

Ms. Emily A. Youssouf

INFORMATION ITEMS

- Audits Update
- Compliance Update

Mr. Chris A. Telano

Mr. Wayne McNulty

EXECUTIVE SESSION

OLD BUSINESS

NEW BUSINESS

ADJOURNMENT

MINUTES

AUDIT COMMITTEE

MEETING DATE: June 11, 2015

TIME: 12:30 PM

COMMITTEE MEMBERS

Emily Youssouf, Chair

Josephine Bolus, RN

OTHER BOARD MEMBERS

Gordon Campbell, Acting Chair, Board Member

STAFF ATTENDEES

Antonio Martin, Executive Vice President/COO

Barbara Keller, Deputy Counsel, Legal Affairs

Deborah Cates, Chief of Staff, Chairman's Office

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

Lynette Sainbert, Assistant Director, Chairman's Office

Marlene Zurack, Senior Assistant Vice President/CFO, Corporate Finance

Ross Wilson, Senior Vice President, Chief Medical Officer

Paul Albertson, Senior Assistant Vice President, CO-Material Management

Julian John, Corporate Comptroller

James Linhart, Deputy Corporate Comptroller

Imah Jones, Senior Director, Central Office

Jeannette Torres, Assistant Director, CO-Materials Management

Gassenia Guilford, Assistant Vice President, Finance

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

Wayne McNulty, Corporate Compliance Officer

Devon Wilson, Senior Director, Office of Internal Audits

Chalice Averett, Director, Office of Internal Audits

Carol Parjohn, Director, Office of Internal Audits

Steve Van Schultz, Director, Office of Internal Audits

Carlotta Duran, Assistant Director, Office of Internal Audits

Delores Rahman, Audit Manager, Office of Internal Audits

Frank Zanghi, Audit Manager, Office of Internal Audits

Roger Novoa, Supervising Confidential Examiner, Office of Internal Audits

Rosemarie Thomas, Supervising Confidential Examiner

Sonja Aborisade, Supervising Confidential Examiner, Office of Internal Audits

Armel Sejour, Supervising Confidential Examiner

Jonathan Delgado, Supervising Confidential Examiner

Sam Malla, Associate Staff Auditor, Office of Internal Audits

Barbarah Gelin, Associate Staff Auditor, Office of Internal Audits

Doriana Alikaj, Associate Staff Auditor, Office of Internal Audits

Nastasya Barnett, Staff Auditor, Office of Internal Audits

Guzal Contrera, Staff Auditor, Office of Internal Audits

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

Jean Saint-Preux, Confidential Examiner, Office of Internal Audits

Roshney Kaur, Staff Auditor, Office of Internal Audits
Linda Maldonado, Staff Auditor, Office of Internal Audits
Rick Walker, Chief Financial Officer, North/Central Brooklyn Healthcare Network
Jaime Gonzalez, Director, Hospital Police, Woodhull Medical & Mental Health Center
Henry Kuzin, Senior Associate Director, Woodhull Medical & Mental Health Center
Ivan Figueroa, Assistant Director, Woodhull Medical & Mental Health Center
Edie Coleman, Controller, Metropolitan Hospital Center
Michelle Figueroa, Senior Associate Director, Metropolitan Hospital Center
Susan Collymore, Associate Director, Metropolitan Hospital Center
Timi Diyaolu, Controller, Bellevue Hospital Hospital Center
Kiho Park, Associate Executive Director, Queens Health Network
Elsa Cosme, Chief Financial Officer, Gouverneur Healthcare Services
Daniel Frimer, Controller, South Brooklyn/Staten Island Network
Martin Novzen, Senior Associate Director, Woodhull Medical & Mental Health Center
Anthony Saul, Chief Financial Officer, Kings County Hospital
Andrew Tymcoz, Senior Associate Director, Kings County Hospital
Ronald Townes, Associate Director, Kings County Hospital Center
Pamela Williams, Associate Director, Kings County Hospital Center
Barbara Wikoren, Associate Executive Director, North Bronx Healthcare Network
Janice Halloran, Senior Associate Director, Jacobi Medical Center
Neville Trouser, Associate Director, Jacobi Medical Center
Shirley Williams, Associate Director, Jacobi Medical Center
Steve Mair, Admissions Office, Jacobi Medical Center
Brenford Baker, Assistant Coordinating Manager

OTHER ATTENDEES

KPMG: Maria Tiso, Lead Engagement Partner; Jim Martell, Client Service Partner; Joseph Bukzin, Lead Senior Auditor

**JUNE 11, 2015
AUDIT COMMITTEE MEETING
MINUTES**

An Audit Committee meeting was held on Thursday, June 11, 2015. The meeting was called to order at 12:33 P.M. by Ms. Emily Youssouf, Committee Chair. Ms. Youssouf then asked for a motion to adopt the minutes of the Audit Committee meeting held on April 16, 2015. A motion was made and seconded with all in favor to adopt the minutes.

Ms. Youssouf then stated that there are no action items, but we have a number of information items. The first one is the KPMG 2015 audit plan. She asked for them to introduce themselves. They did as follows: Maria Tiso, Engagement Partner; Jim Martell, Client Service Partner and Joe Bukzin, Lead Senior Manager on the account.

Ms. Tiso began by stating that I am going to start on page two of the plan. As it relates to KPMG engagement team, probably all of the individuals on this slide are continuity. They are staff professionals that have serviced the Corporation in the past and will be returning to the engagement this year. As part of our team, we use subject matter professionals as it relates to various areas that require management's estimates and judgements. So we have subject matter professionals help us in the area of tax, IT, reimbursement and OPEB. We also have a second party review that reviews the various sets of financial statements that we will be issuing and also healthcare and technicality resources as it relates to technical topics that we encounter during the audit.

Page three are the deliverables that we will issuing which are outlined in the contract we signed with the Corporation. They are consistent to what we issued in the prior year except for the HHC ACO. That deliverable was not issued last year because it was in start-up – this will be the first year we will be issuing that financial statement. Page four is the objective of an audit. It is to express an opinion on the financial statements, making sure that the financial statements are materially stated. We do look at internal controls in order to render an opinion. The next couple of slides, pages five, six, and seven go through the responsibilities of management, KPMG and the Audit Committee. I am not going to go through all of them. Just briefly, management's responsibility is to make sure the financial statements are accurate, all the footnote disclosures are in accordance with GAAP, maintaining effective controls and making sure that all the financial records are appropriate. If there are any material adjustments, that they are recorded on a timely basis and giving the auditors access to all of the information as we conduct our audit. Your responsibility is one of oversight and monitoring – you rely both on your internal auditors, your external auditors, your management team as it relates to the fair presentation of the financial statements. Page eight talks about independence. As your auditors, we have to maintain independence as it relates to the Corporation and affirming that we are independent as it relates to the Corporation. We have various systems in place to make sure we monitor that throughout the year. At this point Mr. Bukzin will walk through the time line as it relates to the 2015 audit.

Mr. Bukzin saluted everyone and said that starting on page nine we have the start of our audit time line. In the April through June period, this is where we are having our meetings with management, having discussions internally as well as determining the overall audit approach. Working though the review from an IT perspective and obviously today we are here to present the audit plan. In the June through July time period, this is where we are spending most of our time visiting the site locations, doing some of our detailed testing and touching upon some of the key controls. We will also work closely with Mr. John's team during the audit to address any non-routine actions, which are described on a couple of pages later on.

Ms. Youssouf asked to give an example of the walk through. Mr. Bukzin responded that one of them is of the DISRIP program. That will be something that we will be working closely with the organization to review the account. Ms. Tiso added that it is very gray at this point of the accounting treatment of DISRIP and how the entire payment process works. Obviously the payment process is different for every health care system. Some are getting payment directly

to the PPS, and others the PPS has to send payments to their downstream providers. We are actually going to consult with our national office and will also be consulting with other accounting firms to make sure that we are consistent in giving advice and consultation to our clients as to how the DISRIP dollars should be recorded. In speaking with Mr. John that payment is supposed to be arriving today for HHC, we will be working with his team regarding the accounting treatment of it.

Ms. Youssouf asked how much today? To which Mr. John answered that we expect \$330 million, the net is about \$110 million because we paid \$167 million yesterday and we are going to be paying another \$50 million in another two weeks.

Ms. Tiso stated that another matter is the upper payment limit funding. Every year we spend a lot of time with the management team making sure we have enough corroborative evidence to make sure it is an appropriate item on the financial statement to record. Sometimes the appropriate documents are not available at the time we are signing off. The other items are FEMA awards, the potential sale of the dialysis services, EPIC implementation and then Gotham FQHC, we will look at that to make sure that it is recorded appropriately.

Ms. Youssouf asked that you say EPIC implementation, are you looking at how we spent the funds allocated to EPIC installation and so forth?

Ms. Tiso responded that we look at the general IT controls to make sure that there is access controls, passwords, making sure it was configured appropriately.

Mr. Bukzin added that my understanding is that the implementation is going to occur in the 1st Quarter of 2016. We started to have some conversations up front this year but we would expect perhaps next year that there may be more involvement once the system is up and running and live. We will have to include that as part of the work.

Ms. Zurack commented that I think there is a little confusion – you do routine IT audits because our financial information is driven by what is in our IT system. You need to make sure that that information is correct as distinguished from doing a real program audit of the EPIC implementation, which is not your scope.

Ms. Tiso stated exactly – it is more around IT controls, we do not look at the operation aspects of that.

Mr. Campbell asked that problematically EPIC would not be part of the KPMG's engagement other than the Board, not to minimize the Board's role, is there any other auditor or any other review?

Mr. Martin responded yes, I have asked the Mayor's Office of Information and Technology to do a financial audit on EPIC implementation.

Ms. Zurack said that as part of that process we are developing a standard format report on the EPIC budget and spending that it is going to be programmed out of the mainframe so that we will have consistent reporting for all of the internal board committees as well as for the City. That is why I wanted to make the distinction because the KPMG piece is sort of a routine thing. They have to check our IT system because our data comes from them.

Mr. Telano added that Dr. Raju has asked internal audit to look at the budget and expenses related to the EPIC project. We have been on that project for about two months now.

Mr. Bukzin stated that we will looking at the accounting for those particular costs depending on what type of expenses were incurred. Some of those costs may be capitalized rather than expensed.

Ms. Youssef asked if that is something you will look at. To which Ms. Tiso answered yes, that from a financial reporting perspective we will look at it.

Mr. Bukzin said that we jumped ahead and covered many of the items on page 13. Jumping back to a couple of previous pages -- the audit time line. I can generally comment that the timing is consistent with what we have done in the past in terms of our reporting style and when we would meet with the committee to communicate results, present the management letter and go over the financial statements. Page 12 highlights where we spend a significant portion of our time during the audit process. These are significant audit areas in terms of where there is significant management judgement involved or estimations or specialists involved such as actuaries and third-party reimbursement issues. Page 14 highlights some of the other members or other organizations that assist us as part of the audit process. We are still working through confirming the minority business enterprise and their scope of work in terms of assisting us with some of the cost report work. We did have a kick off meeting with the internal audit team to discuss their role and the women's business enterprise consistent with the prior year they will assist us with the third-party reimbursement issues.

Ms. Youssef asked how much time of internal audit will you be asking for? To which Mr. Telano responded that we assign one individual for ten weeks to assist them.

Ms. Tiso added that that is consistent to what we have utilized in the past and what is in the contract also.

Mr. Bukzin continued with page 15 which describes some of our general considerations related to risk of fraud in a financial statement audit. If during the course of performing some of these procedures something comes to our attention, we would be required to communicate and describe that and discuss it and assess how it will affect the audit. This is consistent with our audit approach in the prior years. Page 16 highlights the key members of management of the organization where we would discuss the risk of fraud and ask those hard pressing questions and see if there is anything out there that we would need to be made aware of as we go through the audit process. Page 17 and 18 describes our responsibility as well as management's responsibility with regards to liquidity and the risk of going concern. If you were a stand-alone hospital system there would be a different angle from going concern risk. But because you are a component unit of the City that helps from an audit documentation perspective to alleviate the risk of when you are reviewing the financials you would see losses and that net deficit position. We look at a number of things besides just the certain financial statement metrics -- we consider the overall picture.

Ms. Tiso said that on page 18 is some of the information we request so that we document appropriately the going concern factor would be 2016 budgets and cash flow projections. We will speak to management and get their representations about what management's future plans are as it relates to the organization.

Ms. Youssef asked that does that mean? Do you have the ability to look at any meeting from the City or any minutes? Ms. Tiso answered no, we do not look at the City's minutes but we look at the Corporation's minutes.

Mr. Martell added that the issue is, this is documentation from KPMG's perspective. Management has a business plan, a strategy and so forth. As Mr. Bukzin said, if you take a step back, forgetting about the organization is somehow related to the City, the continuing losses, of \$400 to \$500 million a year, obviously is always on the minds of management and are always looking for ways to reduce it. That is what we also look for as part of our overall conclusion. Unfortunately, the industry is not very conducive for an organization like HHC to turn the ship immediately. But that is something that is really secondary, everything here is a documentation to make sure that you will get a clean or unmodified opinion. Then you get to the next step, the operational side which management works on.

Mrs. Bolus asked if the information on page 14 goes to the EEO Committee? To which Ms. Tiso responded that KPMG sends a certification to your committee as it relates to the minority business, the women business enterprise.

I think that as part of the contract, certain information is requested from KPMG. I think it is on a quarterly basis because I get copied on it.

Mr. Martin commented that I will look at that.

Ms. Zurack stated that the way you guys left it you will have an MBE working on the cost reports and a WBE working on third party liabilities and you will meet your subcontractor requirements. I think you said you may not have identified the individual. When you presented this you were less than definite.

Ms. Tiso said that everybody has been identified and scheduled at this point.

Mr. Bukzin continued with the last slide – the new accounting announcements. We will work closely with management to assess the impact that these will or may have on the organization. So we are still going through that process right now.

Ms. Youssouf asked if there anything in here you would like to explain to the Committee? We talked about 69, do you want to talk about 70 or 71? Mr. Bukzin answered that GASB Statement 70 talks about the non-exchange of financial guarantees. If one governmental organization guarantees an obligation of another entity that may require the guarantor to record a liability. So there is an assessment of probability and likelihood that you would actually have to step in their shoes and actually have to pay on behalf of the other organization. That is just an example of GASB 70.

Ms. Youssouf asked if that could be a slight issue. Ms. Tiso said that we are going to work through management to see how it affects the Corporation.

Mr. Bukzin stated that the last one in terms of fair value consistent with GASB perspective the fair value is now defined as what a market participant would pay for a particular asset or satisfy a particular liability. It is just redefining how fair value is from a market participant perspective.

Ms. Youssouf asked if that means our assets have to be reassessed. Mr. Bukzin answered not necessarily, I think a lot of it has to do with disclosure requirements. Your investments requirements for example are going to be recorded at fair market value, fixed assets stay the same.

Ms. Youssouf said that I was asking about fixed assets. Ms. Tiso responded that from our perspective it is more for disclosure changes more than anything changing on the balance sheet. This is early adoptions, it does not really apply for this year's audit and that concludes our presentation.

Ms. Youssouf thanked them and turned the meeting over to Mr. Telano for the audit update.

Mr. Telano saluted everyone and stated that on page three of the briefing is the audits currently being conducted by the New York City Comptroller's Office. The first audit we will discuss is of the affiliation agreement between PAGNY and Lincoln Medical Center. The start date of this audit was July 19, 2013, we received the final draft report on June 1, 2015. The audit took almost two years to complete, the responses to the report are due on Monday, June 15th. Although the report states that PAGNY generally complied with its HHC affiliation agreement to provide services at Lincoln Hospital, there were numerous issues noted resulting in ten recommendations in total. The most significant finding was that \$1.9 million was paid inappropriately to subcontractors because there was either insufficient documentation to support the payments or the services were not provided according to the terms of the subcontractor agreements. The recommendation to that finding is, once again I am quoting, "PAGNY should recoup those payments in which they are unable to verify those services rendered". There are other findings in the report that I will summarize. PAGNY was paying subcontractors without a service agreement, the maintenance of the faculty practice plan bank

account was not adequately controlled or monitored, the audit of PAGNY's financial statements by an independent CPA firm were not completed timely or in accordance to their agreement with HHC, the recalculation of affiliate payments were not completed timely for fiscal years 2012 and 2013, and sessional payments were not consistent with the collective bargaining agreement with the physicians union. Overall, there were ten recommendations. PAGNY was responsible for responding to six of them while HHC was responsible for four of them.

Ms. Youssouf asked which ones was HHC responsible for? Mr. Telano responded that there were three recommendations regarding the Faculty Practice Plan (FPP) and the other was to make sure that PAGNY does their job related to the subcontractor agreements.

Mr. Campbell asked what is our response or plan vis-à-vis. Mr. Telano answered that we just received the response yesterday and right now we are going over them and they will be blue-sheeted tomorrow. Mr. Martin will receive them, along with Mr. Russo, it then ends up in Dr. Raju's office.

Mr. Youssouf asked what department is responsible for the responses? Mr. Telano said that three of the four responses for HHC is by Office of Professional Services and Affiliations and the other one is being given by Lincoln Hospital, the affiliation liaison there.

Mr. Campbell asked if the committee gets the responses? To which Mr. Telano answered that they will receive the entire report. Those responses will be in the final report issued by the Comptroller's office and they attach the final responses from us. But they will be disseminated to executive management before they are sent out.

Ms. Youssouf asked if the entire report will be sent to the committee. Mr. Telano said yes.

Ms. Youssouf asked if there was anyone here from PAGNY? Mr. Telano responded that I do not think so. I think there has been improvement. We did the audit of the corporate PAGNY operations and had minimal findings, mostly recordkeeping related. In the two or three years that we have been doing the PAGNY audits, we have seen vast improvement in their operations.

Mr. Martin added that they still are not where they need to be, and I responded to you when we did the medical professional fair presentation but they are making continued improvement.

Ms. Youssouf stated that obviously internal audit is going to be continuously reviewing them to be sure they are getting to where other affiliations are with this.

Mr. Telano added that we are currently conducting the affiliation audits and in September's meeting we expect to be discussing those final reports. Mr. Telano continued on to page four which is the other audit being conducted which is closed now. It is not being conducted by the Comptroller's office. They decided not to continue doing the review of patients revenue and accounts receivable as we refused to provide all the protected health information and resolve the conflict they decided not go further. On the next page starts the audits that have been conducted by internal audits since the last meeting. First is the audit of patient transportation at Metropolitan. He asked the representatives to approach the table.

Ms. Youssouf asked them to introduce themselves, they did as follows: Keith Tallbe, Office of Legal Affairs and Supply Chain; Jeanette Torres, Assistant Director; Michelle Figueroa, Senior Associate Director; Susan Callymore, Associate Director; Edie Coleman, Controller.

Mr. Telano continued by stating that central office supply chain services contracts with ambulances who are responsible for bed-bound patients and ambulettes who handle patients who cannot walk or need medical assistance.

During the course of the audit there were 34 transportation contracts and we limited our audit to Metropolitan for four of the contracts. I will go over the audit findings and you can respond to it. The first one was about the background checks of the transportation drivers from Hope Ambulette had criminal history that we believe deem them unsuitable to work in a health care environment. The current procedure right now is HHC receives an affidavit from the vendor stating that the background checks were done. We visited the vendors ourselves and we looked at the background checks and determined that some of those individuals had history of robberies and assault and sale of controlled substances and trespassing.

Mr. Tallbe stated that I reached out to Hope Ambulette regarding the three drivers. The one driver who had not had a background check performed has had a background check performed and there is no criminal history for that driver. The driver that had several crimes listed is no longer working on HHC accounts and the third driver had a very old crime dating back to 1981, which was a first degree attempted assault. That driver has been approved to work according to New York State's 8 Point Guideline of when considering whether a criminal background should disqualify a person from employment.

Mr. Martin stated that I believe the issue is what are going to do moving forward in the future. Is that your responsibility to check and assure that the background checks are done prior to employing these people?

Mr. Tallbe said that this goes to the next finding – that is why I did not address it here. Mr. Martin said that I stand corrected, sorry.

Mr. Telano continued with the next finding which is the licenses and the certificates of liability insurance are not kept current, and as a result, there was a three month lapse that Metropolitan was using General Ambulette in which there was no contract signed. The other finding has to do with HHC paying for patients that were non-Medicaid patients. We reviewed 99 of these transactions. It was found that the first 38 of the trips were approved and paid for a higher rate than agreed to per the vendor agreement. Six of the invoices were paid for patients who were covered by Medicaid and HHC should not have paid the fee. There were nine instances in which there was no documentation within the medical records that the patient needed transportation and there was one instance in which there no record that the patient was at Metropolitan Hospital as of the date of service. Also, there were missing forms that they did not provide.

Ms. Youssouf stated that as Mr. Martin just commented, what is the remediation and who is going to make sure that it is in place. Mr. Tallbe answered that the remediation regarding General Ambulette is that specific provider no longer has a contract with HHC. As to the process going forward is that the agreement the vendor signed currently requires that they do a minimum background check in all New York State counties, as well as a criminal background check for any state the driver has lived in within the past three years. Any driver who is hired, they are required to provide us with a certificate stating that driver was hired despite their criminal background and why. That process has not been sufficiently monitored by supply chain currently and we are going through each vendor's certificate and their roster of drivers to make sure it will be and our deadline on that is mid-July.

Ms. Youssouf asked if we rely on the ambulette service to do the background check? To which Mr. Tallbe said that is correct.

Mr. Campbell asked if the background check is done every year. Mr. Tallbe stated the background check is performed by the vendor. So in terms of their periodicity of reviewing their own drivers' background, I believe that is annual. We have not firmed up what we will be requiring as a base minimum for the vendor's policies and procedures. But part of our process going forward is to review each company's policy and procedure for their background check and making sure it meets a base minimum that disqualified all drivers. That bare minimum disqualification standard is going to be based on New York State Justice Center. New York State Justice Center is a New York State agency for employment with certain other state agencies. Those state agencies use drivers in similar capacity that we use our drivers, one-

on-one unrestricted, unsupervised contact with patients that might have diminished capacity. We will be using that minimum to disqualify any drivers.

Ms. Youssef commented and asked that the only thing I'm worried about is we are not looking at the drivers. We are trusting vendors. Unless we do a thorough background check on the vendor and what their record is, how can we take any comfort in what a vendor says?

Mr. Tallbe responded that on audit's recommendation, we plan on doing an annual representative sample of audits of the vendors to assure compliance.

Ms. Youssef asked how does it work as far as liability with them goes. Let's say they have somebody who actually does something awful to a patient, where does the liability status stand, with HHC or with the vendor?

Ms. Keller asked if there is an event and the patient sues will the patient sue us or the ambulette? Ms. Youssef then asked who is liable?

Ms. Keller responded that chances are both. I do not know if we have an indemnification.

Ms. Youssef asked if we have any indemnification. Mr. Tallbe answered that we do. I know that all of these contracts have our standard terms and conditions which would require them to indemnify us for all acts of their drivers. Ms. Youssef asked legal to check and let the committee know the type of indemnification we have in instances like this.

Ms. Keller stated that I'm sure we have a good indemnification provision. The only concern we would have is that an aggressive lawyer will find some role that HHC had in the wrong and that will not be covered in the indemnification. If it is simply a matter of total involvement of just the ambulette company and that is our only connection we should be very well covered.

Mrs. Bolus asked who in central office supply has the responsibility to validate the vendor's taxi and limousine license? To which Mr. Tallbe responded that the contract manager who was managing the contract.

Mrs. Bolus then commented that six times he did not do what he was supposed to do. Mr. Tallbe answered that that is correct, but upon further review, the Taxi and Limousine Commission (TLC) license is not required for this type of service because it is a point-to-point service. Where a call is made ahead of time, a TLC license is not required.

Mrs. Bolus asked if it was something that we required? Mr. Tallbe responded no, it is not a separate requirement of HHC. Mrs. Bolus then asked why not and Mr. Tallbe said that because in the older forms of the contract it either was a requirement by TLC and that requirement has now changed.

Mrs. Bolus asked if it was required in 2010? Mr. Tallbe answered correct.

Mrs. Bolus then stated that someone did not do their job in 2010 because it was required. Mr. Tallbe commented that it was not done on a periodic refresh basis. It was done upon initiation of the contract.

Ms. Youssef asked do you understand what we are saying? I am a little concerned because your answers to me seem very vague and I am not finding a lot of comfort in what you're saying. Especially because I just asked about liability insurance and it says there was not any validation of the certificate of liability insurance of the vendor. So I would really appreciate if you could in fact give to internal audit, and Mr. Telano give to us, some kind of firm specific plan that you have in place to make sure these kinds of things do not happen.

Mr. Tallbe stated that I misunderstood your question. I thought the initial question was just about the liability under the contract. But if we're talking about the liability insurance, the liability insurance plan going forward is that our third-party vendor, Willis Insurance, will be receiving a copy of each vendor's contract along with the insurance requirements stated in the contract. They will then file for the certificate to make sure it is compliant with our insurance policy and follow the expiration of all those policies.

Ms. Youssouf then commented that for each question we had multiple ones to get to an answer. So that does not give me a lot of comfort.

Mrs. Bolus stated and asked that this says going forward, it does not say anything about what you did before. I do not understand why it is all going forward. Why nothing was done beforehand. That is what I am curious about. Mr. Tallbe responded that I have only been in the supply chain for a year so I cannot answer the previous history.

Mrs. Bolus asked if no one else in your organization has been there longer than one year? Mr. Tallbe responded that Ms. Torres has.

Mr. Martin then added that the supply chain was just created two years ago.

Ms. Keller then stated that I think Mr. Tallbe is making an effort to address the issue of mediation and how we can be certain these things will not occur in the future.

Ms. Youssouf then asked that prior to that then some of these issues that occurred were not done by central office because some of them go back to 2010 and 2011 so that was at the hospital; is that correct? Mr. Martin responded yes, I guess so. Supply chain was created two years ago, prior to that I guess it had to be at the hospital.

Ms. Zurack commented that everything that is been said to my knowledge has been accurate but it is one of these nuance situations where there was a central office materials management department that did do central contracts. So, even though it was not as robust as the current function, it did exist; and maybe part of the reason we made it more robust was for a lot of the things you're finding.

Ms. Keller stated that I just want to say, the insurance program is one of these new more robust efforts that is being made in central office. It is really a great effort that we will not have these terrible lapses anymore being exposed.

Ms. Youssouf stated that I think we need something that this great effort that's been developed so we have an idea of how it's going to be prevented. Because our biggest fear in this committee is that in fact something will happen and we will then be facing a giant lawsuit and what do we do? I'm sure you understand the concern, and obviously none of you were responsible for all of this that happened but you are responsible now.

Mr. Martin said that I am ultimately responsible – we will make sure it happens.

Ms. Youssouf thanked them and Mrs. Bolus asked when do they get back to us? To which Mr. Telano answered that we will do a follow-up audit and if the findings are negative we will have them come back. If they are positive or we see they have taken action to correct all the deficiencies we just send out a report saying everything is fine and you do not have to come back.

Mr. Telano continued and stated that moving on to page seven of the briefing – this was an audit of research protocols at Queen Health Care Network and asked the appropriate representatives to approach the table.

Ms. Youssof asked them to introduce themselves for the record – they did as follows: Toni Lewis, Research Administrator; Dr. Glenn Martin, Associate Dean at Mt. Sinai; Kiho Parks, Associate Executive Director; Imah Jones, Senior Director; Ross Wilson, Senior Vice President/Corporate Chief Medical Officer.

Mr. Telano stated that when we conducted this audit there were 101 protocols for the Queens Health Care Network. We selected 20 for review, our findings are a reflection of those 20.

The first finding is that the participation of human subjects in the research studies were not documented in their medical records. The second one was that three of those 20 that we reviewed, the research projects, they are forwarding 90 percent of the expenses reimbursed to HHC by the research project sponsor, they were forwarding 90 percent back to Mount Sinai and no documentation at the time of the audit could be provided substantiating the reason for this practice and the purpose of these payments to Mount Sinai. The third issue we noted, this is in line with Dr. Raju's mission to stress the positive aspects of HHC. One of the goals of internal audit is not only to look at internal control and efficiency of operations but also to ensure that the mission of the Corporation is being adhered to. We believe that this was an opportunity because there were only good findings in the research area and this was an opportunity to stress those things and publicize the results of these projects. So we recommended that that be done more regularly. The fourth finding is that we noted that the CO research administrative staff at the central office, was not documenting their invoicing and payments on an efficient basis. There were also contract agreements that could not be found or partially could not be found during the audit. The fifth finding is that the Queens Health Care Network research coordinator, who is an HHC employee, reports to the Mount Sinai Associate Affiliation. We were concerned about this because this research coordinator is a member of the Facility Research Review Committee, and at this committee they decide the feasibility of the projects. We felt that the independence of this individual was concerning as she would be voting in favor of Mount Sinai maybe more than HHC. I'm not saying it is happening but it is a possibility. The sixth finding is that the Queens Health Care Network does not utilize the automated system used by other facilities to monitor their research projects. The last finding regarding this audit is that the central office research administration does not monitor regularly the grants during the life of the grants. They provide an initial approval. However, they do not control and monitor it on a regular basis after the initial year. Please feel free to respond.

Mrs. Bolus asked that the people who are part of the research project, while it was not put in their records, did they all sign? Everybody clearly understood what they were part of? What research were they part of? Dr. Martin responded absolutely. Mrs. Bolus then asked why a copy was not put in their folder? To which Dr. Martin answered that that is because we have an electronic system at Queens Hospital. The particular PI misunderstood the capabilities of the QuadroMed system that was built for him and did not enter the information in the system. We have since modified the system to make it clearer where that information should go. As far as I know at last look all of it was going in. It was not a question of consent. Nor is it a question of them filling out the appropriate research forms or doing the research testing or anything else. It was paper records that were not integrate into the electronic system fully. We have corrected that issue. It was isolated to endocrinology cancer, which is actually the largest research enterprise that we have that does not have that problem. It was one-of event and we have taken care of it. We appreciate that audit picked it up so we could correct it.

I can address the publicity issue, again in my IRB hat, I am always a little bit leery about publicizing research in terms of marketing because the federal regulations require that any direct contact or recruitment is under the control of IRBs. Therefore it is a little bit dicey about what you mean when you talk about that. We have no problem whatsoever about discussing the contributions at Queens Hospital and Elmhurst Hospital has made to the research enterprises. There are a couple of things cited in the report where actually one of the things that Dr. Kemeny has at Queens, is a grant specifically from the Feds looking for minority recruitment and retention within research projects. Which she has actually been doing. What we are actually able to provide, which a lot of other research institutions are not, is a diverse population.

One of the advantages of living in Queens and working there, and the advantage of years' worth of efforts, and I believe Mr. Martin knows this from his days at Queens, of trying to educate both the personnel and the community. Certainly tooting our own horn is something we probably do not do as well as we could. We will try to improve that. One of the issues also has been, quite honestly, as you probably know, the 30 or 40 year old board resolution having to do with research has been rewritten and signed off by Dr. Raju and approved by the board only I think a month ago which does address some of these. I am pleased to say that Dr. Kemeny and myself and others were very much involved in that committee over the years trying to make the research enterprise throughout all of HHC more robust going forward. It is something that we are aware of, we are trying to address. There is also concerns about projects that are open with no one being enrolled. I want to briefly point out that especially in cancer, if you are looking for people who unfortunately are so sick and they have a certain stage, a certain ethnicity and a certain failure rate, you are going to open up the project almost hoping you do not have too many people in it. Unfortunately at Queens we do tend to get late stage surgical cancer.

There are some projects that are going to be open with no one. Which is almost a good thing because no one was sick enough to have gotten into the project. We are also going to have projects that are closed to enrollment for years because we have two, three, four, five years follow-up that is going to occur afterwards. You still have to keep those open in your books. Then you have a situation where you are going to end up having data analysis and scrubbing. That can take two years where you are still keeping something open. It looks like there is no activity for a lot of projects when in fact there is ongoing activity at a low level. Or we are looking for somebody who can come in. At the point of annual review by IRBs, and in our shop it's mainly Sinai and BRANY, the IRB has an obligation to look over the conduct of the research for the prior year.

One of the things we do look at is enrollment, if you are not going to enroll enough people to be able to get to the end that you said you had given us a power analysis that you could come to a conclusion, then we will indeed push back because if you are doing research that cannot come to a conclusion then there is benefit to anyone.

Ms. Youssef stated that I appreciate everything you are saying. I think the point was that if something really good happens as you recognize the report said, it would be a good idea to kind of work with perhaps even central office to get the information to at least other HHC people, and obviously you all recognize that and that is something that can be done. How about the expenses being forwarded to Mount Sinai as opposed to being reimbursed to HHC?

Mr. Park responded that during the audit period we looked at how many research checks we received and how many checks are processed through Mount Sinai. To put this in perspective, we received 31 checks and we processed these other four checks that we are talking about.

Ms. Youssef asked if you received 31 checks, what did you do with the rest of the checks? To which Mr. Park answered that the rest of the checks stay with the network as a revenue and other checks are given to Mr. Sinai for the PI's direct expenses. Those are the 90 percent, after I keep our network overhead, direct expenses for PIs such as patient incentives when they enroll patients, part-time research coordinators are paid out of those.

Mrs. Bolus asked what is the amount you are talking about? Mr. Park answered \$24,000 that was paid to Mount Sinai. Mrs. Bolus then asked how much did you receive? Mr. Park said \$66,000.00. Ms. Youssef said that is not 90 percent. Mr. Telano added that our sample, which we did 20 out the 101, and of those 20 we came across three of those grants in which \$27,000 was received from the sponsors of HHC and in turn HHC cut a check to Mount Sinai for \$24,000. The other checks that might be totaling up to \$60,000 may not have been in our sample.

Mrs. Bolus asked if we received any portion of the rest of it? Mr. Telano responded that I cannot account for the other. It may not be in our sample. For those three grants there were four checks totaling \$27,000 of which \$24,000 of it was returned.

Mrs. Bolus asked if we have a mechanism where we know where every dollar goes?

Mr. Park said that the research checks come to us in two ways, some grants are sponsored by the central office. I get it from central office administration and they inform central office finance grant saying we received a check and they post it to our research account. If you look at the 6821 call center they list all the recent checks we received. If our network gets it then I forward it to central office finance to put it into research. The record of what we receive is there, and what was audited was the OTPS system, they looked at four checks that were written. Those four checks total amount the sponsor gave us was \$26,000 and the checks that we processed to Mount Sinai was \$24,000. That's the 90 percent of the amount that we received in the process.

Ms. Youssouf asked that your response was that a new form would be completed identifying all relevant information; is that correct? To which Mr. Park responded that I was not disputing the fact that we wrote over 90 percent of the amount we received to Mount Sinai because those are the direct costs for the PIs. But what the audit team, who spent with us for a long time, correctly identified was we did not have a formal process of when we process those checks. We formalized the transfer of money and Mount Sinai affiliation is going to inform us of how they are going to spend those monies and we formalized the process. They created the separate research account, which they did not have before, and they will bill us every three months exactly how much the money was spent. So we will have a complete accounting.

Ms. Youssouf asked if they have a complete record for each grant, how much you keep, and all those forms.

Mr. Jones added that previously, as Dr. Martin pointed out, we did not have any formalized policy of procedure on this issue. For example, they have a process, each facility have their own process as Queens Hospital just described. Now we have a formalized process in place. Mrs. Bolus then asked since when?

Mr. Jones answered since November when the board approved. Again, created from before the policy and procedure was approved. Now we have all this process in place and it describes all these mechanisms happening now established and central office is in charge of monitoring, working with them and making sure all policies and procedures are followed. They report on a monthly basis so all of us know we are on the same page. This information was not available when the audit was conducted, but now we have the information.

Mrs. Bolus asked why did you not have this procedure in place as just now since November. Mr. Jones responded that the last policy and procedure, as Dr. Martin mentioned, was in 1991.

Mr. Martin added that we have been working on this policy and procedures for many years. Then Mrs. Bolus asked did it take three years? Mr. Martin said that all the stakeholders had to agree – this involves the IG, Internal Audit.

Dr. Wilson stated that the research agenda for us over the last four years has been a complicated one. The first thing, the people deserve to be researched, studied more than they have been. So we have to get ourselves in a position so we can provide research. Secondly, the processes we had in place were inadequate and we had significant problems. So we went very quietly until we rebuilt the infrastructure. That ended to two things, one is this document, it is 176 pages, which the board approved in November, and it was finally reviewed by other parties, including the IG, and was signed and released on April 29, 2015. This sets in place policies and procedures around all of the issues raised and sets a framework for them to be addressed. As Dr. Martin said, he and many other key leaders across the Corporation actively participated in the development of this work program.

The second thing that is important is that this research approval process was inadequate. It was a software-based system that the Queens Network did not even participate in. They were on paper entirely and we had replaced that

over the last 12 months with a new approval and tracking system. So that we can track each single application and the status of each grant through the process all the time. That process is called STAR, the rollout of that has only been completed over the last two months or so. Now we have a new a set of rules and regulations. We have a platform for tracking, and I think we have a much clearer role delineation around everybody's function, central office' s role, the facility's role and the facility research coordinator's role. The next phase, is hopefully getting us to a place where we were -- I guess another evidence that I was not happy with where we were is that I asked Mr. Telano way back in 2011, 2012 to come in and review a lot of our processes because of my concerns about the inadequacies that we had and Mr. Telano kicked off this process for us.

The next step is to reconstruct a new corporate research counsel. One of the charges of that counsel will be the promotion and promulgation of the outcomes of the work pertaining to one of the other recommendations. Because there are ways to do that but at the moment mostly they are in professional journals in a narrow way that do not necessarily get the information to all the stakeholders and often do not necessarily reflect on HHC. I think we have made huge steps and progress. We are not quite there yet but we are pretty close. I think over the next 12 months I would welcome Mr. Telano coming back and reviewing again to make sure that firstly we have the policies and procedures right and secondly that we are adhering to them.

Ms. Youssouf asked if the oversight and monitoring of the research protocols and payments is covered in the policy and procedure. Mr. Jones responded yes, this is well addressed. I am going around to facilities to amplify it and make sure we understand what is in there. I provided the training and the workshop working with other finance folks to make sure they understand and will carry out the process.

Ms. Youssouf then said that said that I do not understand why an HHC employee reports to Mount Sinai.

Dr. Martin said that quite honestly, a question of convenience and better functioning within -- basically the way we are set up Ms. Lewis is in fact the person we are referring to. She at this point reports to Mr. Harris, who is the affiliation administrator for Elmhurst. One, because they work next to each other. Two, Ms. Lewis would otherwise be reporting to myself or Mr. Larry Reich would be the way you would normally do it because we are the heads of the research committees. It made more sense to let an administrator do it because frankly they are going to be around and easier to take care of, from at least my perspective. We are talking about vacations and other associated things. It just ended up being a question of convenience and the like. That is basically how it got started, the actually working relationship are with two chairs of the Library Research Committees as well of course with the office downtown and with finance and everything else, you know, she ends up dealing with half a billion stakeholders a day.

Ms. Youssouf asked if she should reporting within HHC. Dr. Wilson responded that if the person is representing HHC's interests they should be reporting within HHC. Ms. Youssouf then asked that that means a change. Dr. Wilson said yes.

Dr. Martin commented that I believe this report had been discussed internally at the Queens Health Network at pay levels above me and it was felt it was better for the operation to do it this way. If there is a need to switch we will switch it back again.

Mr. Park added that there were extensive discussions within our network and we conversed with downtown as well.

Ms. Youssouf said that from an Audit Committee standpoint we cannot be paying somebody not to report to HHC.

Dr. Wilson added that it will happen, but can I just add in the affiliation environment in which we operate this is not a clear cut issue in that we have a number of people who are technically employed by the School of Medicine at Mount

Sinai who operate at Queens Health Network in the interests of HHC through a contract on every day and routine matters.

Ms. Youssouf stated that this is not a contract. This is an HHC employee. Dr. Wilson that we will make it happen, but the audit issue points out the complexity we have. We will find out and report back to you.

Dr. Martin stated that I used to be service line director for the department of Psychiatry for the Queens Hospital Center and HHC employees reported to me all the time as I was service line director and I would report up to the medical director or to Mr. Martin or the Executive Director. It is not all that unusual especially out in our neck of the woods where the affiliation and the Corporation get along well enough that we can do that. I understand what you are saying. If it needs to be changed we will change it.

Mr. Martin said that it is the optics. To which Dr. Martin added that it is not anything beyond that.

Mr. Telano continued by stating that on page nine of the briefing, this is an audit of vital records, which is basically birth and death registrations and this was conducted at Jacobi Hospital. He asked the representatives to come to the table and introduce themselves. They introduced themselves as follows: Barbara Wikoren, Associate Executive Director; Janice Halloran, Network Senior Associate Director; Neville Trowers, Associate Director.

Mr. Telano said that death and birth registrations are input into the software system provided by the Department of Health, Electronic Vital Events Registration System (EVERS). In our review we found numerous input errors as there was no review process by the appropriate departments. We also found that the individuals who are allowed access to EVERS was not current as terminated employees and inactive employees still had access. We also noted that the biometric devices, which are provided by the Department of Health, to certify the input into EVERS was not controlled. Originally the Department of Health provided 17 devices to Jacobi free of charge. During our audit we could only locate four. When additional devices were requested, the Department of Health had changed their policy and now they charge us for them. So, three of the devices needed to be purchased. We also found two devices where we could not determine whether the Department of Health gave them to us. According to their records they did not, and we could not find any invoices as to whether they were purchased. We are not exactly sure how they were obtained. There was also a lack of segregation of duties as registrars fully controlled the process of birth registrations. Lastly, the certification of termination of pregnancies was not being done timely. We found spontaneous terminations were being done between 6 and 33 days and induced terminations were done between 6 and 21 days.

Ms. Halloran said that my segment of this are the terminated pregnancies induced. Seven of which were found to be beyond the five day window. Six of those were at the six or seven day window. The one that is recorded as 21 days was truly done in the five day window but there was one clerical error when the person who entered it put in the wrong date. So the date would say 21 days. It was actually done within the five. The majority of those that were late were because they were entered within the five day window but they were not signed off within the five day window. The majority was attributed to one provider and that is being remedied, they are more cognizant of the need to sign off. We have also enhanced our log. We have actually enhanced that and now it is gone over to an associate director of women's health OPD, who reviews that weekly with her staff to ensure that it is complete. It is signed off, it is in a logbook, it is electronic but then there is a signed copy that goes into a logbook weekly just to ensure that we have everything done within that five day window. Primarily our issue was the certification by the provider.

The Spontaneous Termination of Pregnancies (STOPs), most of those are done in the Labor and Delivery department (L&D). Occasionally they are done in the Termination Unit, but most are done at L&D. The ones that were noted in the report were from women's health were the I2Ps.

Ms. Wikoren stated that having acquired the department in late 2013 some of these plans that were in place were obviously antiquated and I was not familiar with them. When the audit team came and reviewed them this was business as usual.

Mrs. Bolus asked if she was talking about EVERS. Ms. Wikoren answered no, talking about the policies and procedures for birth and deaths via the admitting department. The EVERS policies and procedures are far looser which I learned by meeting with the EVERS personnel. It requires us to be that much stricter because they are not. Having gone through the audit, we realized that the whole process needed to be revamped. We created all new standard work, there are admission officers who now function as admission officers, and they certify every birth and every death before it is submitted. All the documents are reviewed by me personally before they go into the system. There is a purchasing standard work and a relinquishment standard work for the biometric devices. As we purchase them we log them into a database. As we retire them we log them in to a database and they are followed through the relinquishment process. There is also a hierarchy change in the admitting department as the original individual no longer works in that particular area. We monitor the flow of every birth and every death as they proceed in real time. Every document has been revised to include the physician of record where they must sign and indicate they are certifying either the birth or death on the paperwork, not just in the EVERS system. There is a co-signature by the admissions officer and myself.

Mrs. Bolus asked if the person who signs the death certificate is the same person who puts it in the computer and signs. Ms. Wikoren responded that it depends on who is working on the shift. The person can create and certify but they cannot submit it through the EVERS system without the admissions officer reviewing it and then solidifying the process.

Mrs. Bolus then asked what hours are they on duty? Ms. Wikoren said that we have folks 24-7.

Mrs. Bolus stated that there should be no problem with them finding someone when they put the information in.

Ms. Wikoren stated that some of it happened while I was there but there was a different admitting director in charge of admitting at the time. I was the senior associate director for the department. I did not micromanage the department, the department is now being micromanaged.

Mrs. Bolus asked if someone does not log into this system over 365 days, why would they log into it now?

Ms. Wikoren responded that there is usually a rotation schedule, so that physicians may not be on that rotation where a death would occur. They could be on a research rotation, on an EMS rotation or out doing a presentation schedule. Unfortunately we have to keep them in the system because there is a possibility that in two months they may return to a rotation that would require them to certify a death and you them to be active. What we do is we have a very tight connection now with our Medical Staff Affairs Office where in fact daily I receive a list of folks who are on FMLA, who are resigning or being on a leave. If you are on a leave, I am taking you out of the system. If you are resigning, I am taking you out of the system. If you are terminated, I am taking you out of the system. If you come back, I will recertify you.

Mrs. Bolus asked about other devices that was supplied by the Department of Health (DOH). Ms. Wikoren said that all of the devices at that time were supplied by the DOH. The DOH is not in the business of giving us biometric devices any longer, they would like us to purchase our own. There is a handful of vendors that the city has a contract with in which we can purchase them. There is a purchase order attached to anything new that has been purchased.

Mrs. Bolus asked how did you lose 13 out of the 17. Ms. Wikoren answered that I do not know where they were. They were scattered throughout the facility. They may have been discarded by the previous administrator.

Ms. Youssef stated that I think the main thing now is that you come in, fix this stuff. I am very very happy to hear. She thanked them for coming in.

Mr. Telano continued and stated that the last audit if of medical surgical inventory controls at Woodhull and asked for the representatives to approach the table and introduce themselves. They introduced themselves as follows: Henry Kuzin, Senior Associate Director; Jaime Gonzalez, Director; Ivan Figueroa, Assistant Director.

Mr. Telano stated that when we conduct this type of audit the first day we do a surprise count and we counted 104 items. We only found 12 discrepancies of which eight could be accounted for. Overall we felt that there were only four discrepancies. As you can see, we do not comment on that at all because I believe the inventory is controlled effectively. The only comments we have is about security issues, the doors were left open. A piece of cardboard was over the lock so people could enter the side doors. Individuals had access to the warehouse that should not have. The cameras were not working on the loading dock. One of the other issues had to do with access to passwords to certain systems, the employees were sharing the passwords. The other findings had to do with the commingling of the department's inventory with other departments. There was no indication that the materials management department was routinely performing periodic inventory accounts.

Mr. Figueroa commented that we were performing the cycle counts. What we were not doing was filing the documentation for those cycle counts. We did not realize that that was a requirement. As of the time of this audit we are maintaining the documentation for those cycle counts. As far as the exit doors, all the exit doors are maintained closed at this time. The supervisors have been advised, as well as staff, all doors must be closed at all times unless staff are entering or exiting the department. We did create a log to monitor the staff that are accessing the storeroom and identify which supplies are taken. We have a storage room that houses supplies for different departments, and we are now monitoring who accesses it. We have a supervisor who walks with these individuals to assure they are getting the supplies and exiting the department once they have gotten those supplies. The user names for the various programs, the sharing of user names for those various programs has been disallowed. Proper access has been required through each of the staff to access these programs.

Ms. Youssef asked if the cameras were fixed. Mr. Gonzalez responded that there were six cameras that were replaced with high definition digital cameras. Three inside the loading dock, two outside of the loading dock and one in the main corridor that leads to the loading dock and also it gets a bird's eye view of the exit doors from the loading dock. All cameras are functioning right now and recording live.

Ms. Youssef asked what took so long to fix them? To which Mr. Gonzalez answered that we do a monthly check of our system and we identified that those cameras were down. When I identified them, we reached out to material management, did an assessment with them and informed them the cameras were down. We gave them a quote of how much it was going to cost. They put it through the process, generated a purchase order. The vendor came in with his technicians and replaced all the cameras.

Ms. Youssef asked when did you put the cameras in? Mr. Gonzalez answered that I believe about May 5th or May 4th. Ms. Youssef then asked that it took from October 26th to May 4th to get new cameras. Mr. Gonzalez responded that that is correct.

Mrs. Bolus asked was it a vital area? Mr. Gonzalez responded that it is a vital area. Mrs. Bolus then asked did you go up a little bit higher and say we really need this?

Mr. Gonzalez said that I reported it to material management and what we did in the interim we had security patrols that patrol the building. We paid specific attention to that area, during the day tour there is a lot of personnel that

works there. During off tours, weekends and the midnight tour we had constant patrol that goes for that area and since then we have not had one issue.

Mr. Martin asked can you explain why it took six months to obtain cameras. To which Mr. Gonzalez responded that once we identified it we replaced it as soon as we could.

Ms. Youssouf stated that if you were having problems there is a central office you could go to and say I cannot get this fixed or go to the Executive Director. At the worst, on top of that, no video cameras and doors that were open. It seems like people were sleeping or something. People could go in and out and do whatever they wanted and the storerooms were open. This does not sound like very tight security management.

Mr. Figueroa added that that is correct, we have addressed the issues. As far as the cameras not working, the material management department was not aware of this until the audit took place. When we did our monthly inspection, based on our system sometimes our system will go down. Those cameras sometimes were working and sometimes they were not.

Mr. Martin commented that one good thing is that you have a lot of very noble staff because you have all these security lapses and your inventory was intact for the most part.

Mr. Figueroa said that we did not see anything in the inventory to say there is a problem, what is going on.

Ms. Youssouf commented that you are missing the point obviously. The point is that all of this stuff should be checked on a routine basis. You should know that these doors are open. You should fix them immediately, there is no reason, and if the cameras are broken you should get them fixed. This is a hospital, drugs in it. It has vulnerable people in it. We are supposed to be protecting our patients, and working doors that lock and video cameras seem to be like the least we can do. I hope you have protocols in place and you know Mr. Telano is going to be back there when you least expect it. I hope you have protocols in place that somebody is going to be held responsible over checking on this stuff on a regular basis. I cannot imagine that nobody noticed no doors were locked. It is mind boggling.

Mrs. Bolus asked if somebody is supposed to be watching these cameras. Mr. Gonzalez responded that the cameras are recording live as we speak. Mrs. Bolus then asked if you have bank of cameras. Mr. Gonzalez answered that we have a main monitor in the command center which monitors high patient care areas that is the loading dock areas.

Mrs. Bolus asked who was monitoring them? Mr. Gonzalez said that sometimes they were working and sometimes they were not working. When they were working we were able to see, because it is an analog system, sometimes they would go down and sometimes they would go up. We could not put a Band aid on it any more so that is why we decided to go with a new camera system.

Mr. Martin said let me ask Rick Walker, I ask you to be responsible for assuring me and this committee that not only this issue but all security issues within Woodhull. You need to do an assessment that they are taken care of and address it very quickly.

Mr. Walker said we read the findings and we always work closely with Mr. Telano's office. We actually encourage Chris to come out. Then Mr. Martin said what I am saying to you is that this one issue gives me pause to think about other issues that may be going on within your institution that need to be addressed. I am asking you to do an assessment to assure us that everything is being taken care of.

Mr. Walker stated that the point I was going to make, I was just highlighting Mr. Telano's work, yes, at the senior levels we have discussed this, as we do with all audits, and we were concerned with some of the findings, particularly with

respect to the cameras. We have a very old system as identified. It is this old analog system that needs to be upgraded. We are looking at assessing what it would cost Woodhull to revamp the entire surveillance system. However, when we looked at the findings in terms of the actual losses sustained they were not significant. The point is that what was significant for us was that there was constant lapses. For example, when someone chucks a door open that is serious to us. Unfortunately it does not just happen in materials management. It is a common occurrence throughout the hospital that is something we deal with on a routine basis. In this particular case point, we are sitting down with Lisa Scott-McKenzie, who has operational responsibility for this area. They have come up with corrective actions and plans. Then they will report back up and then we will come back with a plan that best meets the operational needs of the institution as it relates to surveillance and practices in critical areas.

Ms. Youssouf and Mr. Martin thanked them.

Mr. Telano stated that that concludes his presentation.

Mr. McNulty introduced himself as Wayne McNulty, Senior Assistant Vice President and Chief Corporate Compliance Officer and saluted everyone and stated that he wanted to provide the Audit Committee with an update of the Corporation's own analysis with HHC's compliance with the HIPAA security rule analysis requirements. He reminded the Audit Committee (the "Committee") that back in February 2015 he reported that HHC has a requirement to satisfy the security rule with respect to doing an assessment of all the potential risks and vulnerabilities to the confidentiality and integrity and availability of electronic protected health information that is accessed, stored or transmitted by HHC's systems and applications.

He further reminded the Committee that our review of HHC's adherence to these HIPAA security rule requirements found that the inventory of HHC's information systems and applications that access, store or transmit EPHI was a work in progress and therefore was not comprehensive at that particular juncture back in February. He added that although HHC's Enterprise Information Technology Services ("EITS") has taken numerous steps and significant measures to enhance and maintain the confidentiality of the security, integrity of HHC information systems, further steps were needed to meet the eight point prongs of the risk analysis that were promulgated by the Office of Civil Rights.

Mr. McNulty stated that in April Mr. Sal Guido, the Acting CIO and Senior Assistant Vice President, informed the Committee that a solicitation for a vendor had taken place. Mr. McNulty announce that a vendor has been selected. In sum and substance, he advised that the vendor would report to him on audit issues with respect to performing audits in IT and information governance. He advised that the vendor would be performing a: (i) risk analysis on all of our high risk applications; (ii) HIPAA audit protocol; and (iii) a number of other information governance audits. He stated, in summary that IT was working on a statement of work with the selected vendor and that the Committee would be provided with a follow up report on the same in September. As to the scope of work, he added, we are hopeful that the vendor will already be started so we will have some findings to report back to Committee.

Mr. McNulty moved on to the external audits and discussed the status of an ongoing review by the Department of Health and Human Services Office of Civil Rights ("OCR"). In summary, he reminded the Committee that, in April 2014, OCR commenced a review of Metropolitan Hospital's Center's ("Metropolitan") meaningful use and access to individuals with limited English proficiency ("LEP"), which included a review of the privacy and security of PHI (protected health information) of individuals with LEP. He advised the Committee that HHC provided a response to OCR's review and OCR thereafter requested numerous follow-up responses and HHC followed back up with OCR in July 2014 with regard to HHC's risk analysis. He further advised the Committee that HHC was recently informed by OCR that they were going to schedule a walk-through of Metropolitan. In sum and substance, he advised the Committee that he believed the walkthrough was scheduled to take place in a week, and that OCR's focus would be the LEP program at Metropolitan. He informed the Committee that directly after the Committee meeting he was scheduled to participate in a telephone conference with OCR with HHC's Office of the General Counsel and Office of

Information Technology Services to discuss HHC's risk analysis status. In summary, he informed the Committee that: (i) OCR was scheduled to have their data security expert on the phone; (ii) he expected OCR to have a number of suggestions with regard to HHC's information governance program; and (iii) he would report the content of said telephone conference with OCR back to the Committee in September.

Mr. McNulty then moved forward to discuss privacy incidents and related reports. He stated that since the last time the Committee convened there were three breaches that he would like to discuss. He explained that two were discussed in a previous executive session, and one was a new breach. Starting with the new breach, Mr. McNulty advised the Committee that a week ago HHC began to notify almost 4,000 patients who received services at Metropolitan about the disclosure of some of their personal and protected health information when a Metropolitan employee sent an email file that contained protected health information through his personal email account. He advised that all affected patients were offered one year of free credit monitoring services. He further advised that the Department of Health and Human Services ("HHS") was notified. He added that notice was provided to the media as required under the HIPAA regulations. He informed the Committee that the employee (who responsible for the breach) was terminated from employment at Metropolitan Hospital and HHC.

Mr. McNulty then discussed one of the breaches that was previously reported in Executive session. He stated that in late April HHC notified 90,000 patients about the disclosure of their protected health information when a former employee accessed their information six days after being separated or after being separated from services from a Network and the Corporation. He informed the Committee, in summary, that HHC provided credit monitoring to all 90,000 patients at a cost of \$220,000 to the Corporation, which is being charged back to that particular Network (the Network where the former employee was previously employed). He stated that notification was provided to the media and HHS. He commented that, since this was an ongoing investigation, he could not provide additional comments with regard to any further findings.

Mr. McNulty then discussed the second breach that was previously reported in Executive Session. He advised the committee that back in April HHC notified 3,300 patients at Bellevue Hospital Center ("Bellevue") when an employee there sent PHI to a relative to help her with an Excel spreadsheet. He told the Committee that employee has since been disciplined. He advised the Committee that HHC provided: (i) credit monitoring to all affected patients; (ii) notification to the media; and (iii) notification to HHS. In sum and substance, he advised the Committee that all these incidents described in the subject report were detected and discovered through HHC's information governance system, which monitors all email communications that leave the Corporation. He explained that HHC now has a system in place that these emails are blocked and screened before they can even go out. He further explained that if any emails are sent to a personal email account or to a vendor that is not known to the Corporation, it automatically gets stop in its tracks and we have to review it and the sender has to provide justification why the information is being sent out.

Mrs. Bolus asked if that is in all hospitals. To which Mr. McNulty replied that all of HHC - - every single facility. He stated that at the next Committee meeting he would provide an update on the numbers and the significant measures that have been made. In summary, he informed the Committee that he met with all the senior vice presidents yesterday and informed them of all the activities that have taken place and they have ensured Mr. Martin and myself that they will take measures within the facilities to make sure the employees are transmitting (information) safely and in accordance with HHC rules.

Mr. McNulty moved along to the monitoring of excluded providers. He informed the Committee that on Tuesday (June 9, 2015) the OCC received one report of an excluded provider at the Northern Manhattan/Generations Plus Network. He stated that the matter was under investigation. He stated that he would provide an update to the Committee on the same at the next Committee meeting.

Mr. McNulty discussed the Revision of Corporate Compliance Policies and Procedures. He reminded the Committee that various policy procedures were being revised, particularly the Corporation's code of conduct. Dr. Boufford recommended that I reach out to Pam Breyer, who is the CEO and president of Maimonides Medical Center. I did reach out to her for her insight. They have a very good code of conduct in place there and I will be following up with them.

Mr. McNulty then discussed the Compliance training update. He stated that at the last Committee he informed the Committee that the health care professional module had a 20 percent completion rate. He stated that the completion rate was now up to 47 percent. He advised that the physicians' module was at 27 percent in April - - and it was now at 39 percent. In summary, he stated that at the senior vice president ("SVP") meeting yesterday he informed the SVPs that he would be providing them with the names of all physicians and health care professionals that have not completed their training to date and that they would, in return, ensure that the training is completed in a very expeditious manner.

Mr. McNulty then continued by discussing the corporate wide risk assessment process. In sum and substance, he stated that, as he previously discussed, on a biannual basis the Corporation performs, through the Office of Corporate Compliance ("OCC"), a Corporate-wide risk assessment on all the risks and vulnerabilities that could affect operations of the Corporation, particularly in the area of fraud, waste and abuse, but in all operations, privacy, record management and HHC's adherence to the conditions of participation for Medicaid and Medicare. He stated that the OCC prepared a list of predefined risks that would be shared with senior leadership throughout the Corporation and all the various compliance committees so they can consider the same. He explained that, with regard to the Office of the Inspector General, they would be looking at their: (i) two work plans; (ii) fraud alerts; (iii) compliance program guidance for the various providers; (iii) and their special advisory bulletins. He added that they would also look at the Medicaid Inspector General's Work plan, the Medicaid and Medicare conditions of participation, and the Department of Health regulations, as well as the New York State compliance program regulations and guidance from the New York State Office of the Comptroller on the practice of internal controls.

He explained, in summary, that the OCC was somewhat delayed (with the risk assessment process) because for the first time this year HHS (Office of Inspector General ("OIG")) issued an interim work plan. He further explained that HHS normally issues a work plan in October and November and won't issue one again for a 12 month period. He stated that this year in May they issued an interim work plan, which was 80 pages long, so that the OCC has to go through that document and look at the particular risks which HHS has highlighted to make sure that is part of the risk assessment process. He stated that the OCC was hopeful that within the next week a document could be issued to the different compliance committees and the risk assessment process could start. He elaborated that once the process was over with, the OCC would go through all of the risks. He stated that the last time the OCC performed this process, 199 risks were identified corporate wide, which were prioritized and scored. He added that, in the end he believed that 18 work plan items were looked at. He stated that, this year, once the process was finished, he expected the (number of) risks to be higher (than the previous year) because the number of people participating in the exercise would be expanded. He explained that, once the risks are prioritized, he would come before the Audit Committee so that the Audit Committee can exercise the risk tolerance and risk appetite, which is under their purview. In the interim, he stated, from now to September he will communicate with the Committee and explain that process and how it will take place.

Moving along to section 8 – the vendor and contractor management. In May the members of my office, along with a number of members of senior leadership, met to discuss contractor and vendor management and governance throughout the Corporation, and included the head of procurement, Paul Albertson, Senior Assistant Vice President, Barbara Keller, Deputy Counsel, myself, and Sal Guido, Senior Assistant Vice President and acting Chief Information Officer and we discussed how information governance will be taking place throughout the Corporation as far as vendor due diligence and looking at vendors before they are procured. We also discussed the requirements under Medicaid

and Medicare for contractors. We discussed the Department of Health regulations, which are similar to Medicare regulations, which basically says that once you hire a contractor the hospital is basically responsible for everything that the contractor does. We were making sure that we have internal controls present to perform random audits as necessary. We are also going to look at compliance with STARK and anti-kickback statutes. We are going to make sure that with respect to any license agreements for space that they adhere to the fair market value for rental of space to comply with the STARK provisions and anti-kickback provisions. We are going to look at any affiliation contract. The smaller affiliation contracts - - the big affiliation contracts are all reviewed very carefully by outside counsel. We are going to look at the smaller affiliation contracts and make sure there are no provisions in there that put us at risk of violating STARK and anti-kickback statutes. We will also look at the business associate agreements to make sure that all of the vendors that have access to protected health care information actually have business associate agreements in place. The Office of Procurement has created a database to make sure that the business associate agreements can be readily identified. The work group will convene again within the next month or so to discuss the Deficit Reduction Act to make sure that all of our vendors are in compliance with the same.

Turning to page 16 of the report. I just want to provide the Audit Committee with an update of the Accountable Care Organization compliance program. On June 12, 2012 the board of directors, by way of resolution, approved the formation of the HHC ACO, Inc., which is a wholly-owned subsidiary public benefit corporation in order to establish an accountable care organization. The CEO of the organization is Dr. Ross Wilson, who is also the Senior Vice President of Quality and Corporate Chief Medical Officer of the Corporation. The medical director is Dr. Nicholas Stine and the Director of Operations of the ACO is Megan Cunningham. As of now the participants of the ACO is Coney Island Medical Practice Plan, Downtown Bronx Medical Associates, Harlem Medical Associates, Mount Sinai, Metropolitan Medical Practice Plan, NYU, HHC and PAGNY.

Turn to page 17 of 18 of the report. Couple of things that we want to make sure of with the participants. Turn to page 18 paragraph nine. The restrictions of patient inducement that the entities will provide that are part of the accountable organization. Not give or offer any gifts or any other remuneration to patients for their participation in Accountable Care Organization and patient avoidance, that the entities and providers that are part of the ACO are prohibited from avoiding at-risk patients, including those patients who have a high risk score for high cost due to hospital utilization are duly eligible or have a disability or mental health or substance abuse disorder.

Just turn to page 20. There are five key elements to the compliance program that we have to meet. Element one is the appointment of a designated compliance official. I have served as the chief compliance officer of the Accountable Care Organization (ACO). Element two is a development and implementation of mechanisms for identifying and addressing compliance problems, we have a reporting system. If there are any issues with the Accountable Care Organization they can report that to the Office of Corporate Compliance. We also meet with the ACO with respect to the risk assessment process. I will be working closely with the director of operations, Megan Cunningham, to make sure they are involved in the corporate-wide risk assessment process. Element three is a method for the ACO and participants and other entities to anonymously report activities and compliance complaints to my office. They can do that by our toll free hotline or email or regular mail or do it in person. Element four is compliance training. All ACO participants that are members of our medical staff they have access to our compliance training. They are mandated to do the compliance training, and there's a particular section in there that is dedicated strictly to the Accountable Care Organization requirements. And five, there is a requirement to report probable violations of law to a law enforcement agency and we have processes in place to do that.

Mr. McNulty moved along to page 24 and discussed the Delivery System Reform Incentive Payments (DSRIP) compliance program. He informed the Committee that in April 2014 the State finalized an agreement with the federal government to allow the State to reinvest over \$8 billion of the \$17.1 billion in savings generated through Medicaid redesign team reforms. He stated that, of this approximately \$6.5 billion was allocated for the Delivery System Reform Incentive Payments, which is the main vehicle that the State will utilize to implement the savings generated through

the Medicare redesign reforms. He stated that, DSRIP's purpose is to fundamentally restructure the health care delivery system by reinvesting in the Medicare program with the primary goal of reducing avoidable hospital use by 25 percent over five years. He explained that the compliance program for DSRIP mirrors the eight elements of the compliance program for all other risks. He informed the Committee that the subject elements were outlined on pages 25 and 26 of the report. He explained that these elements are similar to the same elements as the Accountable Care Organization. Mr. McNulty provided in summary that, the only difference between the providers that will be part of the provider network and HHC - - as the PPS lead in the provider network - - is that HHC will have to be involved somewhat with the training and education. He stated, in sum and substance, that HHC will have to make sure that participating providers have access to OCC's compliance systems to make complaints with respect to any misuse of DSRIP funds.

He advised the Committee that the Office of the Medicaid Inspector General (OMIG) basically said if you are a PPS lead you are required to "follow the money," Mr. McNulty explained that we have a responsibility to make sure the DSRIP funds are appropriately allocated and in compliance with any DSRIP programs requirements promulgated by the State.

Ms. Youssouf asked isn't that going to put an enormous additional work load on you?

Mr. McNulty responded that it will up the work load but added that as part of the DSRIP budget, we will have two compliance officers that will be dedicated to work on DSRIP activities. One will be temporary and if we need to continue have to that person on we will. We will have a permanent person that will be focused on this. The one key point is the training to make sure that people get trained and we can take a certification from them but OMIG requires us to do audits periodically.

Ms. Youssouf asked is the training going to be the same training as HHC training and ACO training. To which Mr. McNulty responded no. He elaborated further by stating that it will be similar in some parts but we will have to with respect to DSRIP outline the requirements of DSRIP. He stated that some of the providers are already certified under the Medicaid program as an effective compliance program. With regard to those providers, he stated that they already have their staff trained. He provided, in summary, that the training in question is more with regard to the smaller providers and that we will have to provide them information and make sure that they disseminate that information to their staff. They will not necessarily have access to our training systems. We will have to provide them with an overview of the topics that they should train their staff on and then audit periodically to make sure it is done.

Mr. Martin asked Mr. McNulty, in summary, if Mr. McNulty was talking about all of the partners that we have within DSRIP? Mr. McNulty answered yes.

Mr. Martin asked if their staff need to be trained. Mr. McNulty said absolutely, they need to receive materials from us.

Ms. Zurack asked if it can be by Computer-based training (CBT) or some kind of electronic form? Mr. McNulty replied that HHC can provide the training at once completely, but then that is a tremendous cost to do that. The alternative is you can provide them the information that they need to train their corporate workers on and then certify that all their workers have been trained.

Ms. Youssouf commented that that is training 200 trainers to train their people. Still a big job, very costly and time consuming.

Mr. McNulty stated that the other key element is that they will have access to our reporting hotline to report any DSRIP-related compliance issues and that we will have respond to that.

Mrs. Bolus asked no way out of it? Mr. McNulty replied, in summary, that there was no way out of it because, as the PPS lead, the State's position is we are giving HHC X amount of money and in return HHC must carry out these responsibilities.

Mr. McNulty continued on with Gotham Health FQHC and compliance oversight. We met with the Gotham chair and members of their board of directors back in April and we provided them with a compliance update with regard to the HIPAA security risk assessment requirements which I discussed earlier and also any privacy incidents that occurred at the diagnostic treatment centers ("D & TCs"). We also discussed whether or not there were any excluded providers at the D & TCs and we talked about the risk assessment process and how we will involve the D & TCs. We plan to meet with the Gotham board and Dr. McCray. We meet bimonthly to provide them an update on compliance issues.

Mr. McNulty move forward as requested that the Committee turn to page 29 of the Report and the corresponding attachment, which was a joint guidance document issued by the Office of the Inspector General; the Association of Internal Auditors; the American Health Lawyers Association; and the Health Care Compliance Association. He informed he Board that the document was titled the *Practical Guidance for Health Care Governing Boards and Compliance Oversight*. He explained that the document covered the following: (i) expectations for board oversight and compliance functions; (ii) roles and relationships of the various departments throughout the enterprise that are responsible for compliance and quality; (iii) the reporting mechanism to the board; (iv) potential auditing and risk areas; and (v) accountability and compliance. In summary, he informed the Audit Committee that he would go over the document in greater detail in September.

If there are not any questions that concludes my report.

Ms. Youssouf said thank you very much. Any questions? Comments? Okay. That was a long meeting. Thank you all for your patience and have a great weekend.

There being no further business, the meeting was adjourned at 2:25 P.M.

Submitted by,

Emily Youssouf
Audit Committee Chair



**AUDIT COMMITTEE OF THE
HHC BOARD OF DIRECTORS**

Corporate Compliance Report

September 17, 2015

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Agenda

I. External Audits – U.S. Department of Health and Human Services (“HHS”) Office of Civil Rights (“OCR”): *Status Report*

Background:

1) In June 2015, the Office of Corporate Compliance (“OCC”) advised the Audit Committee of the HHC Board of Directors (“Audit Committee”) of the status of OCR’s review of Metropolitan Hospital Center’s (“Metropolitan”) compliance with certain federal civil rights and health information technology laws, including Metropolitan’s policies, procedures, and practices related to: (i) meaningful access to services and programs for limited English proficient (“LEP”) individuals; (ii) equal access to services and programs for individuals with HIV; and (iii) the privacy and security of individuals’ protected health information (“PHI”) and their rights with regard to such information.

The paragraphs set forth below outline HHC’s follow up activities as they relate to the privacy and security of individuals’ PHI with particular attention and focus on HHC’s compliance with the HIPAA Security Rule risk analysis requirements that mandate that HHC perform an inventory and risk analysis of its systems and applications that access, house or transmit electronic PHI (“E PHI”).

Agreement with Third-Party Vendor to Perform HIPAA Risk Analysis Corporate-Wide:

2) Since the June Audit Committee Meeting, the Corporation has entered into an Agreement (which was fully executed by all parties on Aug 21, 2015) and corresponding Statement of Work (“SOW”) with Dimension Data to perform, among other various information security services, functions, and duties, a risk analysis on HHC systems and applications that house, store, and transmit EPHI. The assessment to be performed by Dimension may be broken down into the following activities:

A. *Security Assessment and Risk Analysis*, which includes the performance of the following: (i) Infrastructure Security - Perimeter/DMZ Penetration Assessment; (ii) Application Vulnerability Assessment; (iii) Vendor/Third-party Assessment; and (iv) Risk Analysis (Application and EPHI Focused) of all systems and applications that store, process or transmit PHI following the eight steps¹ below:

(1) outline the scope of the analysis including the potential risks, threats and vulnerabilities to the confidentiality, availability and integrity of all EPHI that HHC creates, receives, maintains and transmits;

¹ NIST Risk Assessment Framework -
Available at <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/nist800-30.pdf>

- (2) collect and gather information where it is stored;
- (3) identify and document potential threats and vulnerabilities;
- (4) access current security measures;
- (5) determine the likelihood of threat occurrences;
- (6) determine the potential impact of threat occurrences;
- (7) determine the level of risk present; and
- (8) document all findings and risk analysis conclusions.

B. Compliance Assessment, which includes all of the networks (wired, wireless, virtual, cloud-based, and vendor managed), assets (desktops, laptops, mobile devices, wireless devices removable media/storage, printers, faxes, cameras, and medical devices), operating systems and platforms (including legacy systems), and DR sites are included for assessment in those areas included in scope. The assessment will cover external network testing as part of the penetration test, a physical review of each site in scope, including but not limited to: internal/external doors, locks, cameras, badging, alarms, etc.; an environmental controls review of each site in scope, including but not limited to, fire sensors, alarms, extinguishers, moisture and CO2 sensors, power/internet line redundancy, back-up generators, building siting, etc.; and an evaluation of the effectiveness of the HHC security awareness training program.

3) The current timeline anticipates the entire project to be completed by August 31, 2016 with an expected start in September 2015. Metropolitan will be the first hospital to undergo assessment, which is anticipated to be completed by November 30, 2015.

II. Privacy Incidents and Related Reports

Background

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

Reportable Privacy Incidents for the Second Quarter of Calendar Year 2015 (April 1, 2105 to June 30, 2015 – hereinafter 2nd Quarter’))

2) During the 2nd Quarter 2015, twenty-two (22) complaints were entered into the OCC incident tracking system. Of the 22 reported incidents, eleven (11) were found after investigation to be violations of HHC HIPAA Privacy Operating Procedures; six (6) were determined to be unsubstantiated; one (1) was found not to be a violation of HHC HIPAA Privacy Operating Procedures; and four (4) are still under investigation.

- Of the eleven (11) confirmed violations, six (6) were determined to be breaches and five (5) were determined not to be a breach. A total of six individuals were affected by the six confirmed breaches.

- Of the 22 incidents reported during 2nd Quarter 2015, two (2) were referred to the OCC by the U.S. Department of Health and Human Services Office of Civil Rights (“OCR”). These incidents were complaints initially made by patients directly to OCR. Upon investigation, it was determined by the OCC that both incidents met the criteria of a breach and breach notice was sent to the affected individuals.

Breach Defined

3) A breach is an impermissible use, access, acquisition or disclosure (hereinafter collectively referred to as “use and/or disclosure”) under the HIPAA Privacy Rule that compromises the security and privacy of PHI maintained by the Corporation or one of its business associates.²

4) Pursuant to 45 CFR § 164.402 [2], the unauthorized access, acquisition, use or disclosure of PHI is presumed to be a breach unless HHC can demonstrate that there is a low probability that the PHI has been compromised based on the reasonable results of a thorough risk assessment, that is completed in good faith, of four key risk factors.³

Factors Considered to Determine Whether a Breach has Occurred

5) Under HIPAA regulations, at a minimum the following four key factors must be considered to determine whether there is greater than a low probability that a privacy and/or security incident involving PHI has resulted in the compromise of such PHI:⁴

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

Reportable Breaches in the 2nd Quarter

6) As stated above, there were 6 reportable breaches in the 2nd Quarter. Below is a summary of said breaches:

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

³ See 45 CFR § 164.402[2]; see also 78 Fed. Register 5565 at 5643 and 5695 [January 25, 2013]

⁴ See 45 CFR § 164.402 [2][i-iv].

- Bellevue Hospital Center – April 2015. This breach stemmed from a patient complaint to OCR that PHI was released without proper authorization. An investigation concluded that information was released as pursuant to a subpoena issued by the clerk of the court and in accordance with Bellevue’s policy. However, Bellevue’s policy did not meet the notice requirements or the elements of a court order under HIPAA. The complaint was substantiated and breach notification sent to the patient. Bellevue is in the process of revising the facility policy on responding appropriately to requests for patient information that are in the form of a subpoena or court order to comply with current HHC HIPAA policy. Breach notification was sent to the affected patient on June 25, 2015.
- Bellevue Hospital Center – May 2015. This breaches stems from a patient reported incident involving the unauthorized disclosure of PHI to a case manager at a shelter. The incident was confirmed as a HIPAA violation for the physician fellow at the facility released the information without patient authorization. The fellow was retrained on HIPAA policy for releasing patient information on June 19, 2015. Breach notification was sent to the affected patient on July 23, 2015.
- Queens Hospital Center – May 2015. This matter involved a patient reported incident concerning the unauthorized disclosure of PHI by a member of the patient’s treatment team to a former HHC workforce member. Because the staff member was not authorized to discuss patient PHI with the former employee, the incident was determined to be a breach. The staff member was retrained in HIPAA. Breach notification was sent to the affected patient on July 14, 2015.
- North Central Bronx Hospital – June 2015. A patient reported an incident involving the unauthorized disclosure of another patient’s discharge summary, which was left in a treatment room. The reporting patient informed Patient Relations that he/she took a picture of the discharge summary and wrote the information down. A risk assessment concluded that incident is a breach. HHC was unable to send notification to the patient as the last known address was that of the hospital and no additional contact information (phone, email, etc.) was present in the medical record. Notification has been drafted for inclusion in the medical record should the patient return to the facility.
- Jacobi Medical Center – June 2015. Incident involved the loss of a parcel by the U.S. Postal Service that contained a portion of the medical record of one patient. A risk assessment determined that the incident is a breach. Breach notification sent July 28, 2015.
- Bellevue Hospital Center – June 2014. This breach stems from a patient complaint to OCR of an incident involving the loss of a copy of the patient’s medical record. The complaint was made in February 2015. HHC was made aware of the incident in June 26, 2015. Healthport was responsible for sending the copy of the medical record to the

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patient; however, the package was lost by the U.S. Postal Service. Healthport was unable to confirm delivery of the package. As a result, breach notification is scheduled to be sent on August 25, 2015.

OCR Inquiries regarding potential and/or determined Privacy Incidents

7) As stated above, there were two inquiries from OCR reported in the 2nd Quarter. Below is a summary of said inquiries:

- *See paragraph # 6, bullet # 1, above* - Bellevue Hospital Center – April 2015. This breach stemmed from a patient complaint to OCR that PHI was released without proper authorization. An investigation concluded that information was released as pursuant to a subpoena issued by the clerk of the court and in accordance with Bellevue’s policy. However, Bellevue’s policy did not meet the notice requirements or the elements of a court order under HIPAA. The complaint was substantiated and breach notification sent to the patient. Bellevue is in the process of revising the facility policy on responding appropriately to requests for patient information that are in the form of a subpoena or court order to comply with current HHC HIPAA policy. Breach notification was sent to the affected patient on June 25, 2015
- *See paragraph # 6, bullet # 6, above* - Bellevue Hospital Center – June 2014. This breach stems from a patient complaint to OCR of an incident involving the loss of a copy of their medical record. The complaint was made in February 2015. HHC was made aware of the incident in June 26, 2015. Healthport was responsible for sending the copy of the medical record to the patient; however, the package was lost by the U.S. Postal Service. Healthport was unable to confirm delivery of the package. Breach notification to be sent August 25, 2015.

Update on the Data Los Prevention Program

8) Beginning April 7, 2015, the Data Loss Prevention (“DLP”) program previously implemented by the Enterprise Information Technology Services (“EITS”) began blocking outgoing emails that contained PHI identifiers, including, but not limited to, names, addresses, social security numbers, DOBs, diagnoses, MRNs, etc. By doing so, the number of reportable HIPAA incidents captured by the DLP program decreased to zero since the above-referenced date.

9) HHC workforce members who are identified as having unsuccessfully attempted to breach HHC protocol by transmitting PHI to an unauthorized site shall be subject to discipline which, at the minimum, will involve a referral to the Privacy Officers at their respective facilities for retraining.

III. Monitoring of Excluded Providers

- 1) On June 8, 2015, the OCC received information that a physician affiliated with Harlem Hospital Center (“Harlem”) was excluded from participation in the New York State Medicaid program. By way of background, Harlem performed the required exclusion search on the subject physician prior to granting him privileges at the hospital in January of 2015.
- 2) As recommended by the Office and the Centers for Medicare and Medicaid [“CMS”], HHC performs an exclusion check on all employees and affiliated providers prior to the time they are hired/granted privileges, and periodically thereafter. However, in the matter at hand, miscommunication between the employee who discovered the exclusion and her supervisor led to the subject physician being granted privileges despite his appearing on the New York State Exclusion List. Additionally, human error led to a failure to forward the subject physician’s information to the vendor who performs monthly screenings for HHC. As a result, the subject physician began treating patients at Harlem; Harlem thereafter erroneously submitted claims for his services to Medicaid managed care plans and commercial insurance carriers shortly thereafter.
- 3) When several claims were denied, Harlem billing staff investigating the denials determined that the subject provider was excluded. Accordingly, on June 8, 2015, Harlem ceased billing for his services and notified the OCC. Upon investigation, HHC determined that, during the period from January 2015 through June 2015, some of the subject provider’s inpatient services and outpatient services were paid by Managed Medicaid plans and commercial insurance plans. There were no payments made by Medicaid Fee for Service when the subject provider was the attending physician of record; however, there was a payment from Medicaid Fee for Service for one inpatient stay where the subject provider was not the attending physician of record but had some involvement in the inpatient’s care.
- 4) On August 4, 2015, Wayne A. McNulty, Senior Assistant Vice President and Chief Corporate Compliance Officer, contacted Matthew Babcock, Esq., Assistant Medicaid Inspector General and Director of the Bureau of Compliance, Office of Medicaid Inspector General (“OMIG”) to inform him of the situation concerning the subject provider and, pursuant to 18 NYCRR § 521.3(c)(7) and OMIG’s self-disclosure protocol, on August 20, 2015, Mr. McNulty sent a letter to OMIG to disclose a possible overpayment secondary to the rendering of services by the aforementioned excluded provider.
- 5) As of August 5, 2015, the subject provider was removed from the Exclusion list and reinstated as a participating Medicaid. HHC recently received a letter from OMIG addressed to the subject provider, which informed him that “the original decision to deny [his] request for enrollment/reinstatement into the NYS Medicaid Program [was] overturned” and that he would be separately informed of his effective enrollment/reinstatement date.

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6) Based on the events described hereinabove, Harlem has retrained all relevant staff on its credentialing process with an emphasis on the exclusion check. Moreover, additional measures have been implemented (including the possible hiring of additional staff) in the relevant department to add further oversight to the exclusion check. Finally, both Harlem and the OCC have been in contact with HHC's affiliate, Physicians Affiliate Group of New York, P.C. ("PAGNY") (who employed the subject provider) over its failure to discover the exclusion prior to the subject provider employment and the failure (as advised by PAGNY) of its vendor to discover the exclusion during its regular screenings. PAGNY has assured the OCC that PAGNY is taking steps to address these failures.

7) HHC had determined the overpayment amount to be \$85,429.35. HHC's awaits OMIG's review of HHC's overpayment self-disclosure for final determination on the required repayment amount.

**IV. Outline of Calendar Year 2015 ("CY2015") Corporate-wide Risk Assessment:
*Status Report***

Follow up

1) The OCC started its CY2015 Corporate-wide Risk Assessment (the "Risk Assessment") process in May 2015, which will be used, in pertinent part, by the OCC to develop the fiscal year 2016 ("FY2016") New York City Health and Hospitals Corporation ("HHC") Corporate Compliance Work Plan ("FY16 Work Plan").

2) Risk may be described as "a measure of the extent to which an entity is threatened by a potential circumstance or event, and is typically a function of: (i) the adverse impacts that would arise if the circumstance or event occurs; and (ii) the likelihood of occurrence."⁵ In simpler terms, "[r]isks are events or conditions that may occur and, if they do occur, would have a harmful effect" on HHC.⁶

3) The subject risk assessment process is still on schedule to be completed by September 2015.

Current Risk Assessment Status:

- 4) Following is the status of the risk assessment process:
- The members of the Compliance committees at the various HHC Health Networks submitted their top three risks to the OCC.

⁵ NIST, U.S. Dep't of Commerce, *Guide for Conducting Risk Assessments* (Special Publication 800-30) Information Security, September 2012, at 6.

⁶ HCCA Professional's Manual, Risk Assessment Chapter, ¶ 40,105, at 41,001.

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- Over a period of approximately three weeks in July and early August, the OCC organized and conducted in Central Office and at the various HHC Health Networks a total of 19 Compliance Committees meetings to discuss corporate-wide and facility specific risks. Subsequently, three additional compliance meeting were conducted in late August and early September, bringing the total of risk assessment compliance meetings conducted corporate-wide to 22. During these meetings, risk assessment and scoring processes were conducted and completed. All identified risks were prioritized taking into account, among other things, the potential impact of a given risk, the likelihood of risk occurrence, and the presence of internal controls to mitigate identified risks.
- The compliance committee/risk scoring meetings took place at the: (i) **South Manhattan Health Network** (Bellevue; Metropolitan; Coler and Carter; and Gouverneur – six meetings with two combined meetings at the Coler site covering Coler and Carter and two meetings at the Metropolitan site); (ii) **North and Central Brooklyn Healthcare Networks** (Cumberland; Dr. Susan Smith McKinney; East New York; Woodhull; and Kings County – six separate meetings with two meetings at Woodhull); (iii) **Generations+/Northern Manhattan Healthcare Network** (Lincoln Medical and Mental Health Center, Harlem Hospital Center, Segundo Ruiz Belvis Diagnostic & Treatment Center, Morrisania Diagnostic & Treatment Center, Renaissance Healthcare Network – one collective meeting held at Harlem); (iv) **North Bronx Healthcare Network** (Jacobi Medical Center and North Central Bronx Hospital – one collective meeting held at the Jacobi site); (v) **Queens Healthcare Network** (Elmhurst Hospital Center and Queens Hospital Center – one collective meeting held at the Queens Hospital site); (vi) **Southern Brooklyn/Staten Island Network** (Coney Island Hospital; and Sea View Hospital Rehabilitation Center – two separate meetings held); (vii) the **Executive Compliance Workgroup (“ECW”)** – held at Central Office; (viii) the **ECW Subcommittee on Compliance and Quality** – held at Central Office; (ix) the **HIPAA compliance meeting** – two separate meetings held at Central Office and webconference; and (x) **HHC Health and Home Care** – held at Central Office.
- In the upcoming weeks, the OCC will conduct the following Risk Assessment meetings: (i) a follow-up Executive Compliance Work Group; (ii) OneCity Health/Delivery System Reform Incentive Payment (“DSRIP”) Program Compliance Committee; (iii) the HHC ACO, Inc. Compliance Committee; and (iv) the World Trade Center Health Program Compliance Committee.

Risk Scoring Prioritization & Tolerance⁷

5) The OCC has also started assemble the top risks with the highest risk scores identified across various facilities. Once the remainder of the meetings are complete, the overall risk scores and prioritization will be available for the review of HHC’s President/CEO Ramanathan Raju, M.D., and subsequent presentation to the Audit Committee (and thereafter the HHC Board of Directors).

6) These findings will be used by HHC President/CEO Dr. Raju, Audit Committee, and the HHC Board of Directors to determine and establish the Corporation’s risk tolerance and risk appetite. The findings will also help in establishing an Enterprise Risk Management (“ERM”)⁸ framework across the Corporation. The prioritized risks will be included in the FY16 Work Plan.

V. HHC Health & Home Care Civil Investigative Demand

1) In July 2015, HHC received a Civil Investigative Demand (“CID”) from the United States Attorney’s Office for the Southern District of New York (“USAO”) seeking documents and information concerning the HHC Health & Home Care (“H & HC”) and certain of its “Documentation of Services” practices, including but not limited to, documents concerning its process for submitting claims to Medicare or Medicaid, and documents relating to a vendor known as Select Data. The CID was issued pursuant to the False Claims Act, 31 U.S.C. Section 3733, in the course of a False Claims Act investigation, to determine whether there has been a violation of 31 U.S.C. Sections 3729 *et.seq.* The exact focus of the investigation is not known at this time. HHC has retained Joseph Willey, Esq., Partner, Katten, Muchin Rosenman LLP, to represent its interests and assist in responding to the CID. A Preservation Notice/Litigation Hold letter has been issued to HHC employees who might have information responsive to the CID.

⁷ See Dr. L. Rittenberg and F. Martens, COSO Enterprise Risk Management Understanding and Communicating risk Appetite, (2012) (defining risk appetite as “[t]he amount of risk, on a broad level, an entity is willing to accept in pursuit of value,” and defining risk tolerance as the “acceptable level of variation an entity is willing to accept regarding the pursuit of its objectives,” which is one consideration affecting risk appetite along with existing risk profile, risk capacity, and attitudes towards risk).

⁸ Enterprise Risk Management – Integrated Framework

http://www.coso.org/documents/coso_erm_executivesummary.pdf