NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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125 Worth Street ▪ New York, NY ▪ 10013

BOARD OF DIRECTORS MEETING
THURSDAY, MARCH 21, 2013
A~G~E~N~D~A

Call to Order - 4 pm	Dr. Stocker
1. Adoption of Minutes: February 28, 2013	
Chairman's Report	Dr. Stocker
President's Report	Mr. Aviles
>>Action Items<<	
Corporate	
2. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. (NSLIJ) (i) to establish a jointly controlled not-for-profit hospitals cooperative (CoOpLab) that will provide laboratory services at cost to NSLIJ's and the Corporation's respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services to have NSLIJ's existing not-for-profit corporation, which operates its core laboratory perform the Corporation's reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business; AND authorizing the President of the Corporation to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described below consistent with these Resolutions. *(Finance Committee – 03/12/2013 & Med & Professional Affairs Committee – 03/14/2013)*	Mr. Rosen/ Dr. Stocker
3. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate a contract with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396. *(Med & Professional Affairs Committee – 03/14/2013) EEO: Approved / VENDEX: Pending*	Dr. Stocker
4. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to negotiate and enter into a sole source contract with Microsoft Corporation to purchase software licenses and related maintenance and support on an on-going basis in an amount not to exceed $34,500,000 for a three year period. *(Med & Professional Affairs Committee – 03/14/2013) EEO: Pending / VENDEX: Pending*	Dr. Stocker
Southern Brooklyn/Staten Island Network	
5. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to execute a fifteen year lease agreement with 2857 West 8th Street Associates (the "Landlord") for 24,000 square feet of space at 2857 W. 8th Street, Borough of Brooklyn, to house the Ida G. Israel Community Health Center operated by Coney Island Hospital at an initial rent of $24/square foot. *(Capital Committee – 03/14/2013)*	Ms. Youssouf
Generations+ /No. Manhattan Health Network	
6. RESOLUTION authorizing the President of the New York City Health and Hospitals Corporation to approve a Capital Project for Harlem Hospital Center to relocate and modernize the Dental Clinic for a total project cost of $6.25 million. *(Capital Committee – 03/14/2013)*	Ms. Youssouf
MetroPlus Health Plan, Inc.	
7. RESOLUTION reappointing Margo Bishop as a member of the Board of Directors of MetroPlus Health Plan, Inc., a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York (MetroPlus) to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws. *(MetroPlus Board – 3/12/2013)*	Mr. Rosen

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BOARD OF DIRECTORS MEETING
THURSDAY, MARCH 21, 2013 AGENDA ~ Page Two

Committee Reports	
➢Capital	Ms. Youssouf
➢Community Relations	Mrs. Bolus
➢Finance	Mr. Rosen
➢Medical & Professional Affairs / Information Technology	Dr. Stocker
➢Strategic Planning	Mrs. Bolus
Facility Governing Body / Executive Session	
➢Coler Nursing Facility	
➢Goldwater Specialty Hospital & Nursing Facility	
>>Old Business<<	
>>New Business<<	
Adjournment	Dr. Stocker

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

A meeting of the Board of Directors of the New York City Health and Hospitals Corporation (hereinafter the "Corporation") was held in Room 532 at 125 Worth Street, New York, New York 10013 on the 28th of February 2013 at 4:00 P.M. New York time, pursuant to a notice which was sent to all of the Directors of the Corporation and which was provided to the public by the Secretary. The following Directors were present in person:

Dr. Michael A. Stocker
Mr. Alan D. Aviles
Josephine Bolus, R.N.
Dr. Vincent Calamia
Dr. Christina L. Jenkins
Dr. Adam Karpati
Ms. Anna Kril
Mr. Robert F. Nolan
Mr. Bernard Rosen
Ms. Emily A. Youssouf

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

ADOPTION OF MINUTES

The minutes of the meeting of the Board of Directors held on January 31, 2013 were presented to the Board. Then, on motion made by Dr. Stocker and duly seconded, the Board unanimously adopted the minutes.

1. RESOLVED, that the minutes of the meeting of the Board of Directors held on January 31, 2013, copies of which have been presented to this meeting, be and hereby are adopted.

CHAIRPERSON'S REPORT

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

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

Dr. Stocker announced that the final annual public meeting will take place at Coney Island Hospital in Brooklyn on April 8, 2013.

Dr. Stocker announced that Robert Pollack, the Court Reporter is retiring. Dr. Christina Jenkins will also step down as a member of HHC's Board of Directors. She has been serving since 2010 and stated that she respects the mission and the work that is done by HHC. She will now be leading HHC's initiative to improve primary care access throughout the Corporation. Dr. Stocker stated that Dr. Jenkins will be missed as a Board member, but happy she will be a part of the work that HHC endeavors to improve.

PRESIDENT'S REPORT

Mr. Aviles' remarks and his 2012 Year-in-Review were in the Board package and made available on HHC's internet. A copy is attached hereto and incorporated by reference.

Mr. Aviles also reported on the incident at Kings County Hospital Center that the press raised as a concern regarding the statute of limitations.

ACTION ITEMS

RESOLUTION

2. Authorizing the President of the New York City Health and Hospitals Corporation to approve the budget for **relocation of the "T" Building at Queens Hospital Center,** estimated to be $8.4 million.

Julius Wool, Executive Director, Queens Hospital Center explained that approximately 30 departments and services from the T building will be moving to the main campus of Queens Hospital Center campus.

In response to Ms. Youssouf's question about the financing of the project, Mr. Wool explained the cost of the various components of the project.

In response to Ms. Youssouf's question about future plans for the T building, LaRay Brown, Senior Vice President, explained that HHC is exploring various uses for the T building including supportive housing, as well as focusing on units being used for individuals who are high Medicaid users which will help with the Corporation's strategic aim of reducing inpatient readmissions and unnecessary emergency room presentations.

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

BOARD COMMITTEE REPORTS

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

FACILITY GOVERNING BODY/EXECUTIVE SESSION

The Board convened in Executive Session. When it reconvened in open session, Dr. Stocker reported that the Board of Directors as the governing body of Gouverneur Healthcare Services and Lincoln Medical and Mental Health Center discussed and adopted the facility's report presented.

ADJOURNMENT

Thereupon, there being no further business before the Board, the meeting was adjourned at 6:25 P.M.

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

COMMITTEE REPORTS

Audit Committee – February 14, 2013
As reported by Ms. Emily Youssouf

Ms. Youssouf began the meeting by announcing that the first action item - the KPMG 2012 Management Letter to be presented by--Jim Martell, Engagement Partner and Camille Fremont, Senior Manager. Mr. Martell stated that he welcomes the opportunity to present their management letter, with the Corporation's Corporate Comptroller, Jay Weinman sharing his comments on the organization and the responses. He stated that Ms. Fremont will walk through the bulk of the management letter and he will interject when necessary but he will spend some time on the industry issues in terms of what he sees is going on in the industry in the last five to six months.

Ms. Fremont began her presentation by stating that she wanted to note that there are no significant deficiencies or material weaknesses included within the management letter. All of their provisions are just informational opportunities for improvement.

Ms. Fremont stated that on page two, they laid out what they called the matrix of observations. It indicates which facilities they performed test work for the 2012 audit and whether or not there were findings in the different categories they tested. As indicated for the facilities that they went to, there were minimal comments. She stated that she will highlight some of the corporate comments. In terms of the accounts receivable evaluation process, the process that management goes through is that they look at the evaluation on a net basis, so they do not take credit balances into account. KPMG is suggesting that management look at debits and credits separately when they do their evaluation and analyze that on a quarterly basis.

Mr. Martell stated that one of the things he wants to highlight is that when management looks at the number and it says $74 million of credit balances, when you take a step back and you think about the size of the Corporation, close to $7 billion in revenue, yes, $74 million is a significant amount of money and so forth, but when you are dealing with a $7 billion revenue stream and compared to other organizations on a percentage basis, it is relatively small. The goal is to always improve the process, and this is a process issue more than anything else.

Ms. Youssouf asked if management is comfortable doing it. To which Mr. Weinman responded yes, that currently we net the credits with the debits, but our methodology includes ratios that include that—it should represent a cleaner way of doing it.

Ms. Fremont continued by stating that the next area is the affiliation contracts. Some observations they had are that there are certain contracts that were executed after the commencement date of the contract period. This year Internal Audit is doing the compliance audit - there are certain affiliations that could not have their compliance audits done for the current year because their audited financial statements were not given to Internal Audit. The last compliance audit they had was based on their last audited financial statements, which were prior to 2011. Similar comments to last year – compliance audits did identify certain time keeping issues with time sheets or lack of controls in place to monitor the time sheets. There was also an affiliate who entered into a subcontract with a vendor without a signed contract. KPMG recommends that prior to the affiliation contracts coming to you, you have signed contracts. All reconciliations should be performed timely and in accordance with the contracts. Management should continue to work with the affiliates and enforce the terms of the contracts so all information is given timely.

Ms. Youssouf asked who oversees the affiliate contracts. To which Mr. Martin responded that he does.

Ms. Fremont continued and stated that they also observed that there are several construction projects that have been ongoing at the Corporation and they have gone into cost overruns from the original established budget. KPMG's recommendation would be that management analyze all aspects of the construction management process and determine ways to help meet or reduce those costs overruns which she understands that currently management is going through the process.

Ms. Youssouf agreed that it is under control in the Capital Committee.

Ms. Fremont stated that they also looked at the Corporate Compliance Program and stressed that they continue to see improvement needed surrounding the Corporate Compliance Program. There are updates provided to various committees that are very detailed and provide significant amount of information for the committee to understand how you are addressing that. KPMG did note that there was certain open status of risk assessments from the work plan that relates to prior years. This is not a criticism, it is a factual observation. That just because you close something quickly does not mean that you have addressed it. Corporate Compliance is going through the process and making sure that when they close them, they are appropriately closed. KPMG also noted that compliance utilizes outside legal counsel to make sure that they fulfilling their responsibilities, and that they are implementing an effective compliance program – so their recommendation would be to continue to strive to be the best in class, realizing that Corporate Compliance is a living, breathing document that is never stagnant, and that you continue to utilize external counsel's help.

Mr. Martell stated that at least as far as he is been involved over the last three years, the Compliance Program has clearly made a major step forward in terms of process, controls, reviews, etc. and taken the appropriate steps to have appropriate level of detail, the appropriate level of reviews associated with the program. Mr. Martell added that he thinks there has been significant change over the last year and a half.

Senior Vice President & General Counsel, Mr. Salvatore Russo asked why it is a requirement to have outside counsel review the Compliance Program. To which Mr. Martell responded that it is not a requirement, he just thinks that external review is left to the process, that another set of eyes that looks at the program will validate you as management and the Board. Mr. Russo asked that this is not a reflection on in-house counsel's ability to do that. Mr. Martell responded absolutely not. Ms. Youssouf added that that this is just best practice.

Board Chairman, Dr. Michael Stocker asked KPMG if the Compliance Program is a good one. Mr. Martell answered that it is a good program and it has gotten a lot better. The cross section has really improved, and the documentation, the association he thinks comes from the Board, the Committee all the way down to the people on the allied committees. This does not mean next year they won't say they need to be more, because being a CPA or an external; they always want to see the best.

Dr. Stocker stated that Mr. Alan Aviles was the driving force.

There was a round of applause directed at Mr. Wayne McNulty, Corporate Compliance Officer.

Ms. Fremont continued with her presentation and stated that in terms of the facilities visited, on page eight are the various observations they had. They included a time sheet that had no evidence of supervisor approval, a purchase order dated subsequent to the invoice date and on the open visit reports, there are visits greater than one year. These are all relatively minor comments – just opportunities to strengthen the process and the controls already in place. Ms. Fremont then turned the presentation over to Mr. Jim Martell who will discuss some of the industry comments.

Mr. Martell stated that as it relates to site visits and so forth, these observations would typically be put in a letter to the Chief Financial Officer saying that these are not significant, by no means is this saying that the process and the use of controls are not working effectively – they are. Page ten talks about the industry comments, which are some of the things the committees are dealing with and perhaps have already put some these things behind on a normal basis. We see many organizations having the challenge of the health care world in general. As an FYI in terms of documenting, KPMG recognizes that there is always going to be liquidity issues and concerns as it relates to the mission which the Corporation is embodied to do.

Mr. Martell stated that the next item is very interesting as it relates to the SEC (the Securities and Exchange Commission) – the SEC is getting involved more and more in the not-for-profit world. KPMG is currently working with management on the new offering debt which is an SEC requirement. It is an exchange issue and he believes that you will see under the new SEC administration more focus in the not-for-profit world, mainly because of the municipal debt, which is our form of issuing equity or offerings to the public and your bonds are traded. The public world is scrutinizing your results, your MD&A (Management Discussion & Analysis), etc.

Ms. Youssouf stated that she thought there was a requirement already that we have to update disclosures. Mr. Martell said that this is above that. Ms. Youssouf added that the letter states that it requires them to prepare and disseminate an official statement, which KPMG has to do and disclose during the onset of internal securities which we also have to do. Mr. Martell added that is on a quarterly basis, you issue certain disclosures on restrictive covenants – it is going to get more detailed. Moody's just sent out a requirement identifying an additional disclosure that is going to be required by not-for-profit organizations, statistical information, payer category and things of that nature. This is going to become a very detailed quarterly process.

Mr. Martell continued with the presentation with the next item – social media. His concern is how the Corporation will deal with certain commentaries made on Twitter and so forth that could be negative to the Corporation.

Ms. Youssouf stated that she heard that this may become a requirement, because most municipal entities do not do that. Mr. Martell responded that he had not heard that, but he would not be surprised. He added that after this meeting, he is going to another audit committee meeting where they will have a presentation by a firm who went in and did an entire risk profile of the organization. So it is already being done in the not-for-profit space. He does not see why it would not naturally gravitate towards municipalities and so forth. He offered to follow-up with some of his governmental colleagues to see what they see.

Mr. Martell continued with the last item community needs assessments. It has gotten a lot more detailed, a lot more drastic in terms of what needs to be done and so forth. The organization is involved in it and the federal laws are a lot more stringent in terms of the requirements we have been accustomed to in the past. Each organization needs to deal with it and again is a continual oversight and there will be more as we move forward into the new world of health care transformation.

Mr. Russo stated that HHC is sort of different because it is a quasi-public entity and in a certain way, the difference between free speech and all of that filters into it, which a Memorial Sloan Kettering does not have restraint in terms of responding – that is the difference. Then Mr. Russo asked when the IRS provision relating to community needs takes effect. Mr. Martell responded that the law he believes is for calendar year December 31, 2012. It was effective July 1, 2010 – you may do the community needs over a period of years, now it is becoming more restrictive. Mr. Russo

added that now it has to go to the Board which he never realized that. Ms. Fremont added that became effective for HHC's taxable year beginning July 1, 2012. Mr. Russo stated that we must see when we do this to have it authorized by the appropriate committee of the Board.

Mr. Martell stated that these are some of the highlights. KPMG tries to take things that they're dealing with and what other organizations are dealing with that you are dealing with on an operational basis. There is issue of ICD10; management is handling that, the whole clinical information screen. There have been a lot of things over the past several years that the Corporation is dealing with that are ongoing in nature. It is a turbulent time right now and he thinks as we go forward and deal with this on ongoing basis, you are going to have more and more issues and he thinks you will have more and more oversight. He thinks it is going to become a lot more restrictive.

Ms. Youssouf stated that she agrees with him and thanked him for a good management letter and appreciated his time going through it in detail.

Ms. Youssouf then moved on to the next information item – a presentation on the procurement process.

Mr. Antonio Martin, Executive Vice President/COO stated that he wanted to give the Board a sense of where they are with their compliance with Operating Procedure 100-5. Clearly, he thinks that they have made a lot of great strides in terms of compliance. He believes that they still have some areas for improvement, and what the Assistant Vice President for Contract Administration & Control, Mr. Joe Quinones is going to do is annotate that and also to tell the committee where they want to go in terms of procurement for the Corporation.

Mr. Quinones started his presentation by stating that first he wanted to show when the operating procedure was executed – it was executed in January 2012. These operating procedures reformed Board of Directors contracts authorization process so that the Board had greater transparency of consequential contracts. It restructured and reorganized procurement activity reports. A report was submitted to Dr. Stocker, it is a comprehensive report of all the applications reviewed by the Contract Review Committee (CRC), and it also shows expenditures of the Office of Facilities Development (OFD) and expenditures related to IT.

The next slide is Board of Directors contracts and expenditures that were previously below the threshold that are being seen by the CRC; anything above $100,000. Anything above $3 million is now going to the Board. It also integrated 14 procedures that were previously decentralized; now it is only one expanded procedure. The CRC membership was expanded and that has been an enormous success to have Senior Vice Presidents and Executive Directors. They have added enormous value to how to proceed, especially with solicitations. The procedure clearly identifies the procurement methods for staff in terms of construction, equipment, goods, non-professional services and professional services. The Supply Chain Council was created through the procedure and now have standardized all of our laboratory equipment and supplies. A contract will be submitted to the Board related to the scope instruments and procedures of surgical solutions. The new process has also increased awareness of the need to leverage Corporation size and use fewer contracts to reduce costs.

Mr. Quinones continued by stating that one of the things that they are finding is that currently under the decentralized process, compliance with 100-5 is at the local level; product decisions are at the local level as well as solicitations. Receipt of goods is at the local level and payment is at the local level. One of the things needs to be done is try to incorporate a corporate oversight. That oversight is simply to bring all those local decisions into a room so that we can begin doing a couple of things that are on the slide: (1) Identifying and planning for procurement as a Corporation rather than 11 acute care facilities and long term care facilities doing it. (2) Identify recurring purchases at each one of the facilities as a Corporation. We need to help the requisitioners right now because one of the things is new products that are coming into the facilities, changes in the products that are recurring. We need to make sure that the requisitioner has an "Amazon.com" experience by making sure that we have 80 percent of their purchases in what is called a favorites list so that all they have to do is simply say I need two of these, five of these, six of these and make the process really seamless and efficient. Especially for the OR, Cath Lab and Interventional radiology, these are the super users, and those are the people that we really need to make the process easy. There is also a need for an item master that is maintained and the only way do that is if we know what those product decisions are at the local level. Again, it requires corporate oversight so that we know what those products are and those can be included in the item master.

Mr. Quinones continued and said that in the Compliance Program, we have special requests that are substantial, and we need to see who those buyers and requisitioners are that are doing special procurement requests, that actually go around the system, retrain them, make sure that they understand the need for them to follow and use the tool as appropriate. A task force is being created to be the oversight and implement the program that he just identified and all the facilities will be represented there. He wants to bring nursing and clinicians into the process because that is really the way they are going to have compliance with Operating Procedure 100-5. They are reviewing centralization of the process and are looking at models at North Shore; they will do a walk-through with the Senior Vice Presidents and also having discussions with various other organizations. They are finding out that centralization does bring efficiencies, product standardization and better control of product value analysis. Currently all the acute cares perform value analysis, but they do it separately and there is much variation across the Corporation. Mr. Quinones continued by stating that they also need to change the way they look at products, the life cycle of a product from beginning to end – is it going to be thrown away or will it be reused and how is it going to be used and how should it be sourced. Should it be leased, should it not be a leased, should it be a purchase, etc.

Mr. Quinones continued with product planning and leveraging – He thinks that many times they don't do that but they need to do that and the only way to do that is if they plan the purchases. By increasing productivity and efficiency they'll be able to reduce labor costs. He showed the

committee a visual of how the centralized supply chains process works. He put GHX as a tool and stated that GHX is programmed and requires planning – he broke it down as follows:

• Centralized Product Review Committee – to really identify what are the products that we are going to use and plan for those purchases.

• Centralized Product Sourcing – in many organizations centralized product sourcing is really called business intelligence. That is where you go out and find what is the best way of buying something, what the best way of contracting for it is. Currently we have decentralized contracting; every one of our facilities contracts their own at the local level. We find that there are efficiencies in centralizing and contracting process.

• Centralized Product Procurement – centralizing the item master so that there is only one entity that allows items to be brought into the system, and they identified in the item master.

• Centralized monitoring and centralized charge, master updating, centralized reimbursement monitoring, centralized budget expenditure and payment, outpatient.

Dr. Stocker commented that there has been at least a couple of years work, working on how to procure. It is clear that multiple hospital chains meet deficiencies if they procure, unlike construction meet deficiencies if they centralize. But it is clear that it is pretty hard to do, you have to be responsive to the needs of the local facility. He also said that he is a bit worried – this is a positive report, and that is good, but for example, by using GHX does it fulfill our needs and is it compatible with our other systems and do we have further work to do in terms of how we systematically do that. He believes that the ability to organize this appropriately in the system should allow us to respond very quickly to a hospital with efficiency as we purchase centrally. He asked Mr. Quinones on that.

Mr. Quinones responded sure – he sees this in two parts. The transactional part, the contracting and requisitioning, receipt and payment are the administrative part. Those things are the easiest things to do; he believes that they can put a plan in place that would seamlessly implement that portion of it. What no organization can do seamlessly is what you just alluded, Dr. Stocker, and that is to fulfill the doctor preference items of a large organization like this one. That is the difficult part, but it has been done, it takes time to do it and what is needed is a plan of how to make sure that the patients are best served by the products that the organization decides on. Mr. Quinones thinks that the only way to do that is to do it in a corporate way so that we are making corporate decisions, and not necessarily have eleven different value analysis processes going on.

Mr. Quinones continued by stating that they are going to go to a walk-through of North Shore. As indicated, they are trying to develop a long term strategy around the supply chain and where HHC should go and what that vision should be. There are three different systems that they work with: (1) GHX is on the left, they also have to work within the platform of ORACLE, which is the legacy platform that they have and then they have the 30 year old OTPS system.. They worked through that, and it is not easy, it is not an integrated system. For instance they found out that ORACLE does not talk back to PS Blue, GHX – this means that buyers actually make contract alignments that occur in ORACLE that are not shown.

Dr. Stocker commented that that is good – that they have identified the problem and will be getting into a really complex discussion. Ms. Youssouf added that this is not what they are trying to get to and asked Mr. Quinones if that was correct. Mr. Quinones responded that that is correct. Then Ms. Youssouf added that this is the bad thing that they are doing now. Mr. Quinones added that he has people that work very hard to make it work. Ms. Youssouf commented that this not what we want correct? To which Mr. Quinones responded correct.

Ms. Youssouf also stated that this is very impressive that this is something they have talked about for a very long time and she knows that this had been on Mr. Martin's to-do list and she hopes that they can actually get there with all of this. Then she asked when the walk-through to North Shore is. Mr. Martin answered March 5th. Then she stated that maybe by the March meeting Mr. Martin will be able to say how it went and share something they learned. Then Ms. Youssouf added that she thinks that would be important because this shows a lot of progress and that she is sure that the Committee as whole and the Board as a whole really want to commend you on doing this and she thanked them.

Ms. Youssouf directed Mr. Christopher Telano, Chief Internal Auditor to begin his presentation.

Mr. Telano saluted everyone and stated that he has three quick reports to go over. The first one is of patient property and valuables at Woodhull Medical Center. He asked the representatives to approach the table and identify themselves. They identified themselves as follows: George Proctor, Senior Vice President of the North Central Brooklyn Health Network; Milton Nunez, Chief Financial Officer for the North Brooklyn Network. Mr. Telano continued by stating that the intention of this audit was to ensure adherence with relevant HHC operating procedures, New York City Administrative Code and Guidelines and department procedures. We also evaluated the processes for adequate internal controls. Overall, we found that the controls and record keeping of the patient property and valuables were lacking. Management was asked to take the necessary action to resolve the issues found and requested that Mr. Nunez comment on that.

Mr. Nunez thanked Mr. Telano and his staff for a very collaborative audit. He thinks that as a result of the audit, they have increased collaboration, and increased communication from the departments. They also believe that at this point 90 to 95 percent of the recommendations have been fully implemented.

Ms. Youssouf stated that that is great, really good that this is something that is their best practices that should be disseminated to other facilities.

Mr. Martin added that this is best practice and he wants to be able to share the results of this audit with the other Senior Vice Presidents and see if there are some things that they can do make sure that is part of HHC behavior. Ms. Youssouf thanked them.

Mr. Telano continued by stating that the next audit he will be discussing is of the purchasing practices and procedures at Kings County. This audit was done at the request of Dr. Stocker and the Audit Committee; it is the first of a corporate-wide initiative, so he will be discussing other purchasing audits at subsequent meetings. He then asked the representatives to approach the table and introduce themselves. They introduced themselves as follows: George Proctor, Senior Vice President of the North Central Brooklyn Health Network, Ernest Baptiste, Executive Director of Kings County and Anthony Gavasci, Director of Procurement.

Mr. Telano stated that he will quickly go through the findings. We noted seven vendors with sales of at least $100,000 did not have contracts approved by the Contract Review Committee (CRC). We found 19 vendors which had purchase orders processed cumulatively for more than $5,000, but they were not using the bidding procedure as required by 100-5. Lastly, we found that there was inappropriate access to systems for employees who no longer worked for HHC or no longer worked for purchasing. The Purchasing Director had responded immediately to all our issues and took the necessary action to resolve everything either during the course of the audit or immediately after.

Ms. Youssouf commented that there are some discrepancies, but it is part of the process of trying to figure out the procurement operation. The process here is accountability access and the Board is supposed to review purchasing, which is relatively easy for the Board. The Board talked about it and we had 13 months ago this relatively elaborate operating procedure 100-5 that replaced 14 operating procedures.

Dr. Stocker added that 14 other operating procedures is a lot of work just for management. As we learn about this, we are going to have to change again. We knew so little about the volume that we could easily overwhelm ourselves. The operating procedure calls for contracts over $100,000, under $3 million which do not go to the Board because there is no time to review it that well, but go to the CRC. The vast majority of the contracts that are going to the CRC now are pretty much from Central Office. Dr. Stocker read part of the language of the 100-5 which says “additionally, the CRC shall be responsible for reviewing and approving all procurements, except for goods, when the contract amount will be over $100,000, even if the transaction will not require Board approval. No such contract shall proceed without CRC approval”. There are parts of the document that are a little ambiguous, and we will need you to work on, but that is not what he was asking. Dr. Stocker is curious about how certain contracts did not go through this process.

Mr. Galvasci stated that the vendors he is mentioning were not new vendors and that he is relatively new to the corporation, so he did not go back to the vendors to see what their cumulative dollar amounts were. Going forward, he will be doing that process, evaluate the vendors, and once it reaches that dollar mark, it will be sent out to the CRC for review.

Mr. Telano added that these vendors that did not have contracts at all, but they had activity exceeding $100,000 within our audit scope period.

Ms. Youssouf asked if these were sole source vendors. To which Mr. Telano responded no, none of them were. The system is lacking, and it makes it difficult for the purchasing area to monitor the activity. Mr. Martin added because it doesn’t aggregate.

Ms. Youssouf asked if this is something that can be changed. Mr. Galvasci responded that it is actually a manual process. That he is now keeping a manual log with every purchase order that comes through his desk. He has a manual log which he writes each vendor down and the amount of the purchase order and he reviews that monthly to see where the dollar amount is going. Ms. Youssouf stated that she has no idea of the cost, but is it feasible to make that so it is not manual. Mr. Galvasci added that in conjunction with him doing this manually, he prints out OTPS vendor by vendor to see where that dollar amount is coming. Yes, it is a manual process, but they can look it up through OTPS but they have to go to a specific vendor. The vendors are not listed together; you have to put in each individual vendor.

Ms. Youssouf asked Mr. Bert Robles, Chief Information Officer to approach the table. Mr. Robles stated that he does not know all the particulars, but that he knows with the eCommerce system, they are able to query the individual vendors, and then they manipulate the data and consolidate it; but it is a routine outside of the current system because it is not well integrated. Not understanding the details clearly, he thinks to a great degree they can generate reports to show specs. There are some complexities with that and our purchasing habits make it more difficult for the way we do it with purchase orders, but ultimately he thinks it can be done certainly, because we have been able to do it within IT. It is a substantial effort beyond just a query generating report; ultimately we can generate a report.

Ms. Youssouf asked that they don’t have to go through all the agonizing details now, but if it is possible to see if there is a way to fix that, because it would be great if we could.

Mr. Martin added that yes, as you have heard, our system is rather clumsy. One of the things that he would like to say is that he actually met with a group of purchasing directors. You hear about a number of the things that they have to go through to really maintain compliance with management and there a number of issues that they are really struggling with. They are really trying their best to adhere to 100-5, but a lot of the manual things that they have to do make it very difficult. He said he also brought them to the meeting of the Senior Vice Presidents, and the SVPs were able to hear from their own purchasing directors about the troubles they have in complying.

Ms. Youssouf stated that what might be helpful if there are certain things that everybody kept citing that is causing the difficulty, putting that together to distribute to the Committee. That they should think about if there is a way, as Dr. Stocker said, to modify this, to make it more user-friendly or appropriate. She thinks that might be a good idea.

President Aviles added that he thinks unfortunately, some of the core issues here is, we are just going to have to require for the interim, for the local purchase officers to actually go through this manual process that is quite labor intensive. Perhaps that can be aided somewhat with some automated reporting capability so that it can be somewhat easier. But the long term solution is for full automation of this process, so that when things are ordered, you automatically get a literal readout of what the cumulative purchasing has been for that vendor over a relative period of time.

Ms. Youssouf stated that she agrees with President Aviles. She was talking more generally if there are additional items that need to be addressed, but she agrees with him on that.

Dr. Stocker said that they are trying to do this jointly and cooperatively and he asked Mr. Galvasci to comment on the 100-5 and its utility.

Mr. Galvasci said that to be quite honest, the purchasing directors got together and we talked about 100-5. It is ambiguous to us. There are times where each purchasing director calls each other to get what they feel what 100-5 says. Then we go with a consensus. To which Ms. Youssouf commented that that speaks volume. Mr. Galvasci added that he was being honest. Ms. Youssouf responded that she hears him, but that she is happy he is. Ms. Galvasci stated that it is ambiguous to them and at the meeting Mr. Martin, we did some training for the purchasing directors and the buyers now.

Mrs. Bolus asked what the biggest reason why you can't implement it is. To which Mr. Martin responded that it is multi factorial. When he sat with purchasing directors, they came up with at least six different items that impede them from adhering to this policy. They know that this is their responsibility; they are really sort of committed to working through it. So this is one of the ongoing things that we have.

Ms. Youssouf said that they should consider 100-5 as kind of a living document at this point, but this is exactly the kind of feedback they need. Dr. Stocker added that he understood that they are kind of all in this together and are all kind of learning as they go along.

Mr. Galvasci added that he was not part of when 100-5 was being compiled, but if he could suggest that if you do have some type of committee to go over it again, to include some of the purchasing directors in that meeting, because we are the ones who are on the battlefield dealing with that on a daily basis.

Ms. Youssouf stated that that would be a good idea.

Dr. Stocker said that his guess is when we get done with this, it will disrupt some relationships with local vendors and that is going to be hard to work through. Ms. Youssouf added that she thinks every facility has certain things that they order, and even though the orders are small, cumulatively, they know that these vendors add up to well over $100,000 so this is not a surprise. Those are things that people who have been at the facility for a while should not be surprised as far as going forward with this. It might be a good idea for them to look at that and say yes, every year we end up putting in a million dollar order from these companies; then just do it up front for the CRC.

Ms. Youssouf thanked them and stated that there was one more guest.

Mr. Telano continued by stating that the last audit report is of the accounts receivable area at Lincoln Medical Center and asked the representatives to approach the table. He wanted to point out that since he came here three years ago, he has always stated that he has no problem issuing an audit report with no findings and this is the first.

Dr. Stocker said that they just wanted them to come so that they could say thanks to you. Ms. Youssouf added yes, that is true that the Committee was incredibly impressed and wanted to thank you for all your hard work on making sure this works, and this would be a good best practice, right Mr. Martin.

Mr. Telano asked them identify to themselves. They did as follows: Victor Bekker, Chief of Finance; Paula Mandell, Associate Director for Finance, Patient Accounts; Mr. Chris Provenzano, Associate Director, Contracts and Finance.

Ms. Youssouf stated that once again, thank you very much, we are very happy.

Ms. Youssouf added that given the time constraints, in that room is filled up with people that are anxious to start the next meeting, she suggested that the Compliance update be postponed to the next Committee meeting. She asked Mr. Wayne McNulty if there is anything critical that he needs to let the Committee know at this time.

Mr. McNulty responded no, and agreed to do it next time.

Capital Committee – February 14, 2013
As reported by Ms. Emily Youssouf

Assistant Vice President's Report

Alfonso Pistone, Assistant Vice President, Office of Facilities Development, provided an overview of the meeting agenda. He informed members of the Committee that there was one action item for consideration; an impromptu information item regarding issuing a Request for Proposals (RFP) for Construction Management (CM) services relating to mitigation projects resulting from Super-storm Sandy; a status report on the major modernization project at Gouverneur Healthcare Services; and, two brief delay reports. Additionally, as follow-ups to previous Committee meeting inquiries, Mr. Pistone advised that John Levy, Base Tactical, was in attendance to provide answers with respect to the 100 and 500 year flood lines, and Jeremy Berman, Deputy Counsel, was prepared to give a brief update on the relinquishment of the steam plant on the Coler campus of Coler-Goldwater Specialty Hospital and Nursing Facility.

The Committee was also advised that HHC had received written commitment from the Office of Management and Budget (OMB) with respect to the representation that OMB would make HHC whole in the event that the $1.7 million required for decommissioning at Goldwater was required to complete the Henry J. Carter Skilled Nursing Facility.

That concluded his report.

Action Item:

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve the budget for relocation of the "T" Building at Queens Hospital Center, estimated to be $8.4 million.

Julius Wool, Executive Director, Queens Hospital Center, read the resolution into the record on behalf of Ann Sullivan, Senior Vice President, Queens Health Network, who was present. Mr. Wool and Ms. Sullivan were joined by Robert Rossdale, Deputy Executive Director, and Juan Izquierdo, Associate Executive Director, Queens Hospital Center.

Mr. Wool explained that the "T-Building" was an approximately 250,000 square foot structure, that at present was approximately 85% vacant, with only about 30 programs occupying space; mostly administrative with a few ambulatory care services. Since the recent major reconstruction project on the campus the plan has been to evacuate the building, and as a result of that decision there have been no capital investments made on the structure in the past 10 years. At present, the facility has space available on campus as a result of Healthcare Efficiency and Affordability Law (HEAL) funded projects, which include creation of shell space that is available to house these programs.

Josephine Bolus, RN, asked if the trailer located off-site is convenient, and whether that is where volunteers would be reporting. Mr. Wool advised that the trailer is on-site and Mr. Rossdale added that volunteers would likely be moved to the Parson's trailer. He specified that the offices for the volunteer program would be relocated but the volunteers themselves would only visit that site for initial registration purposes, they will not sign-in there on a daily basis.

Ms. Youssouf asked if the building would be left standing once it was evacuated. Mr. Rossdale said yes. Ms. Youssouf asked why it wouldn't be reused if it would be sitting empty on the facility's campus. Mr. Izquierdo advised that there had been previous discussions about the site being used for assisted living and that agreement fell through during the economic downturn. He said it still is widely known that the building is available and the subject is being discussed. Ms. Sullivan advised that LaRay Brown, Senior Vice President, Corporate Planning, and her office has been in some preliminary discussions with the facility as to whether an organization like Communilife may be interested. The topic has been raised. The goal is to have the building be useful to the community and in some way beneficial to the hospital.

Mrs. Bolus asked if any possible future occupant would be responsible for upkeep, refurbishing, and/or remediation work necessary on the structure. All parties said yes. Any agreement would be sure to include that.

Antonio Martin, Executive Vice President, added that he was familiar with the building and believed that it is a life-safety issue and decommissioning the structure, with the hopes that repurposing in the future, is the best plan.

Mrs. Bolus asked what the Corporation would have to do to make the building safe. Mr. Rossdale said he did not believe that the building was an imminent disaster, although there are leaky roofs and unstable balconies. He noted that the building was built in 1938, as a tuberculosis hospital, and therefore was not designed in a way that is practical for a modern healthcare facility's needs.

Mrs. Bolus asked whether there was any need for concern that the structure would in some way injure passersby. Mr. Rossdale said no, but if there is no immediate plan for occupancy or take-over by another party then there are a few precautions that would be taken, such as scaffolding, or small decommissioning projects.

Ms. Youssouf asked if an RFP had been issued regarding developing the site. Mr. Martin said he believed that was the path that was being investigated but at this point it is most important to get the staff out of the site. Ms. Youssouf agreed but said there should be a plan and it should be high priority so that the building does not become a hazard on the property.

Ms. Youssouf asked about the trailer and the modular structures, and whether these were long term solutions. Mr. Rossdale advised that the modular buildings are in fact pre-fabricated structures with foundations, footings, etc. He noted that the Parsons trailer has been on the campus for 25-30 years, but the structures need to be legalized, which is part of the plan. Mrs. Bolus asked what that meant. Mr. Rossdale said that the site would then be considered an official building by the Department of Buildings, but in order to do that some work is needed to bring the structure up to code, such as, installation of sprinklers, and proposals are being solicited for someone to do that design work. Mrs. Bolus asked how much that would cost. Mr. Rossdale said the budget had allotted $350,000 for that part of the project.

Ms. Youssouf asked why the contingency was only 5%. Mr. Rossdale explained that project contingencies vary. Some are low because there isn't much possibility of overrun, or because work has already been completed and it is clear that contingency would not likely be needed. For example, portions of the design are almost complete and that contingency will not likely be needed Ms. Youssouf asked if unused contingency would then be shifted to another part of the project if necessary. Mr. Rossdale said yes.

Ms. Youssouf asked about decommissioning costs. Mr. Rossdale said that is not part of the project. If an organization takes over the building then HHC will not be responsible for that. Ms. Youssouf asked if, prior to the upcoming Board meeting, it could be determined how quickly an RFP could be issued and what the cost of decommissioning would be, as the longer the building sits idle the more likely HHC gets stuck paying for some decommissioning work.

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

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

Information Items:

RFP for Construction Management Services

Joseph Quinones, Senior Assistant Vice President, Operations, explained that the Corporation would be issuing an expedited RFP for Architectural and Engineering (AE) Services for mitigation work resulting from the effects of Super-storm Sandy. Mr. Quinones was joined by John Levy, Base Tactical.

Mr. Quinones advised that while the final contract(s) will go before the Contract Review Committee (CRC) and will be presented to the full Board, it was determined that this was the best time to present the plan, in the interest of keeping the Capital Committee informed. Since there is no active contract, no action item could be presented, but the information item will allow them to have some knowledge of future items that may be seen by the full Board, if not at the Committee.

Mr. Quinones advised that the AE firms being solicited are for specialized services, which is why current AE firms do not have capacity to provide the types of services needed. Mr. Quinones shared an image of Lourdes Hospital in Binghamton, New York, that featured nine (9) foot flood gates that prevented severe flooding at that facility. He explained that this is an example of the type of mitigation work that is being considered for HHC facilities that were affected by the Super-storm; Coney Island Hospital, and Bellevue Hospital Center in particular.

Mr. Levy explained that the image showed a flood level of 8'3" running up against a 9' flood barrier.

Mr. Quinones explained that the need to expedite the RFP was in part due to the fact that the upcoming hurricane season begins in June. He added that there are a number of questions and engineering issues that will need to be answered in order to determine whether this is feasible for HHC facilities.

Dr. Stocker asked for clarification on the timeline of the RFP and issuing the contract. Mr. Quinones explained that this item will be brought before the full Board in March.

Mrs. Bolus asked if there was any estimate as to how much studies would cost. Mr. Levy said that soliciting the appropriate firms was the first step but until the RFP process is executed it was unclear what type of mitigation work would be suggested. He added that it is possible that the Committee may select more than one firm, in which case there would possibly be multiple options to consider. Until ideas are flushed out, the benefits of soliciting from firms across the country will provide detailed and useful responses from firms that specialize in this specific area.

Ms. Youssouf asked if this is something that is potentially covered by the Federal Emergency Management Agency (FEMA). Mr. Levy said yes. There is potential. HHC has been given a sense from sources inside and outside of FEMA that HHC should be looking at long-term solutions for preventing these things from happening again.

Alan Aviles, President, advised that another reason for expediting the process, and not coming before the Capital Committee at a later date, is the possibility of seeing some short-term mitigation options that may be able to be put into place prior to the upcoming hurricane season, being that much of the long-term, extensive mitigation projects may be projects that require longer lead time with regards to necessary funding and actual project completion.

Ms. Youssouf asked if this was an appropriate time to discuss the 100 and 500 year flood plan and asked for an explanation. Mr. Levy advised that flood plans were drafted by FEMA based on information secured by a Corps of Engineers and national engineering firms. They provided data over the last 15 years which transitions into these levels. They are scientists' best guess as to what could occur. He stated that the last significant study for the metropolitan area was done in 1972. Mr. Levy noted that these are parameters that provide guidance as to what is at risk. Since FEMA is the institution that can provide funds they have the ability to enforce guidelines that organizations need to follow should they wish to be reimbursed for future damages. Advisory levels are three (3) to four (4) feet higher than the 500 year plans. FEMA has advised that in order to receive hazard mitigation money, money to build walls, move pumps, etc., work had to be no less than the 500 year flood line in place at the time of the storm. Ms. Youssouf asked if FEMA said that. Mr. Levy said yes. Doing better than the minimum is the idea. He advised that switch gear repairs at Coler and Bellevue have been completed according to 500 year plan requirements.

Ms. Youssouf asked about whether any additional HHC facilities were included in new flood zones. Mr. Levy said he was unsure. Mr. Aviles said he did not believe that other facilities were in the flood zone, but some facilities that were not previously at risk are now considered so, such as, Harlem Hospital Center and Metropolitan.

Mrs. Bolus asked if HHC's insurance had increased. Mr. Aviles said no, HHC self-insures.

Relinquishment of Steam Plant at Roosevelt Island – Coler Campus

Jeremy Berman, Deputy Counsel advised that it was determined that costs relative to leaving the steam plant and turning it back over to the Roosevelt Island Operating Corporation (RIOC) are limited to the costs of remediating the existing bulk storage petroleum tanks, there are no other costs involved. The Committee had asked what the cost would be and the estimate from Liro, through DASNY, was $838,000. Mr. Berman explained that the estimate included $100,000 for removal of contaminated soil, although testing shows no contamination (that's just in case), so in his opinion the $838,000 may be higher than necessary.

Ms. Youssouf asked if this is being contracted out for. Mr. Berman said no, the plant will continue to operate for about a year from now so there is no obligation to close now. Timing is under HHC's control. In the coming months planning will be taking place.

Gouverneur Healthcare Services – Major Modernization – Status Report

Mendel Hagler, Executive Director, Gouverneur Healthcare Services, provided the status report on the major modernization project. Mr. Hagler was joined by Lynda Curtis, Senior Vice President, South Manhattan Health Network, Dean Moskos, Director, Office of Facilities Development, John Pasicznyk, Managing Director, Construction and Metro New York Operations, and Steve Curro, Managing Director, Construction, Dormitory Authority of the State of New York.

Mr. Hagler advised that the Construction Manager had recently completed work on floors four (4), five (5), six (6) and seven (7) of the original building. The Department of Buildings (DOB) had issued temporary Certificate of Occupancy and the facility is waiting for pre-inspection surveys by the Department of Health (DOH) anticipated for February 21st and February 26th. Renovations merged the new ambulatory care building with the existing facility to create what appears to be a single 40,000 square foot space on each floor. The new fourth floor now houses Surgical and Imaging Services including a new Cat scan and expanded ophthalmology suite. Mr. Hagler thanked Dr. Stocker for his assistance in securing funding from LMDC for said scanner. On the fifth floor is a 21 inpatient bed Rehabilitation Center, and primary sub-acute care space. These are the central components to present the facility as a leader in sub-acute and rehabilitation services. This progress also enables the facility to work with other HHC facilities to discharge patients. The sixth and seventh floors hold 74 sub-acute and long term care beds, bringing the total number of renovated beds to 135.

Mr. Hagler noted that patients and residents, community and staff have been through a lot. This is a big project and renovating a facility while it is fully occupied is quite difficult but the progress has been significant in delivery of care. The overwhelming sentiment is extremely positive. Mr. Hagler took a moment to read a note from a recent patient, who said, "… choosing Gouverneur was the best choice I could have possibly made."

Mr. Curro confirmed that floors four (4), five (5), six (6) and seven (7) have been turned over to the facility, and the Department of Health (DOH) would be coming in soon so that floors ten (10) and eleven (11) can then be decanted and construction can begin. Work continues to advance on

floors two (2), three (3), eight (8), and nine (9). Demolition and abatement phases are complete on ten (10) and eleven ((11), turnovers for two (2) and three (3) are scheduled for May 2013, in September for floors eight (8) and nine (9) and October for ten (10) and eleven (11). The final phase will be the first floor. Mr. Curro expressed confidence that the project had stabilized from a budgetary standpoint, noting that changes, errors and omissions, and any general surprises have likely by this point been mitigated.

Ms. Youssouf asked whether additional monies would be requested. Mr. Curro said no. He advised that regarding MWBE stats are 14% for Minority, 8% for Women, totaling approximately 22% at this point. Almost everything has been contracted out.

Mrs. Bolus asked about a section of the report that referenced the exclusion of CON fees, some planning fees, Value Engineering Services, and other things. Mr. Moskos advised that additional funding sources, outside of the scope of DASNY work, such as DOH fees and value engineering were funded by City General Obligation (GO) Bonds and were under separate Certificate to Proceed (CP), and were therefore not included in the total DASNY budget.

He noted that the budget breakdown shows Information Technology (IT) infrastructure was funded separately and the budget reflects the $4.4 total as well as the separate parts of that. $1.7 million was a separate DASNY WO and the balance of $2.2 million is managed by HHC. So that is a separate funding source outside the DASNY scope.

Ms. Youssouf asked if $251 million is all inclusive amount. Mr. Moskos said yes. Ms. Youssouf asked if there was money available to cover the shortfall. Mr. Moskos said yes, in the recent past the Office of Management and Budget (OMB) approved an additional $33 million plus some funds reallocated from within the capital plan. Ms. Youssouf asked what the $33 million was for. Mr. Moskos explained that was what HHC had asked for to make the project whole. He explained that $5 million of that, for contingency, will be provided if necessary. Mr. Pasicznyk explained that of the full contingency they will not approve $5 million of that until it is deemed necessary.

Mrs. Bolus asked who determines if the money is needed. Mr. Curro said that if the project reaches a point where change orders cannot be completed or no encumbering can be completed, than prior to that point OMB would be asked for the money or at least a portion of it. Mr. Aviles advised that OMB has been closely tracking the project and he feels that because this is not actual contingency they do not wish to approve if not necessary. Ms. Youssouf asked that the numbers be included in the total project cost. The project is $251 million not $246 million. Whether they are related to DASNY or not the costs should all be included. She asked that the budget reflect that moving forward. This has to be reported as a whole. No missing pieces.

Dr. Stocker advised that as a result of the significant cost overruns on this project, and others, there has been some discussion about the construction management process at HHC. We have three (3) suggestions; 1) move to a CM at-risk process for construction projects, so that people doing work are responsible for timeliness, etc., that is common in other city departments, 2) need better data system for Capital project information, and, 3) OMB needs to be worked with very closely, as projects always come in low and then go over budget, which has affected our relationship with them. We owe it to them to have all costs included in initial estimates, and we need to have an honest working relationship with OMB. Ms. Youssouf added that the projects need to be fully investigated before beginning, and Central Office should review all preliminary estimates and scopes to be sure everything is included, and all planning is in place; i.e., moving, decommissioning, etc., and that everything is phased and planned appropriately.

Mr. Curro said he supported the idea and felt that it imposes a certain discipline on the project owner. It means money will need to be spent at the forefront, but it will be less than money that what is being spent on the back end, as in these recent situations, although, CM at-risk has to be an option for HHC. He inquired as to whether HHC is allowed to hold the contract (single-prime). He explained that DASNY is permitted to do CM at risk, but only with certain legislation, and as long as there is a project sponsor. Mr. Pasicznyk added that there is blanket authorization within the State of New York (SUNY) Dormitory Authority statute to be able to use CM at risk at any dormitory facility, but otherwise it is specifically written in legislation for specific projects. He noted that DASNY has been looking for more broad legislation. Mr. Aviles said that HHC would be happy to work together on getting that legislation. Mr. Curro said the good news is that alternative delivery methods are advantageous and therefore things are changing. DASNY has asked repeatedly over the years to open up to any contracting methodology so that organizations can choose their preferred contracting methodology. Multiple prime is being moved away from. The city PLA allows for single prime contractor. Ms. Youssouf requested that Counsel check with HHC legislation to see if these are possibilities and what the limitations are, and to determine what Economic Development Corporation (EDC), and the New York Power Authority (NYPA) legislation reflects. She asked that Counsel report back by the next Capital meeting. Mr. Berman said discussions were already taking place. We have more flexibility then currently exercised. Mr. Curro said that legislation is already in place that allows for under $3 million projects to be Wicks exempt. Ms. Youssouf said that was not HHC's primary concern.

Project Status Reports
North Bronx Health Network
South Manhattan Health Network*
South Brooklyn/Staten Island Health Network*
* Network contains project(s) that require a delay report

Mr. Pistone advised that two projects were reporting delays of six (6) months or more, the Boiler Replacement at Coney Island Hospital Center, and the Expansion of the Inpatient Psychiatric Unit at Bellevue Hospital Center. He explained that both projects experienced some delays due to the impact of Super-storm Sandy. With regards to the boiler project, NYPA is reviewing the plans to be sure the project is in line with any anticipated mitigation. He noted that he had further delay report information available but in the interest of time the report was kept short.

Medical & Professional Affairs / Information Technology Committee
February 14, 2013 – As reported by Dr. Michael Stocker

Chief Medical Officer Report:

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

Health Home

Since the Health Home soft launch in August 2012, enrollment activity in Phase I HHC facilities continued at a steady pace for targeted eligible populations. HHC COBRA and CIDP care coordinators have worked to outreach and enroll their legacy patients and succeeded in enrolling 70% of their assigned patients. Outreach workers, using the roster of newly eligible patients provided by NYSDOH, sought to locate these individuals and initiate community-based enrollment. Of approximately 1,600 eligibles, 616 were contacted with 74 agreeing to enroll in HHC Health Home. Through these combined outreach and enrollment strategies, HHC Health Homes have enrolled 558 patients.

Since Phase II sites in Queens and Manhattan were approved in December 2012, NYSDOH issued a new roster of patients on January 21, 2013. This roster is comprehensive, representing 3,900 eligible FFS and MetroPlus-managed patients from both Phase I and Phase II regions. Importantly, the quality and accuracy of the patient information is much improved and supersedes the previous roster that had been provided. An analysis of the roster again shows a population of high acuity with 67% of the population having composite scores 125-149 or low high acuity; 20% having a composite score of 150-174 (similar to the CIDP patient population); and finally 13% with the highest acuity and complexity and composite scores in the 175-200 range. The boroughs of Queens and Brooklyn have the majority share of this roster with 2,381 patients linked to their facilities where outreach activities have been initiated in February. CIDP and COBRA programs in Phase II boroughs have a total of 802 active legacy patients. Care coordinators have also initiated engagement and enrollment of these patients this month.

To help guide the enrollment process, the HHC Health Home Office has been holding training sessions on the use of health Home enrollment and consent. Staff from legacy programs at Queens and Elmhurst Hospitals has already been trained; training for Bellevue, Harlem and Metropolitan is scheduled to take place this month.

Infrastructure for HHC's Health Home is being developed in a number of ways. The prototype for an interoperable Care Plan Management System (CPMS) will be ready for launch in March with user testing and training scheduled beginning in February and continuing through March. The web-based CPMS will be available to care team members via password; members of the Interboro RHIO will have view access to the care plans developed in the in the CPMS later this year. The Health Home Network is being developed through a phased-in strategy beginning with executing Data Exchange Application and Agreements (DEAAs) for the community-based organizations that were vetted and prioritized by HHC facility leadership in May 2012. We currently have completed DEAAs with 24 unique organizations and 16 additional DEAs are in progress. HHC Health Home will begin to develop contracts with community providers who are currently providing COBRA services to HHC patients who are eligible for Health Home services.

Dialysis Transition Project Report

- Project Manager for Transition has commenced – David Veras from Woodhull MMHC
- HHC / Atlantic Dialysis Contract has been signed
- PAGNY Contract to be signed soon (by 2/15/2013).
- Transition Schedule:
- Woodhull Medical Center by March 4, 2013
- Queens Medical Center by March 11, 2013
- Coney Island Hospital by June, 2013
- North Central Bronx Hospital by July, 2013
- Jacobi Medical Center by August, 2013
- Lincoln Medical Center tentatively by September, 2013
- Standardized flow sheet has been developed for utilization at all sites
- IT Risk Assessment being conducted by HHC IT Security Dept. preparing for software integration between EPIC & QMS (Atlantic Dialysis EMR Software)
- ADMS is finalizing Policy & Procedure Manual to be distributed to each hospital for review and input.
- Fresenius Medical Care has been notified of transition and impending supplies & water testing contracts being phased out facility by facility at

the point of their scheduled transition.
- Dialysis Equipment to be sold has been identified. Relinquishment & Depreciation is being conducted and will be produced to ADMS for purchase by Friday 2/15/2013 for Woodhull & Queens. Other facilities by April 2013.
- Working on standardizing and streamlining the HR & Nursing Onboarding process throughout HHC for all ADMS staff. Working closely with HR Directors and Nursing Directors.
- ADMS has updated their Liability Insurance Policy to cover Acute Facilities.
- ADMS Architect has visited NCB (2/6/13) & Lincoln (tentatively scheduled for 2/15 @2pm) to view space for new Chronic unit.
- Transition process to be presented at HR Directors, CNO Council and Chiefs of Internal Medicine – scheduled for Supply Chain Council and the CFO Council

HHC'S Teen Health Improvement Program

The Mayor's Young Men's Initiative funded HHC's Teen Health Improvement program that began in April 2012. The program's mission is to improve population health outcomes among HHC's adolescent patients by ensuring the accessibility and quality of health services HHC provides with a focus on sexual and reproductive health.

The Teen Health Improvement program has completed a needs assessment, and has a Health Improvement Panel at all 17 facilities. Supplies of contraceptives and patient education materials have been distributed to all facilities. In addition, the Standardized Patient program for pediatricians won 3rd prize among over 1,000 entrants at the International Meeting for Simulation in Healthcare. Adolescent Patient Satisfaction Survey is underway at all open facilities (not yet at Coney Island or Bellevue).

Future work includes:
- develop and deliver a multi-faceted provider training program;
- expand adolescent Standardized Patient program throughout HHC;
- assist pediatric/adolescent clinics qualify to be listed in widely-distributed DOHMH teen clinic listing;
- develop teen-friendly web page promoting HHC's services;
- investigate opportunities for increasing revenue for adolescent care (e.g. via use of the Family Planning Benefit Program, a little-known Medicaid program that covers sexual health care, or better financial practices; and
- support inter-facility collaboration regarding adolescent health quality improvement work.

Improving Access to Primary Care

As has been previously discussed, providing adequate access to primary care is an essential component of the future HHC healthcare delivery system. It directly impacts many areas which include the capacity to enroll and maintain managed care patients as well as to attract beneficiaries to our new ACO. Current performance in providing adequate access and satisfying the needs of our patients needs to be improved. In order to progress this issue, an engagement with McKinsey & Co is commencing this month to assist the corporation to meet the needs of our current and future patients. This is a large and complex task and will be reported further in detail to the Committee as the work progresses.

Chief Information Officer Report

Bert Robles, Senior Vice President/Chief Information Officer provided the Committee with an update as to the Corporation's status to meet Meaningful Use Stage II.

The Corporation continues efforts to meet requirements under the American Recovery and Reinvestment Acts (ARRA) program for Meaningful use of Electronic Health Records. This national program aims to increase the prevalence of electronic health record use across all providers of care including hospitals and community practitioners with the aim of forming a more connected healthcare system that is necessary to coordinate care, improve efficiency, decrease cost, and improve quality. This multi-year program has several Stages which will evolve over the coming years. Each Stage contains new requirements and providers are rewarded with incentive funds for achieving and sustaining each Stage.

In the fall of 2012, all eleven HHC facilities attested to achieving Stage 1 Meaningful Use. As a result, HHC received $17million of incentive funding under the Medicare portion of the Program and another $43.5 Million in Medicaid incentive dollars. In Stage 1 of the program, Hospitals need to meet minimum thresholds with fourteen core program measures as well as five menu measures. This stage continues for another year. HHC will receive additional incentives in 2013, provided Hospitals continue to meet these minimum thresholds. HHC is currently on track to do so and we continue to monitor performance across the system. To monitor for ongoing compliance all eleven hospitals run monthly reports on these performance measures.

Even as HHC remains focus on sustaining Stage 1, the Corporation is preparing for Stage 2 of the program. Stage 2 of the program includes both new requirements not previously part of Stage 1, as well as increased achievement thresholds for existing requirements. Among the changes are the requirements for Bar Coding of medications as well as the ability for a patient to download an admission summary within 36 hours of hospital

discharge. In addition, several of the measures, which were optional in Stage 1, are now required in stage 2, including transition of data to immunization registries, medication reconciliation, and patient specific education resources. In addition to meeting the Meaningful Use Criteria described above, each hospital will need to electronically transmit sixteen Quality measures to CMS.

As was the case in preparing for Meaningful Use Stage 1, Stage 2 will require several major software upgrades. These include moving from the current QuadraMed software version of 5.2, first to version 5.4 and ultimately to version 6.0. QuadraMed has advised HHC that the 6.0 version will not be generally available until the third quarter of calendar year 2013. However, it is anticipated that several HHC facilities will participate in the Beta release of this version which will give HHC an opportunity to test the system and test the features and functions in the release. All facilities are expected to be on version 5.4 by June 30, 2013. In addition to these software upgrades, there is also a database upgrade for the Cache database as well as updates to the MediSpan drug database.

As was the case for attestation in Stage 1, the first year of Stage 2 is allows for a 90 day compliance period as opposed to 365 days in subsequent years. However, unlike stage 1, which allowed hospitals to choose any 90 day period, Stage 2 requires the period to coincide with a quarter within the Federal Fiscal year. HHC plans to have all software upgrades completed by the fall of 2013, thus permitting hospitals to attest in one of the three remaining quarters of the fiscal year: January – March 2014; April – June 2014; or July – September 2014 (last chance).

MetroPlus Health Plan, Inc.

Arnold Saperstein, MD, Executive Director, MetroPlus Health Plan, Inc. presented to the Committee. Dr. Saperstein informed the Committee that the total plan enrollment as of January 31, 2013 was 443,173. Breakdown of plan enrollment by line of business is as follows:

Medicaid	377,914
Child Health Plus	13,466
Family Health Plus	36,467
MetroPlus Gold	3,287
Partnership in Care (HIV/SNP)	5,679
Medicare	6,354
MLTC	6

From December to January, MetroPlus gained 4,630 members. MetroPlus experienced a positive gain in Medicare, gaining 160 enrollees.

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

Dr. Saperstein informed the Committee that MetroPlus' membership losses to Health First and Fidelis are holding steady at 1,200 per month. MetroPlus continues to reevaluate their marketing and retention efforts to address these losses. The losses due to the dental plan change have tapered off, and MetroPlus is working with Healthplex to continually improve their dental network's satisfaction.

MetroPlus was informed this month that 160 Water Street will be open and available for occupancy on February 15, 2013. Their move back to 160 Water Street is dependent on air quality safety, as well as full availability of phone and data services. MetroPlus is working on their plan for relocating all areas and anticipate having all operations back at 160 Water Street by mid-March 2013.

This month, MetroPlus completed an analysis of their Medicare disenrollments and found that the majority of their losses were because members voluntarily disenrolled to join another plan. The largest segment of the members surveyed left MetroPlus' Platinum product to join Healthfirst Medicare.

Enrollment for MetroPlus' new Managed Long Term Care product began on January 1, 2013. MetroPlus currently has six members and are expecting 22 new members in February, including 13 new auto assignments.

MetroPlus is in the process of preparing to submit an application for the Fully Integrated Duals Advantage (FIDA) program. FIDA is a three-year demonstration project designed to test new service delivery and capitated payment models for beneficiaries dually eligible for Medicaid and Medicare. These beneficiaries must require more than 120 days of long term support and services. The demonstration project will be effective in January 2014 and will service eight New York counties, including Bronx, Kings, New York, Queens, Nassau, Suffolk, Richmond and Westchester. The total number of beneficiaries eligible for the demonstration is estimated at 123,000. Beneficiaries currently enrolled in the MetroPlus MLTC program will be passively enrolled in the FIDA program, with an option to opt-out. All Medicare Advantage plans will transition to a product line to provide FIDA. Otherwise, plans that do not transition to FIDA will only serve duals that opt-out or dis-enroll from FIDA. The initial application is due to CMS February 15, 2013.

On January 31, 2013 the New York Health Benefit Exchange issued its invitation to health insurers and dental plans to participate in the New York Health Benefit Exchange. The letter of interest is due on February 15, 2013, and the submission of a participation form is required by April 5, 2013. NYS Health Benefit Exchange will go live in October 2013. Qualified Health Plans (QHPs) are classified into 4 types of product levels, Platinum, Gold, Silver, and Bronze; with progressively increased copayments and deductibles. Within each plan there will be an additional pediatric option and within the Silver plan there are three additional levels of coverage based on a member's income as compared to the federal poverty level. Given these requirements, MetroPlus must offer a minimum of 16 products in the NYS Health Benefit Exchange, which will also include a Catastrophic Plan.

Governor Cuomo released his Executive Budget on Tuesday January 22, 2013. The Executive Budget proposes to revise existing Medicaid categories and convert eligibility levels to a Modified Adjusted Gross Income (MAGI) equivalent standard. The Executive's proposal establishes a new adult category for individuals ages 19 to 64 with incomes below 133 percent of the Federal Poverty Level (FPL) and provides that these beneficiaries receive a Benchmark benefit package. There will also be unique eligibility levels for pregnant women, parents, infants and children The Executive Budget also defines the Medicaid eligibility categories that will not be subject to MAGI financial methodologies and adds a new mandatory eligibility category for former foster care children, up to age 26 years old, who were receiving Medicaid when they aged out of foster care. The Executive Budget establishes 12 month continuous eligibility for individuals whose Medicaid eligibility is based on MAGI methodologies, except for individuals whose eligibility changes due to citizenship, residency or failure to provide a valid social security number.

Other changes in the Executive Budget include:

- Medicaid global cap (3.9%) remains in place and the 2% across-the-board payment cut, which was scheduled to expire at the end of this fiscal year, is extended through March of 2015;
- A repeal of "prescriber prevails" authority for atypical antipsychotics in Medicaid managed care and in the entire Medicaid fee-for-service (FFS) pharmacy program;
- Institutes a new $20 million quality incentive program for the Managed Long Term Care program;
- Eliminates statutory impediments to enrolling excluded FFS populations into Medicaid managed care;
- Amends the autism mandate to replace the $45,000 annual benefit cap with 680 hours of treatment per policy or calendar year;
- Enacts numerous provisions that will enable New York to align and conform with the federal Affordable Care Act (ACA) and move forward with the New York Health Exchange including:
- Beginning a phase out of the Family Health Plus (FHP) and FHP buy-in programs;
- Eliminating the standardized individual direct pay products, effective October 2013, and establishing a new individual market product outside of the Exchange that must conform to Exchange requirements;
- Eliminating the Healthy New York program, effective December 31, 2013.

Information Item:

Meaningful Use Update – Stage 2

Presenting to the Committee was Louis Capponi, MD, Chief Medical Informatics Officer. Starting in 2014, providers participating in the EHR Incentive Programs who have met Stage 1 for two or three years will need to meet meaningful use Stage 2 criteria. Stage 2 includes new objectives to improve patient care through better clinical decision support, care coordination and patient engagement. With this next stage, EHRs will further save our health care system money, save time for doctors and hospitals, and save lives.

Dr. Capponi reviewed the core objectives and menu objectives comparing the changes from Stage 1 to Stage 2 (see attached table for details). Highlights of the changes are below.

More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH have their information available online within 36 hours of discharge (Stage 1 was 10%, menu set). More than 5 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH view, download or transmit to a third party their information during the reporting period (new). Clinical summaries provided to patients within 24 hours for more than 50 percent of office visits (Stage 1 was 3 days).

More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency departments (POS 21 or 23) are provided patient- specific education resources identified by Certified EHR Technology (Stage 1 was menu set). A secure message was sent using the electronic messaging function of Certified EHR Technology by more than 10 percent of unique patients seen during the EHR reporting period (New – Eligible Provider).

The eligible hospital or CAH performs medication reconciliation for more than 65 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) (Stage 1 was 50%, menu set). The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. The eligible hospital, or CAH that transitions or refers their patient to another setting of care or provider of care

electronically transmits a summary of care record using certified EHR technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals (Stage 1 was one test of transmission).

Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1), including addressing the encryption/security of data at rest in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process (added data at rest).

In summary, there are a total of 22 Meaningful Use objectives of which 16 are core items required for Stage 2 and 3 of 6 menu items required for Stage 2. In Stage 2, Stage 1 menu items are now required, seven new objectives added and some related Stage 1 objectives combined. In addition, quality reporting now separate element of meaningful use. Hospitals now must report on 16 measures. Quality measures include the following 29 measures in six domains: Patient and Family Engagement (5); Patient Safety (6); Care Coordination (2); Population and Public Health (0); Efficient Use of Healthcare Resources (2); and Clinical Processes/Effectiveness (14).

Core Objectives

Core Objective	Measure Stage 1	Measure Stage 2
1. CPOE	**30%** medication	Use CPOE for **more than 60%** of medication, **30%** of laboratory, and **30%** of radiology
2. Demographics	**50%** demographics	Record demographics for more than **80%**
3. Vital Signs	**50%** vital signs over age 2	Record vital signs for **more than 80%**, blood pressure over age 3.
4. Smoking Status	**50%** smoking status	Record smoking status for **more than 80%**
5. Interventions	1 clinical support	Implement 5 clinical decision support interventions + drug/drug and drug/allergy
6. Labs	**40%** lab results	Incorporate lab results for **more than 55%**
7. Patient List	Same	Generate patient list by specific condition
8. eMAR	NEW	eMAR is implemented and used for **more than 10%** of medication orders
9 Transitions of Care Record	**50%** patients who request electronic copy are provided within 3 days.	Provided for more than 50% of transitions of care or referrals (does not have to be electronic) More than 10% are transmitted electronically • Care plan, including goals and instructions • List of team members, including PCP
10. Education Resources	Provide education resources. (previously a menu item)	Provide education resources **more than 10%** by certified EHR technology
11. Rx Reconciliation	Same (previously a menu item)	Medication reconciliation **at more than 50%** of transitions of care
Core Objective	Measure Stage 1	Measure Stage 2
12. Summary of Care Record for Patient	(New)	Updated measure. Patients can View, Download, and transmit to a Third Party a summary of care document within 36 hours, 50% of the time and 5% of patients actually do so.
13. Immunizations	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing transmission of immunization data
14. Reportable Labs	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing submission of reportable laboratory results
15. Syndromic Surveillance	Perform 1 test on EHR to submit data (previously a menu item)	Successful ongoing submission of electronic syndromic surveillance data
16. Security Analysis	Conduct or review security analysis	Conduct or review security analysis and incorporate in risk management process addressing encryption of data

Menu Objectives

Menu Objective	Measure Stage 1	Measure Stage 2
1. Advanced Directives	**50%** of transactions of care.	Record advanced directives for **more than 50%** of patients 65 years or older
2. Progress Notes	NEW	Enter an electronic progress note for **more than 30%** of unique patients
3. Imaging Results	NEW	**More than 20%** of imaging results are accessible through Certified EHR Technology
4. Family History	NEW	Record family health history for **more than 20%**
5. E-Rx	NEW	**More than 10%** electronic prescribing (eRx) of discharge medication orders
6. Labs	NEW	Provide structured electronic lab results to EPs for **more than 20%**

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

ALAN D. AVILES
HHC PRESIDENT AND CHIEF EXECUTIVE
REPORT TO THE BOARD OF DIRECTORS
FEBRUARY 28, 2013

RECOVERY AND RESTORATION WORK CONTINUES THROUGHOUT HHC

Both Bellevue and Coney Island hospitals have resumed receiving ambulances to their very busy emergency departments.

On February 6, a team from the state Health Department completed its site inspection, and gave Bellevue Hospital permission to re-open fully. Effectively, this means Bellevue is now ready to admit patients, offer full medical, surgical and critical care services, and most importantly, provide all the specialty services and support necessary to fulfill the stringent requirements of Level 1/Trauma designation. Since Bellevue is the only trauma center in Manhattan south of 68th Street, resumption of this service was of critical importance.

Ambulances began arriving at Coney Island Hospital on Wednesday, February 20. The hospital is accepting most types of 911 patients, including heart attack and stroke cases. Trauma care and labor and delivery remain closed. Repairs are ongoing at Coney Island, and its emergency department continues to function at a reduced capacity due to storm damage. However, the hospital's Tower Building has re-opened along with most of its inpatient beds and imaging and laboratory services, and the hospital has for several weeks been admitting patients from its emergency department and from other HHC facilities. Inpatient adult psychiatric beds, operating rooms, and medical/surgical beds, including intensive care, are all now available. All primary and specialty outpatient clinics are open, and a fleet of mobile medical vans continue to provide primary care services and flu shots in parts of Brooklyn and Staten Island affected by Sandy.

Earlier in the month, Coney Island Hospital also announced the re-opening of its Women, Infants and Children (WIC) food and nutrition program made possible with a $50,000 grant from Public Health Solutions and the Robin Hood Foundation. The two WIC offices run by the hospital have been closed since Hurricane Sandy, affecting 5,000 participants. The grant funding will support a temporary new WIC office, chosen for its easy access to public transportation. The grant will cover the rent of the temporary location, new office furniture, supplies, and clinical equipment, as well as client and community outreach.

Damage at several other HHC sites is extensive and work continues on the restoration of those sites. Continuing updates are provided to HHC staff on the specially established Restoration and Relief intranet site at http://restoration. We remain hopeful that a large portion of the more than $900 million estimated cost of full recovery from Sandy will be covered by FEMA. We are working closely with emergency recovery experts in our planning to restore and protect our facilities going forward, as well to set up the optimal FEMA claims process for this work. So far, FEMA has approved a preliminary submission for $103 million.

HHC STAFF KICKS OFF JOINT COMMISSION SURVEY YEAR WITH ORIENTATION

The 2013 multi-hospital survey of HHC by The Joint Commission began on Tuesday, February 19th with an Orientation Program for the survey team leader. The Orientation Program provides an opportunity for me and members of my senior staff to present The Joint Commission lead surveyor with an overview of HHC and how we provide oversight and support to the HHC facilities to assure that we meet the intent of TJC standards. This year's survey team leader, Mr. Siward Hazelton, RN, also briefed the participants on changes to the survey process and new requirements for 2013 and 2014.

The meeting was attended by senior staff from Central Office as well as from the facilities being surveyed in 2013, namely Elmhurst, Gouverneur, Jacobi, McKinney and Metropolitan. I am confident that each facility will perform well on this triennial evaluation of the quality and safety of the care we provide.

HHC BONDS GET TOP RATINGS FROM MOODY'S, S&P AND FITCH

The global credit rating agencies Moody's Investors Service, Standard & Poor's Ratings Services, and Fitch Ratings have assigned Aa3/A+/A+ ratings, respectively, to $110.5 million of new bonds to be issued next month by HHC. The agencies also said the rating outlook is stable.

Fitch also affirmed HHC's A+ rating on approximately $1 billion in outstanding debt. HHC expects to issue the new bonds the week of March 18, with proceeds used to pay off a portion of the outstanding debt.

The three agencies said the high ratings are linked to HHC's strong support from New York City and its essential role as the primary safety net provider to the City's Medicaid and indigent population. The ratings are confirmation of HHC's essentiality to the City of New York and our well-developed programmatic initiatives to transform our service delivery to meet the challenges of health care reform.

Citing HHC's management team as one of the organization's strengths, Fitch said HHC "has a seasoned management team in place that has produced stable financial performance, completed or is near completing major capital modernization projects at seven of 11 of its acute care hospitals, received federal approval as an accountable care organization, maintained productive relationships with key stakeholders, including NYC officials, and implemented an enterprise-wide process improvement tool that has led to enhanced quality and approximately $487 million in system wide savings."

FEDERAL UPDATE

The Budget Control Act mandated sequester begins cuts April 1. These cuts will apply to reimbursement for services provided in March. Medicaid and Electronic Health Record incentive payments are exempt from sequester. Medicare provider payments cuts would be limited to 2%. HANYS estimates the Medicare cut to HHC at $9.17 million in the first year and $81 million over 10 years. Many programs, including the Sandy Supplemental, September 11 health, Ryan White, among others, would be cut 6%. Thus, the $60 billion Sandy appropriation would be cut $3.6 million but it is not possible to calculate a specific reduction in any expected HHC reimbursement. This is also true of the WTC Zadroga funding, which is estimated at $27 million for the total national cut and possibly an estimated cut of $2.25 million or less to HHC. It is unpredictable whether or when Congress will act to avoid or end the sequester.

The Obama administration issued a final rule on Wednesday, February 20 defining "essential health benefits" that must be offered by most health insurance plans next year. The ACA requires insurers to cover benefits in 10 broad categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The rule will have a significant effect on the coverage of mental health services. As a result of the rule, the Administration estimated that 32 million people would gain access to coverage of mental health care and 30 million people who already have some mental health coverage will see improvements in benefits.

BELLEVUE GETS $1.6 MILLION GRANT FOR TRAUMA SERVICES

Through a $1.6 million Substance Abuse and Mental Health Services Administration grant, Bellevue Hospital Center in partnership with the Administration for Children's Services (ACS) will provide trauma-focused care at two ACS secure juvenile detention facilities -- Crossroads in Brownsville, Brooklyn, and Horizon in Mott Haven, The Bronx. Bellevue will establish trauma-informed mental health screening and evidence-based skills groups to reduce trauma-associated problems and will build partnerships in systems associated with juvenile detention to increase trauma responsiveness in those areas.

The grant was announced by Mayor Bloomberg on February 12, as part of a group effort which also includes the Child Study Center and the Atlas Project Administration on Children, Youth and Families, to improve trauma services for children and young people in New York City's child welfare and juvenile justice systems. The three organizations, which will also work with ACS, the Ulster County Department of Social Services and the New York State Office of Children and Family Services, have received grants totaling $7 million to support programs assisting children in New York City with mental health assessment and treatment, as well as train service providers who care for these children.

The grants are funded by the Substance Abuse and Mental Health Services Administration and the Administration on Children, Youth and Families. Key partners in this collaboration include the New York State Office of Mental Health and Office of Children and Family Services, the National Child Traumatic Stress Network and regional medical centers across the country.

HHC REACHES OUT WITH THE MESSAGE: "IF YOU'RE 50 OR OLDER, IT'S TIME FOR A COLONOSCOPY"

In observance of National Colorectal Cancer Awareness Month this March, HHC will continue our annual tradition of encouraging our staff and patients over 50 to get a life-saving colon cancer screening. As you already know, most cancers are diagnosed in people 50 years or older. A study from the American Cancer Society shows that half of Americans over 50 have not had any type of colorectal cancer screening. If everyone were tested as recommended, thousands of lives could be saved each year. My message to all HHC employees who are 50 or older and have not been screened for colon cancer: it's time for your colonoscopy.

This year, we are collaborating with the NYC Department of Health and Mental Hygiene and members of the Citywide Colon Cancer Control Coalition to create awareness through a unified social media campaign. Throughout next month, each agency will post a series of important messages, tips and stats about colonoscopy on Twitter and Facebook to help educate thousands of "fans" and "followers" about the benefits of colon cancer prevention, screening and early detection.

DEVIATION FROM OPERATING PROCEDURE TO EXTEND CRITICAL IT CONTRACTS

This month, after consulting with the Corporation's Senior Vice President for Legal Affairs and General Counsel, Salvatore J. Russo, I granted a deviation from our procurement Operating Procedure 100-5 due to exceptional and urgent circumstances presented by the expiration of certain information technology services contracts in the next three months if not extended. These contracts have been extended through July 31, 2013 so that Enterprise IT Services (EITS) can complete the competitive selection process in connection with the Health Information Related Services RFP for the Integrated Clinical Information System (ICIS) Project. The total authorized spending authority for all of these contracts is $4.35 million, based upon historical spending for each contract. The RFP process, which will take up to six months to complete, was

delayed because of unforeseen circumstances. The longest delay was caused by the need to finalize the award of the ICIS enterprise-wide software system contract to Epic Systems Corporation, since the RFP outlines EITS's requirement for Epic-certified consulting resources. As you are aware, although the Board of Directors approved the Epic contract award on September 27, 2012, the actual formal award was delayed due to a vendor protest, and was not resolved until late in 2012. Continued support from the consulting firms under contract is integral to the success of our on-going projects and operations.

BLACK HISTORY MONTH CELEBRATED THROUGHOUT HHC

HHC hospitals have held celebrations of Black History Month throughout the month of February. On February 7th, Elmhurst Hospital Center hosted keynote speaker Esther Armah, a radio host and national best-selling author. Also on the 7th, Lincoln Medical Center celebrated the month through an art show featuring the work of Robert Daniels, whose work with historic themes relates to his African ancestry. On the 14th, the Kings County Hospital Center tribute featured keynote speaker Annette Robertson, NYS Assembly Member and civil rights advocate. Finally, on February 22nd Governor Andrew Cuomo hosted his celebration at Harlem Hospital Center in the Mural Pavilion. The event featured the governor's traveling art exhibit of important figures in Black History, including Sojourner Truth, Frederick Douglass, Adam Clayton Powell and David Dinkins.

HHC STAFF AMONG CURRENT YEAR'S NAPH FELLOWS

Four HHC staff members have been accepted as 2013-2014 NAPH Fellows. The fellowship program, *Leading High Performing Organizations*, provides a valuable opportunity to network with colleagues who share similar missions and understand the unique challenges of the safety net. The NAPH Fellows will gain the invaluable knowledge and tools that can help them be even more effective leaders. Participating in this year's program will be Alina Moran, CFO at Elmhurst; Marie Elivert, Senior Assistant ED at Queens; Lillian Diaz, Deputy ED at Metropolitan; and Frank Piacenti, PharmD, at Lincoln.

HHC BIDS FAREWELL TO IRIS JIMENEZ-HERNANDEZ

I am sad to announce that Iris R. Jimenez-Hernandez will soon be leaving HHC. For the past six years, she has served HHC first as Senior Vice President of the North Brooklyn Network and Executive Director of Woodhull Medical Center and then as Senior Vice President of the Generations+/North Manhattan Health Network and Executive Director of Lincoln Medical Center. Under her leadership, Harlem Hospital opened its new Mural Pavilion, underscoring the historical role that Harlem Hospital Center has played in the community; the Renaissance Health Care Network relocated its flagship site, Sydenham Health Center, to a modern facility; and Lincoln Medical Center is on track to complete its Emergency Department expansion and renovation later this year. Lincoln also received the prestigious 2012 American Health Association-McKesson Quest for Quality Finalist Award for leadership and innovation in quality improvement and safety.

Prior to her most recent appointments at HHC, Iris spent 15 years at the New York City Human Resources Administration as Executive Deputy Commissioner, overseeing diverse and complex social services programs, including Medicaid, Adult Protective Services, Home Care Services, HIV/AIDS Services and the Food Stamp Program. Just as she excelled in managing those programs for the City, she has done a magnificent job as a leader with HHC. I know the Board joins me in both thanking Ms. Hernandez for her stellar service and in wishing her well in her future endeavors.

HHC IN THE NEWS HIGHLIGHTS

Broadcast

Beneficios de la vacuna contra la gripe durante el embarazo (Benefits of the flu vaccine during pregnancy), Telemundo Ch. 47, 01/18/13

Health and Safety Tips in the Snow, Dr. Fernando Jara, Lincoln Hospital, Telemundo Ch. 47
02/08/13

Partnership Aims To Pinpoint Trauma's impact On City Youth, NY1, 02/12/13
(Also covered by WCBS TV and WCBS Radio)

Ambulances Return To Coney Island Hospital, NY1, 02/22/13

Print

Fitch rates NYC Health and Hospitals Corp 2013A revs 'A+' HHC, Reuters, 02/21/13

Bellevue Hospital Fully Returns 99 Days After Evacuation, The New York Times, 02/07/13
(Also covered by NY1, WCBS, Reuters, Modern Healthcare, The Wall Street Journal, WNBC, iTech, Crain's Health Pulse, Ch 7, Ch 5, Ch 4, Associated Press, Chicago Tribune)

Hospitals Eye Big Changes After Sandy, Bellevue, Coney, Coler-Goldwater,The Wall Street Journal, 02/03/13

Bellevue Hospital Center in Manhattan Getting Federal Funds to Help Recovery, WFUV, 02/01/13

Bellevue Hospital's Slow Comeback After Superstorm Sandy, WNYC/NPR, 01/30/13

Coney Island Hospital Resumes Some Services, The Wall Street Journal, 02/22/13
(Also covered in Crain's Health Pulse, Newsday, WABC, Sheepsheadbites.com, Brooklyn Daily, The Washington Post)

Coney Island Hospital Reopens WIC Program After Sandy, Sheepshead Bites, 02/07/13

Performance-Based Bonuses Offered To Physicians by HHC, The Chief, 01/28/13

Medical Pay Model: Hospitals and Doctors Weigh In, Dr. David Stevens, HHC and Dr. Bruce Siegel, NAPH, Letters to Editor, The New York Times, 02/03/13

Dr. Wheelchair keeps things rolling, Mike Acevedo, Coler-Goldwater, HHC, The New York Times, 02/15/13

Managed care helps nurses guide members through rough waters, HHC, Nurse.com, 02/25/13

Managed-Care Market Consolidates as it Grows, MetroPlus, Crain's Health Pulse, 02/20/13

DOH Wants to Go Metric, Dr. Art Cooper, Harlem Hospital, Crain's Health Pulse, 02/11/13

Curbside medical check saves man's life, Coney Island Hospital, Brooklyn Daily, 02/05/13

Road to recovery, Terry Mancher, RN, Coney Island, Bellevue Hospital, HHC, Nurse.com, 01/28/13

theGrio's 100: Dr. Robert J. Gore, saving lives even before the trauma, Dr. Robert J. Gore, Kings County, theGrio.com, 01/15/13

Harlem Black surgeons saved the Civil Rights, Harlem Hospital, Caribbean Life, Jan 25-31, 2013

Matters of the Heart, Dr. Lekshmi Dharmarajan, Lincoln, The Bronx Free Press, 01/30/13

Patient Safety Awareness Week is March 3-9, HHC, Patient Safety Monitor Journal, March 2013

Community Album: First baby born at Bellevue Hospital after re-opening, El Diario, 02/10/13

2012 Year in Review:
Recovering and Reforming for the Future

ALAN D. AVILES, PRESIDENT
NEW YORK CITY
HEALTH AND HOSPITALS CORPORATION

FEBRUARY 28, 2013

Introduction

As has become customary for me at the February Board meeting, I report on the general state of HHC, review some of the accomplishments and challenges from the past year, and relate our most recent work to our strategic agenda moving forward.

As you know, last year we continued to confront formidable challenges to our system and our mission. As we worked hard to weather the ongoing fiscal storm in healthcare that has driven our budget into deep deficit, we came up against a literal storm of historic magnitude that inflicted heavy damage. Superstorm Sandy battered several of our facilities, forcing the evacuation of hundreds of patients (some critically ill), and disabling two of our hospitals for an extended period of time. With two major facilities closed for many weeks, we suffered staggering revenue losses and still have much work to do to fully restore the impacted facilities and to better protect them from any further mega-storm damage going forward.

However, before the year-end storm diverted so much of our attention and resources, we achieved a number of important milestones that narrow our budget deficit, further the transformation of our system consistent with the demands of healthcare reform and position us to better serve our patients and communities in the future.

Hurricane Sandy

Bellevue Hospital and Coney Island Hospital, among other non-HHC hospitals, were severely damaged during the storm, requiring us to evacuate hundreds of patients, including those who were critically ill on ventilators and more than 15 NICU babies.

The Coler campus of the Coler-Goldwater Specialty Hospital and Nursing Facility on Roosevelt Island was also hard hit, losing power, heat and hot water for an extended period. Although nearly 100 of Coler's most vulnerable patients were transferred to the Goldwater campus, the remaining residents remained sheltered at Coler until power, heat, and hot water were ultimately restored through mobile emergency generators and temporary boilers.

Other HHC hospitals and nursing homes received evacuated patients from Bellevue and Coney Island, as well as patients and residents from non-HHC hospitals and nursing homes damaged by the hurricane. The temporary redeployment of Bellevue and Coney Island staff to other HHC facilities helped to provide the extra hands needed to meet the surge in patient volumes elsewhere.

Both Bellevue and Coney Island worked quickly to restore, first, outpatient services and then limited emergency department services. Coney began to accept inpatients in the middle of January and has now restored most of its services; however, its emergency department capacity remains limited due to the extensive rebuilding that is needed. Bellevue fully re-opened on February 7 and has resumed its Level 1 Trauma Center status.

The Coler campus continues to operate on temporary electrical switchgear and emergency generators but steam distribution from the local co-generation plant has been restored and has now replaced the temporary boilers. The permanent repairs necessary for restoration of Con Ed electrical services at Coler are on track to be completed ahead of the air conditioning season.

Central Office operations also sustained damage from the storm. More than 1,200 staff members working in key areas such as Finance, Home Care, IT, and MetroPlus were displaced from their severely disabled office building at 160 Water Street. Despite being deployed among several sites across the City, these resilient and dedicated employees kept our core functions operational.

Although we have completed the first phase of our recovery from the storm by reopening our most heavily damaged facilities, there is still much work to be done to complete permanent repairs and to protect the facilities against any future storms of this magnitude. We are grateful that the City has appropriated $710 million as an advance against anticipated FEMA reimbursements for repair, restoration and risk mitigation efforts related to HHC facilities.

We remain very concerned, however, about the roughly $180 million dollars in lost revenue incurred during the period when our Bellevue and Coney Island facilities were fully or partially closed, as these losses are not FEMA-reimbursable. If not addressed, this loss will severely destabilize our finances going into next fiscal year. We remain hopeful that a portion of the several billion dollars appropriated by Congress recently in storm-related Community Development Block Grant funds can be tapped to cover these losses.

In the months leading up to the next hurricane season, we will continue to reposition critical systems within our vulnerable facilities to higher elevations and take other steps to better protect those facilities from any similar storm surge. However, some of the mitigation efforts, especially at Coney Island hospital, which remains vulnerable to a re-flooding of its first floor, will be longer term projects of significant cost and will require confirmation of FEMA reimbursement eligibility or commitment of other capital funds.

Confronting the Financial Challenges

The cost containment pressures for healthcare providers, and especially for safety net systems like HHC, continue to escalate. Nearly three years ago, projecting a very large future deficit, we laid out and began to implement a four-year cost containment and restructuring plan, "The Road Ahead."

Continuing on the Road Ahead

This past year we completed the implementation of the Crothall contract for the management of environmental services and the JCI contract for the management of plant maintenance services. Both of these will generate significant long-term savings. In addition, we contracted with a vendor to provide dialysis services and expect to complete implementation of that contract across our system by the end of this calendar year. We project that this contract will ultimately increase our dialysis capacity by 35% while saving an estimated $146 million over the nine-year agreement period. We will continue to guarantee access to dialysis services for all patients without regard to insurance or

immigration status, and no HHC staff member will lose employment as a result of this contract.

We also have submitted to the federal Health Resources and Services Administration (HRSA) our application to confer federal-qualified health center (FQHC) status on our six Diagnostic and Treatment Centers. We expect that HRSA will grant our application by the start of the next fiscal year. We continue to project that FQHC status will result in at least $25 million in additional revenue for services HHC provides at our DT&Cs.

The first phase of our work toward lab consolidation, focused on equipment and reagent standardization, was largely completed this past year and is now yielding about $7 million in annual savings. The second phase of the lab initiative, which will consolidate our four core laboratories into a single shared core lab, will be submitted to the Board for its approval imminently. Once fully implemented, this consolidation will yield further savings of at least $20 million annually.

Our preparation for the relocation of our Goldwater Skilled Nursing Facility (SNF) and Long Term Acute Care Hospital (LTACH) operations at the end of this calendar year to the new Henry J. Carter facility in Harlem has been progressing on schedule. As we have placed lower acuity Goldwater residents in appropriate community residences this past year, the census at Goldwater has been steadily reduced toward an ultimate decrease of several hundred long term care beds. This is consistent with the state emphasis on offering patients in need of long term care support at home, whenever feasible, and with overwhelming patient preference for community-based options. Toward this end, the completion of housing on the Metropolitan Hospital campus early next fiscal year for 175 individuals discharged from Coler-Goldwater. Residents will be linked to supportive services at Metropolitan Hospital.

Our four-year cost containment and restructuring plan sought to close our budget gap by $600 million and reduce the size of our workforce by 3,700 FTEs, while retaining most of our service capacity. At this point - more than two and one-half years into The Road Ahead -- we have reduced our workforce by more than 3,400 FTEs, and we project that

we will achieve $567 million of our targeted $600 million budget gap reduction by July 1, 2013.

HHC is in the process of refinancing $141 million in debt to achieve an estimated $30 million in debt service savings. Moody's Investor Service, Standard and Poor's Rating Services, and Fitch have sustained HHC's Aa3/A+/A+ ratings. These ratings reflect HHC's strong support from the City of New York, its essential role as a safety net healthcare provider, and its strong management and strategic plan. These ratings should support the sale which is anticipated later this month.

These impressive fiscal achievements have narrowed a projected budget shortfall between our revenues and expenses so large that it threatened the viability of our mission. This progress has not been easy, and it is a tribute to the commitment of our corporate and facility leadership, as well as the dedication and hard work of our co-workers throughout HHC, that we have been able to continue meeting the needs of our patients and communities with a workforce that has shrunk by 8%.

Despite this boost in productivity and considerable progress in reducing over all expenses, further cuts to reimbursement at the federal and state level, and spiraling expenses beyond our control, including pensions, still leave us facing a residual structural deficit of several hundred million dollars as we go into the next fiscal year. Some of the cost containment initiatives in our four-year plan that remain to be implemented will contribute toward the reduction of that residual deficit. In addition, the possible granting of federal funds under the state's pending 1115 waiver related to the redesign of the Medicaid program (which envisions a significant five-year grant to public hospitals) would help greatly.

New Revenue Opportunities

There are also opportunities to generate more revenue going forward. First, the expansion of Medicaid coverage under the Affordable Care Act, although modest in New York by comparison to other states that have set less generous Medicaid eligibility thresholds, will bring coverage to some currently uninsured HHC patients starting in

January 2014. In addition, our health plan, MetroPlus, will continue to grow both its Medicaid and Medicare enrollment, and it has begun to enroll members into its newly licensed Long Term Managed Care (LTMC) line of business. As an LTMC plan, MetroPlus's goal is to help the chronically ill or disabled, who would otherwise be eligible for nursing home admission, to stay in their homes and communities as long as possible. Care at home, when feasible, is generally a cost effective alternative to nursing home admission and is most often a patient's preference.

Further, in anticipation of the imminent transition of all behavioral health services to an integrated managed care model, MetroPlus has been meeting with community-based behavioral health providers to identify a robust specialized provider network as it prepares to apply as a Mental Health Special Needs Plan or to integrate behavioral health into its mainstream plan.

MetroPlus is also preparing to participate in the Fully Integrated Dual-Eligible Advantage (FIDA) pilot program to be launched by the State, and to participate in the new federally subsidized Health Insurance Exchange that will start operating at the end of this year. All of these new lines of business for MetroPlus constitute additional revenue opportunities, and equally important, represent a shift away from fee-for-service and toward a capitated reimbursement system that values and rewards the effectiveness of service delivery in promoting better health.

Operating More Efficiently: Breakthrough

The challenges that we continue to face in healthcare place a premium on two critical organizational competencies: the ability to engage in continuous improvements that increase efficiency and effectiveness, and the ability to drive enterprise-wide adaptive change. Breakthrough -- HHC's version of a process improvement methodology developed in the manufacturing sector and commonly called "LEAN"-- has been our means of deepening our organizational abilities on both of these fronts.

Five and half years into our active involvement with Breakthrough, nearly 7,000 staff have engaged in training, rapid improvement events and other planning and problem

solving activities to better our system. The more than 1,200 rapid improvement events -- intensive employee driven activities focused on redesigning care -- conducted across a wide variety of operations within HHC have shown outstanding results where it matters most - in the care of our patients. Most importantly, the staff -- from unit nurses to chiefs of service to managers, clerks, residents, social workers, and senior vice presidents -- have invested their time and talent to learn and spread new ways to solve often long-standing and complex problems. To accomplish this, they focus on eliminating waste, standardizing practices, and collective creativity. Over the past 19 months, our Breakthrough activities generated more than $85 million in new revenue and cost savings, for a cumulative total financial benefit of $280 million.

Going forward, we are focusing on how we bring to scale across our entire system the Breakthrough improvements achieved in key areas of operation within individual facilities and networks. Increasing proficiency in developing improvements of common operational activity at one facility and then bringing those to scale for the benefit of the entire organization will be invaluable as we continue to adapt to rapid changes in the healthcare environment.

Transforming the Healthcare Delivery System

HHC facilities served 1.4 million New Yorkers last year, including 479,000 without insurance. This service encompassed 220,000 inpatient stays, 1.2 million ED visits, and more than 5 million outpatient visits. Even as we continue to offer a prodigious volume of essential services to our patients and communities, and work to make our system more efficient in the face of intense cost containment pressures, we also must work to transform our entire healthcare delivery system to meet the demands of evolving healthcare reform.

The federal government is steadily moving the Medicare program toward value-based purchasing, with reimbursement amounts increasingly tied to the efficacy of services rendered. Financial penalties and rewards are now imposed based upon comparative rates of preventable readmissions, adherence to targeted evidence-based clinical

practices, and patient satisfaction scores. In addition, Medicare reimbursement is increasingly being tied to patient outcomes through "bundled payment" initiatives, the Shared Savings Program available to designated Accountable Care Organizations, and Medicare managed care programs.

At the state level, New York continues to move forward aggressively with its Medicaid Redesign Program which is intended to provide "care management for all". To achieve this goal, virtually all Medicaid recipients, including those with long term care needs, those with serious and persistent mental illness, and others previously excluded, will be transitioned into a managed care model over the next two years.

Both our federal and state governments have declared their goal of moving the healthcare system toward the achievement of the Triple Aim: better care for the individual patient, better health for the broader community, and lower per capita costs. The Triple Aim encapsulates the central challenge of healthcare reform for providers: the need to simultaneously improve patient and population health, even as we lower the cost -- or, at least the rate cost increase -- of healthcare.

HHC's long-standing commitment to, and capacity for, delivering robust primary and preventive care serves us well as we position the organization to achieve the Triple Aim and to succeed under healthcare reform. Indeed, the close partnership between our facilities and our health plan, MetroPlus -- which last year again received the top rating for quality and member satisfaction -- gives us a competitive advantage as the reimbursement system (at least for Medicaid) begins to pivot more decisively toward a capitated model. During the past year, we have continued to work on transforming our service delivery model and on building the care management infrastructure essential as managed and "accountable" care reimbursement approaches become more dominant.

Information Technology: Improving Quality through Management and Coordination of Care and Data

HHC was an early adopter of electronic health record (EHR) technology and has used that technology to improve clinical care -- and garnered two related national awards

along the way. Today's challenges related to the management and coordination of care going forward clearly require a state-of-the-art EHR system with more robust decision-support, patient portal capabilities and other advanced functionality. Accordingly, after an exhaustive review of the available products, HHC entered into a long-term contract with EPIC as its new EHR system. The installation of a new EHR across our vast organization is a complex, multi-year effort, but we expect to have our first facility up on the new EHR application within the next 18 to 24 months. Full implementation will take four to five years.

In the interim, we continue to leverage our existing EHR, QuadraMed, to meet the federal "Meaningful Use" requirements that will ultimately entitle us to roughly $190 million in federal funds over a three-period to support EHR adoption and development. Last year, all of our facilities met the requirements for Meaningful Use, Stage One and we have already drawn down more than $60 million of the anticipated $190 million. These funds will be used to offset some of the costs associated with the acquisition of our new EHR.

We also are moving forward aggressively with several other information technology initiatives that will provide critical support to the transformation of our clinical service delivery. Last year we acquired, and this year we will complete the implementation of, a specialized software application that will enable the care management of patients across all settings, both within our system and outside of it, under a single comprehensive care plan. By June of this year, we also will have completed the installation of our new Soarian appointment scheduling system that will allow us to plan for the ultimate consolidation of our appointment call centers. And by the end of this year, we expect to complete installation of a centralized system that will streamline the credentialing process for our physicians and enable us to credential providers across our entire system under one application.

Redesigning Ambulatory Care – PCMH and Health Homes

Building on a decade of work around ambulatory care redesign, our broad array of screening services and preventive care, and our longstanding focus on more effective

chronic disease management, HHC has achieved the highest available level of NCQA certification of all of its primary care sites -- encompassing more than 600 primary care providers -- as Patient Centered Medical Homes (PCMH). Patient Centered Medical Homes, which match each patient with a dedicated team of providers who offer coordinated, comprehensive care, also earn additional reimbursement. For HHC, PCMH certification means about $25 million in additional annual revenue, which we are reinvesting in expanding access to primary care. We will need to continue to deepen our PCMH capabilities even further this coming year as the bar for re-certification has been raised and all of our sites must be recertified.

In addition to the care management and care coordination capabilities that are inherent in the PCMH model, we also have been working on piloting the further infrastructure necessary to better manage and coordinate the care of patients with more complex needs, including those with multiple chronic disease and/or severe and persistent mental illness. Under the federal Affordable Care Act, states have the ability to seek time-limited federal funding to cover 90% of the cost associated with establishing "Health Homes" which undertake the care management of patients with complex conditions who are high utilizers of healthcare resources. Under New York's Health Home initiative, HHC and MetroPlus have been jointly designated and funded as a Health Home in each of the four most populous boroughs, the only entities designated in more than one borough. As a Health Home, we will continue to build the infrastructure necessary to better manage and coordinate care to especially vulnerable populations, link these complex patients to appropriate outpatient services, improve their health status and outcomes, and decrease their need for emergency department visits and hospital admissions. We began enrolling patients as a Health Home in August 2012.

Becoming an Accountable Care Organization (ACO)

Our foundational PCMH and Health Home work has been critically important in our successful application this past year to participate in the Medicare Shared Savings Program as an Accountable Care Organization (ACO). Under this federal program, we offer Medicare beneficiaries better coordination and integration of all their healthcare

services and focused support to more effectively manage their chronic disease. If we reduce their need for expensive emergency department or inpatient services, we have the opportunity to share in those Medicare savings. The affiliate organizations employing the large majority of our physicians are partners with us in our ACO and they will share equitably in any Medicare savings that result from our collective efforts to improve the health status of these Medicare patients.

The work that we have done this past year to embed care managers in our emergency departments to reduce avoidable admissions, and in our inpatient units to reduce preventable readmissions after discharge, gives us valuable experience for building our ACO capabilities.

Pay for performance incentives for physicians

All of these efforts to fundamentally change care delivery to achieve greater efficiency and better patient outcomes requires much closer collaboration with our physicians and aligned financial incentives. Toward this end, last year HHC successfully negotiated new provisions into its physician affiliation agreements that will reward doctors with up to $59 million in incentive payments over the next three years. Payments will be made when physicians meet specific goals related to adherence to evidence-based clinical care, greater efficiency, higher patient satisfaction, and better patient outcomes. These performance-based incentives replace routine cost-of-living increases and "productivity-based" incentives that focused on volume or intensity of services.

When coupled with potential earnings related to shared savings from our ACO services, the total pool of performance-based financial incentives for physicians becomes significant. This will assist our efforts to reinforce the type of collaboration that can improve patient and population health outcomes and reduce unnecessary utilization of acute care services, i.e., help meet Triple Aim goals.

Quality of Care

We have ample evidence from this past year that we are becoming more adept at implementing best practices across our system and achieving system-wide improvements in important aspects of care. For example, our work to identify hospital patients at increased risk of readmission and to provide them with additional support after discharge has reduced readmissions for congestive heart failure and heart attack significantly.

Another of our clinical improvement priorities was to reduce our rates of Central Line Associated Blood Stream Infections (CLBSI) and Catheter Acquired Urinary Tract Infections (CAUTI). The most recently available data show that by late 2012 CLBSI rates were more than 25% lower than at the beginning of the year, and CAUTI rates were reduced by more than 75%. These reductions in hospital-acquired infections represent very meaningful advances in patient safety across our system.

Modernization of Facilities

Harlem Hospital opened its new, $325 million mural pavilion last September. Apart from the state-of-the-art inpatient units, the Pavilion also features restored historic murals by WPA-era African-American artists. Those murals are now on exhibit in a magnificent first floor gallery, and vivid images from one of the murals are reproduced across the block-long glass façade of the new pavilion. The final phase of the current modernization effort at the hospital -- a renovated and expanded Emergency Department -- should be substantially complete by July.

The new Henry J. Carter Specialty Hospital and Nursing Facility will be located on Madison Avenue and 122nd Street. It will be the new home of the Goldwater Specialty Hospital and Nursing Facility currently located on Roosevelt Island. This Harlem-based long term care hospital and skilled nursing facility, consisting of nearly 400,000 square feet of combined new and renovated space, will be completed in the fall of this year.

On the lower east side, HHC's $250 million Gouverneur Major Modernization project will expand local access to needed ambulatory care services, as well as increase

Gouverneur's skilled nursing facility capacity from 210 to 285 beds. The first stage was completed last year, and the final stage should be completed by March 2014.

The renovation and expansion of Lincoln Hospital's Emergency Department -- the busiest in our system -- is on schedule for substantial completion by September.

HHC remains firmly committed to build a $23 million state-of-the-art Diagnostic and Treatment Center at 155 Vanderbilt Avenue on Staten Island. The project will be put out for bid in May 2013. Construction will begin this summer and the facility should be open to serve patients in February 2015. The 21,000 square foot, three-story building will provide adult and pediatric primary care, diagnostic and specialty care, and behavioral health services.

Looking Forward

Carrying out our responsibilities as the primary safety net for so many vulnerable New Yorkers is an awesome task, and one that ultimately requires strong support by the public and government at all levels. We appreciate the unwavering support that we have received from our Mayor, City Council, and other elected officials as well as from our board of directors, our partners in labor, our community advisory boards and auxiliaries, and many community-based organizations that care about our mission.

I am proud, especially after Hurricane Sandy, of the work that our dedicated HHC staff performs every day across our city to surmount challenges and meet the healthcare needs of our patients. The path ahead will continue to be formidable and the quickening pace of change related to healthcare reform will be stressful. However, our past accomplishments demonstrate our collective resilience, resourcefulness and commitment to mission. And that is a formidable force of its own.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve the budget for relocation of the "T" Building at Queens Hospital Center, estimated to be $8.4 million.

WHEREAS, the conditions of the "T" Building are deteriorating and require major capital investment if Queens Hospital Center's clinical and non-clinical programs remain in the "T" Building; and

WHEREAS, it is in the best interests of the New York City Health Hospitals Corporation (the "Corporation") to vacate the building within the next eight months; and

WHEREAS, the current estimate for the project is $12 million, with $3.6 million of in kind support from Queens Hospital Center's capital plan; and

WHEREAS, the revision to Operating Procedure 100-5 now requires that construction projects with budgets of $3 million or more receive approval of the Board of Directors not just the approval of work orders through the Capital Committee as had previously been the case; and

WHEREAS, the proposed expansion to the total project budget will exceed $3 million.

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to approve the budget for relocation of the "T" Building at Queens Hospital Center, estimated to be $8.4 million.

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. ("NSLIJ") (i) to establish a jointly controlled not-for–profit hospital cooperative ("CoOpLab") that will provide laboratory services at cost to NSLIJ's and the Corporation's respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services, to have NSLIJ's existing not-for-profit corporation, which operates its core laboratory perform the Corporation's reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to the launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business.

AND

Authorizing the President of the Corporation to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described below consistent with these Resolutions.

WHEREAS, the Corporation's internal studies as augmented by independent consultants lead to the determination that the best way to assure high quality laboratory services and achieve savings is to collaborate with another large health system to establish a shared core laboratory to process clinical lab work for the Corporation's health system; and

WHEREAS, not-for-profit NSLIJ, the biggest integrated healthcare network in the New York metropolitan area, currently operates an efficient, high quality consolidated core laboratory to serve the needs of its member hospitals, and wishes to establish a new, larger consolidated core laboratory in collaboration with the Corporation to achieve even greater efficiencies; and

WHEREAS, a core laboratory shared by HHC and NSLIJ is expected to benefit the Corporation by achieving economies of scale, improved quality of services, lower prices and savings, and data sharing of best practices; and

WHEREAS, NSLIJ will be solely responsible to finance the purchase or lease of the selected site for the new laboratory facility, its improvements and outfitting; and

WHEREAS, the amount charged to CoOpLab by NSLIJ shall be capped at an amount based on a maximum agreed upon capital project cost; and

WHEREAS, both NSLIJ and the Corporation will appoint members of the board of directors of CoOpLab under an agreement providing that the following actions of CoOpLab will require the consent of the Corporation in its capacity as a founding member: (i) any sale, relocation or dissolution of the laboratory or of CoOpLab and any action that terminates the Corporation's membership status; (ii) any capital call; and (iii) the establishment of the level of reserves to be maintained by CoOpLab; and

WHEREAS, the governing documents of CoOpLab shall clearly establish that the Board of

CoOpLab shall act in the interest of all of its members and that any action that is proposed to be taken that will benefit NSLIJ and will impose any significant risks or costs on HHC will require the consent of HHC; and

WHEREAS, the Corporation will be indemnified by CoOpLab for any costs, damages or liability that arise from NSLIJ's activities conducted within the cooperative structure or prior to its establishment and CoOpLab will purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business; and

WHEREAS, a CoOpLab joint standards committee with representatives of NSLIJ and the Corporation will develop the laboratory quality assurance standards and other methods and metrics for the laboratory operations of CoOpLab; and

WHEREAS, current employees of NSLIJ and the Corporation will be provided to CoOpLab to provide the needed laboratory services with all associated costs paid by CoOpLab; and

WHEREAS, through the cooperative structure, the Corporation will benefit from volume discounts on its purchases of laboratory equipment, blood products, systems and supplies;

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation") be, and hereby is, authorized to negotiate and execute a contract and related agreements with North Shore-Long Island Jewish Health Systems, Inc. ("NSLIJ") (i) to establish a jointly controlled not-for–profit hospital cooperative ("CoOpLab") that will provide laboratory services at cost to NSLIJ's and the Corporation's respective health systems in a new cooperative laboratory facility to be located within the City of New York for this purpose; (ii) for the period prior to CoOpLab obtaining the requisite licenses to provide such laboratory services, to have NSLIJ's existing not-for-profit corporation, which operates its core laboratory perform the Corporation's reference laboratory work that is now sent to commercial vendors at cost and have the Corporation join such not-for-profit corporation as a member; and (iii) to provide for NSLIJ to indemnify the Corporation for any cost, damage or liability arising out of its laboratory activities prior to the launch of the cooperative venture and out of any ongoing laboratory activities unrelated to the cooperative venture and for CoOpLab to purchase liability insurance to cover any claims that may arise in the conduct of CoOpLab's cooperative business; and

BE IT FURTHER RESOLVED, that the President of the Corporation be, and hereby is, authorized to effectuate the establishment of CoOpLab and take such other actions as he/she deems appropriate to establish the cooperative laboratory structure described consistent with these Resolutions.

HHC Laboratory Restructuring Project

March 21, 2013
HHC Board of Directors

Agenda

- Overview
- Vision of the Cooperative
- Structure of the Cooperative
- Governance
- Business Model
- Staffing Changes
- Five Year Cost Savings Projections
- North Shore LIJ Current Core Lab

Overview

- Restructuring project:
  - Efforts and savings to date
  - Identification of opportunity to achieve greater efficiencies through a shared core lab with another large health system
- Process to identify potential partners
- Cooperative with North Shore Long Island Jewish (NSLIJ)
- Through collaboration will achieve economies of scale, better pricing, savings for both entities, improved quality and data sharing of best practices

Vision of the Cooperative

- Standard test menus for local hospital clinical tests
- Hospital labs provide:
  - Clinical lab results needed in less than four hours on behalf of Emergency Departments and Inpatient Units
  - Surgical and Anatomical Pathology
  - Blood Bank
- NSLIJ and HHC will cooperate to create one Shared Core Laboratory to process:
  - Clinical lab work on behalf of nursing homes, diagnostic and treatment centers and hospital clinics
  - Micro and Molecular Biology tests
  - Tests on behalf of community physicians and/or other outside business

Structure of the Cooperative

- **“CoOpLab”**
  - Not for profit corporation
  - NSLIJ and HHC will have joint membership and operate shared core lab
  - Board of Directors from NSLIJ and HHC
  - CEO and management
  - Maintain NSLIJ outreach business and support HHC commercial insurance collection
- **NSLIJ and HHC**
  - Collaborate on lab methods but independently operate hospital rapid response labs
  - Share information technology
  - Same test menus
  - Group purchasing of equipment, reagents, and Blood products

Governance

- NSLIJ will have majority seats on the Board of Directors of “CoOpLab”
- Critical decisions will require HHC’s consent as a founding member:
  - Sale, closing, or relocation of core lab
  - Requirement that HHC contribute capital
  - The addition of any new member with the same rights as HHC
  - Termination of HHC’s membership
  - Increases to the level of reserves of CoOpLab requiring increases to the cost per test
  - Any action taken to benefit NSLIJ at the expense of HHC

Governance

“CoOpLab”
Board of Directors
HHC/NSLIJ

CEO and Management Team

Shared Core Lab

Shared Suppliers
- Vendors (Best Pricing)
  - Reference Test and Blood products
  - Equipment
  - Reagents
  - Information Technology

Joint Standards Committees
HHC/NSLIJ
- System Interoperability
- Equipment and reagents
- Policy and Procedures
- Test Menu
- Research

Rapid Response Laboratories

HHC Hospitals

NSLIJ Hospitals

Business Model

HHC

- Staff and operate hospital labs
- Provide staff to “CoOpLab”
- Pay “CoOpLab” per test

“CoOpLab”

- Sell tests to HHC and NSLIJ at actual cost
- Pay HHC and NSLIJ for staff
- Pay NSLIJ rent
- Bill Commercial Insurers
- Group purchasing
- Methods best practice sharing

NSLIJ

- Staff and operate hospital labs
- Provide staff to “CoOpLab”
- Pay “CoOpLab” per test

Staffing Changes

Staff at HHC facilities	Base	FY2014	FY2015	FY2016	FY2017	FY2018
Clinical*	636	591	545	487	455	446
Microbiology**	162	162	132	71	0	0
Pathology and Blood Bank	607	607	607	607	607	607
HHC staff at HHC	1405	1360	1285	1165	1062	1053
HHC staff at the Core**	0	0	30	91	162	162
Total	**1405**	**1360**	**1315**	**1256**	**1224**	**1215**

*Clinical staff will not be replaced as they leave and will be redeployed across HHC

**Microbiology staff move to the core as we transition our hospitals

Five Year Cost Savings Projections ($s in millions)

Change	Base	FY2014	FY2015	FY2016	FY2017	FY2018
Total Cost Current State	$ 233.3	$ 242.9	$252.5	$255.3	$260.5	$ 265.9
Total Cost Future State	$ 233.3	$ 231.8	$238.7	$240.9	$245.9	$ 247.4
Savings		**$ 11.1**	**$ 13.9**	**$ 14.4**	**$ 14.6**	**$ 18.5**
Additional Revenue			**$ 0.3**	**$ 1.9**	**$ 2.6**	**$ 4.6**
Total Benefit		**$ 11.1**	**$ 14.1**	**$ 16.3**	**$ 17.1**	**$ 23.1**

North Shore LIJ Laboratories
North Shore-Long Island Jewish Health System

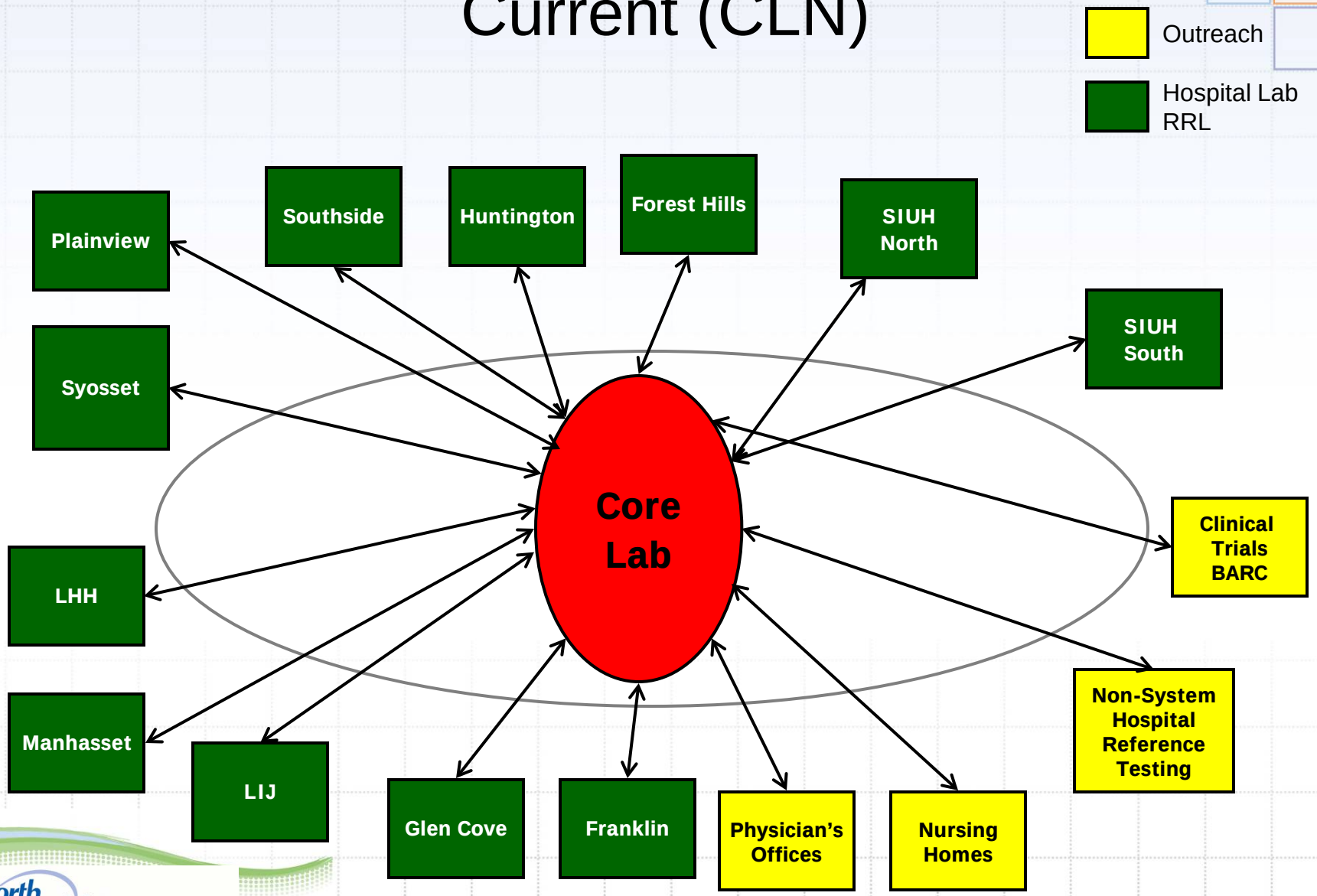
North Shore LIJ Health System Laboratories Presentation to HHC Board of Directors

Merryl Siegel – Executive Director Post Acute Services North Shore LIJ Health Systems
Bob Stallone - Vice President North Shore LIJ Health System Laboratories

Overview

- Strategically Located Core Laboratory
  - 15 years of continuous integration and growth
  - Current space limitations
- 11 Rapid Response Laboratories
  - Unified Management
  - Standardized Information Systems and Equipment
  - All testing capabilities available on site for patient management
  - Highly developed logistics service and infrastructure
- Goals:
  - Strategically partner with another non-for-profit organization who shares similar public/community/ teaching mission
  - Increase volume to reduce cost and improve quality and depth of service
  - Develop additional value opportunities through the relationship

NSLIJ Centralized Laboratory Network Current (CLN)

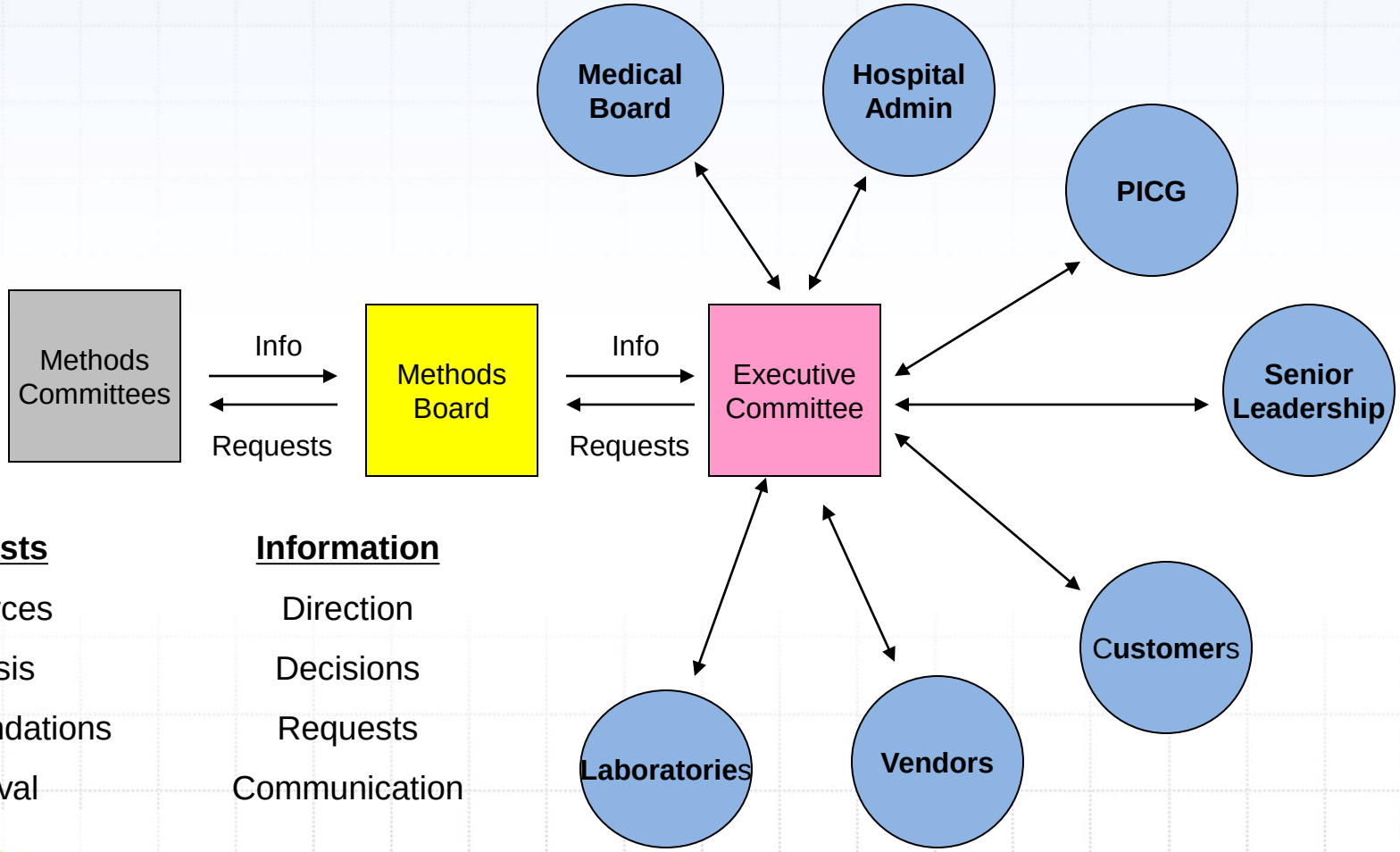


Performance Metrics

Core Lab Key Indicators

Metric	Performance Area	Goal	Current
Stat Turn Around Time (call to call)	Service Excellence	240 min	186 min
Routine Turn Around Time	Service Excellence	95%- less than 4 hours	99.6%
Laboratory Error Rates	Operational Performance	275 DPMO (.03%)	229 DPMO (.02%)
“Likelihood to Recommend” (patient)	Customer Service	95%	99.7%
“Likelihood to Recommend” (physician)	Customer Service	95.8%	97.5%
Abandoned Call Rates	Customer Service	4.4%	3.4%
Live Voice in 20 Sec.	Customer Service	70%	71%
Critical Value Notification	Patient Safety	98% in 15 min	98%

Joint Standards Committee Process



Requests	**Information**
Resources	Direction
Analysis	Decisions
Recommendations	Requests
Approval	Communication

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to negotiate a contract with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853, 396.

WHEREAS, the Corporation is committed to providing equitable, safe, timely, efficient patient centered care in the languages spoken by its patient populations; and

WHEREAS, in fiscal year 2012 over twenty-five percent of the Corporation's patient population was deemed limited English proficient; and

WHEREAS, in fiscal year 2012, over 190 languages and dialects were spoken by the patients receiving care by the Corporation; and

WHEREAS, the Corporation requires the assistance of firms specializing in over-the-phone medical interpreting services to support the provision of patient care services in the languages spoken by the populations served by the Corporation's acute care hospitals, long term care facilities, diagnostic and treatment centers, certified home health agency and, community based clinics.

WHEREAS, CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. are recognized leaders in the provision of over-the-phone medical interpreting services; and

WHEREAS, the Corporation will benefit from the provision of over-the-phone medical interpreting services to its patients requiring such services; and

WHEREAS, the provision of over-the-phone medical interpreting services will enable compliance with external review agency regulations, standards and law; and

WHEREAS, the responsibility for monitoring these contracts shall reside with the Senior Vice President for Safety and Human Development.

NOW, Therefore, BE IT

RESOLVED, THAT THE President of the New York City Health and Hospitals Corporation (the "Corporation") be and hereby is authorized to negotiate a contract with CyraCom International, Inc.,

Language Line Services, and Pacific Interpreters, Inc. to provide over-the-phone-medical interpreting (OPI) services to the Corporation to meet the patient care needs of its limited English proficient patient population and comply with external review agency requirements for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396.

EXECUTIVE SUMMARY

The accompanying resolution requests authorization to negotiate a three year contract with two-one year options to renew with CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. for the provision of over-the-phone medical interpreting services for the HHC acute care hospitals, long term care facilities, community based clinics and certified home health agency.

Contracts with these Vendors are required to enable HHC to provide culturally competent care, meet the patient care needs of its diverse limited English proficient patient population, and comply with federal law, and external review agency requirements/standards. To assure patient care quality and safety, under these contracts, CyraCom, Language Line, and Pacific will provide medically qualified interpreters for 100% of interpretation calls requested by any HHC facility or program. Each Vendor will provide the equipment to enable over-the-phone interpretations. Each Vendor will also provide on-demand and monthly reports detailing duration of each interpreting assignment, language requested, hospital unit, provider name, medical record number, or any other information the specific facility requests be collected for reporting purposes. Reports of all languages requested by an HHC facility that was unavailable at the time of the request and the action(s) taken, including response time to provide the language will be standard.

CyraCom, Language Line, and Pacific have been providing OPI services at the HHC facilities since 2002, 2006 and 2009, respectively. The existing agreements with the three (3) Vendors were entered into in 2009. The contracts with the three Vendors expire on March 31, 2013, May 6, 2013, and May 9, 2013.

Consistent with Operating Procedure 100-5, a competitive request for proposals process was initiated in October 2012. Subsequent to a robust evaluation process, CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc. were selected to provide medical interpreting services because they each met the requirements as set forth in the RFP, offered a competitive rate of $0.75 per minute of medical interpreting services, and, had positive references. HHC currently pays $0.90 per minute of medical interpreting services. The proposed contracts are for a term of three years with two-one year options to renew, solely exercisable by the Corporation, for an amount not to exceed $30,853,396.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: **Over-the-Phone Medical Interpreting Services**

Project Title & Number: **Over-the-Phone Medical Interpreting Services DCN#: 2014**

Project Location: **HHC Acute Hospitals, Community-based Clinics, LTC Facilities, Certified Home Health Agency**

Successful Respondents:

CyraCom International, Inc., Pacific Interpreters, Inc., and Language Line Services

Contract Amount: $ 30,853,396.00

Contract Term: **3 years with 2 additional one year options to renew solely exercisable by the Corporation**

Requesting Dept.: **Division of Safety and Human Development, Office of CLAS/LEP**

Number of Respondents: **Ten**
(If sole source, explain in Background section)

Range of Proposals: **$ 0.67/minute to $ 0.99/minute**

Minority Business Enterprise Invited: **X** Yes If no, please explain:

Funding Source: **X** General Care Capital
Grant: explain
Other: explain

Method of Payment: **X** Lump Sum Per Diem **XX** Time and Rate
Other: explain Payable upon invoice based on utilization

EEO Analysis: **Complete**

Compliance with HHC's McBride Principles? **X** Yes No

Vendex Clearance Yes No N/A **PENDING**

(required for contracts In the amount of $50,000 or more awarded pursuant to an RFP or as a sole source, or $100,000 or more if awarded pursuant to an RFB.)

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

The Division of Safety and Human Development is seeking authorization to contract with three vendors to provide over-the-phone medical interpreting services (OPI) to enable HHC to meet the patient care needs of its diverse patient population and comply with external review agency requirements. The selected Vendors are CyraCom International, Inc., Language Line Services, and Pacific Interpreters, Inc.

The provision of effective, timely and medically accurate interpreter services is a patient's right that is essential to the provision of patient-centered care, and foundational to assuring patient safety. Regulatory and accreditation agencies (Centers for Medicare and Medicaid Services, New York State Department of Health, The Joint Commission), federal law (Title VI of the Civil Rights Act), and national standards (National Standards for Culturally and Linguistically Appropriate Services) mandate the provision of healthcare services in a manner understood by patients. This includes providing an interpreter for those patients who are not proficient in English. The Joint Commission explicitly requires the following: "The hospital respects the patient's right to and need for effective communication"; "The hospital provides information in a manner tailored to the patient's age, language, and ability to understand"; and "The hospital provides language interpretation and translation services."

Historically, HHC has contracted with external vendors to provide OPI services. Given the volume of services required, it is necessary for HHC to contract with multiple vendors. In FY 12, over 25% of HHC's patient population was deemed limited English proficient. In FY 12, OPI services were utilized enterprise-wide for over 680,000 interpretation requests in over 190 different languages and dialects for a total of more than 7 million minutes of interpreting services at a cost of $6,665,000 to the HHC acute hospitals, long term care facilities, diagnostic and treatment centers, community health clinics, and certified home health agency. The need for OPI services will not diminish.

OPI services are currently being provided to HHC by three (3) vendors: Pacific Interpreters, Inc., Language Line Services, and CyraCom International, Inc. HHC entered into the existing agreements with the three (3) vendors in 2009 and the contracts expire on March 31, 2013, May 6, 2013, and May 9, 2013, respectively. The agreement with Language Line and CyraCom were extensions to a prior contract. The agreement with Pacific was new in 2009. The current negotiated rate per minute of medical interpreting is $0 .90. Each vendor invoices the HHC facilities that utilize their service; payments are remitted to the vendor by each facility.

Consistent with HHC Operating Procedure 100-5, a request for proposals for OPI services was issued on October 12, 2012. Ten (10) proposals were received of which three (3) vendors were selected. The selected vendor(s) have the capacity to meet HHC's current and potential increasing demand for OPI services. The proposed term of the new contracts with each of the three vendors will be for a period of three years, with two additional one-year options to renew, solely exercisable by the Corporation. The anticipated total cost of the contract over 5 years is $30,853,396.00 which includes a 10% contingency of $2,804,854.00.

CONTRACT FACT SHEET (**continued**)

Contract Review Committee

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

Yes. October 3, 2012

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

No

CONTRACT FACT SHEET(**continued**)

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

List of Selection Committee Members

Chairperson: Aleksandra Sas, Associate Director, CLAS
Patricia Banks, Assistant Director, Language Coordinator, Coney Island Hospital
Melanie Colon, Assistant Director, Bellevue Hospital Center
Joanne Grimes, Director of Patient Relations, Jacobi Medical Center
Lucila Jimenez, Associate Director, Language Assistance Program, Lincoln Medical and Mental Health Center
Fernando Lee, Assistant Director, Volunteer Public Department, Elmhurst Hospital Center
Irene Quinones, Associate Director, Metropolitan Hospital Center
Frederick Covino, Assistant Vice President, Corporate Budget
Mark Walter, Senior Counsel, Legal Affairs

List of Firms Responding to RFP

Certified Languages International
CyraCom International, Inc.
Language Line Services
Language Select
Linguistica International, Inc.
Optimal Phone Interpreters
Pacific Interpreters, Inc.
Telelanguage, Inc.
Translation Plus, Inc.
Transperfect Remote Interpreting

Process used to Select the Proposed Contractors

Proposals were received from ten (10) Vendors. Each proposal received by close of business November 13, 2012 was reviewed to determine if it met the minimum qualifications as specified in the RFP: Vendor must have a minimum of 10 years of experience working with hospitals and healthcare organizations to provide over-the-phone medical interpreting; Vendor must adopt the National Standards of Practice for Interpreting in Healthcare and the National Code of Ethics for Interpreters in Healthcare; Vendor must be capable of providing exclusively medically qualified interpreters; and, Minimum of three non-HHC healthcare facility or healthcare system client references, for services provided within the past three years. None of the proposals were eliminated and all 10 were considered for evaluation by the Selection Committee.

The proposals were sent to the members of the Selection Committee for review along with the evaluation criteria. The Selection Criteria included points for:

A. Technical Qualifications (40%)
- Evaluation of the Vendor Qualification Requirements delineated in the Scope of Services
- Evaluation of the Medical Interpreter Qualification Requirements delineated in the Scope of Services
- Clear description of emergency back-up process for providing medically qualified interpreters
- Capacity to provide services compatible with standard/vendor/brand neutral phone equipment
- Adequacy of currently provided capacity/volume of OPI medical interpreting, in minutes
- Documented proof of languages provided (including lesser diffusion languages)

B. Previous Client References (10%)
- Minimum of three non-HHC healthcare facility or healthcare system client references for services provided within the last 3 years.
- List of current/recent clients for similar scope of work as delineated in this RFP (volume, languages, etc.)

C. Company Organization and Qualification (15%)
- 10 years of experience working with hospitals and healthcare organizations in OPI medical interpreting

- Evidence that the Vendor has adopted the National Standards of Practice for Interpreting in Healthcare and the National Code of Ethics for Interpreters in Healthcare
- Description of Company and its organizational structure

D. Cost of Proposal ((25%)
- Reasonable flat fee cost per minute for the three year contract term and for each one year renewable option

E. Other (10%)
- Capacity and willingness to meet the performance requirements as indicated in the RFP: Response time to provide qualification data on each interpreter when requested within 24 hours; and, Evidence of connection time within an average of 40 seconds

Selection Committee Members reviewed and scored each vendor proposal and submitted their completed evaluation forms to the Associate Director CLAS/LEP. Total score per bidder ranged from 40.34 to 69.61. Price per minute per vendor ranged from $0.67 to $0.99 per minute of interpretation. The Associate Director CLAS/LEP aggregated the scores.

Selection Committee members met to discuss and agree on the potential finalists. Subsequent to the meeting, a Selection Committee member re-tabulated the scores given to each proposal to validate the accuracy of the initial aggregated scores.

The three vendors with the highest evaluation scores were selected as finalists pending reference checks.

Three references were contacted for each of the 3 proposed finalists.

After review of references, Committee Members re-confirmed the selection of the 3 vendors. A “best and final offer” was requested from each of the three vendors.

On December 26, 2012 correspondence was sent to CyraCom International, Inc, Language Line Services, and Pacific Interpreters, Inc. via e-mail and postal service notifying each that they had been selected as a potential vendor pending approval by the HHC Board of Directors.

Correspondence was sent to the remaining 7 vendors via e-mail that they had not been selected.

All original materials submitted in response to this solicitation are maintained in the Office of CLAS/LEP.

Justification for the Selection

Of the 10 proposals received, the Selection Committee determined that CyraCom International, Inc., Pacific Interpreters, and Language Line Services met the RFP requirements, received the highest evaluation scores, received positive references, and offered a competitive rate of $0.75/minute of medical interpretation. Based on a review of the proposals, the 3 vendors combined can meet the current and future OPI volume requirements of the Corporation.

Scope of work and timetable:

The selected vendor(s) have demonstrated expertise and extensive experience in over-the-phone medical interpreting for healthcare agencies and are capable of meeting HHC’s volume and language requirements. Each vendor will provide medically qualified interpreters for 100% of interpretation calls requested by any HHC facility or program, within an average of 40 seconds. Each Vendor will provide monthly reports detailing duration of each interpreting assignment, language requested, hospital unit, provider name, medical record number or other information the specific facility ask to be collected for reporting purposes. Each Vendor will also provide monthly reports of all languages requested by an HHC facility that was unavailable at the time of the request and the action(s) taken, including response time to provide the language. The contracts will be effective April 1, 2013 pending Board approval.

Costs/Benefits:

Given the extensive range of languages and dialects spoken by HHC's patient population, particularly lesser diffusion languages, it would be impossible and cost-prohibitive for HHC to internally staff the provision of medically qualified interpreter services, across 21 facilities plus home health services, 24/7/365. Qualified medical interpreters have extensive training to accurately interpret complex medical terminology and convey this information between members of the healthcare team and the patient and his/her family. Qualified medical interpreters allay the concerns of both patients and providers by effectively communicating with the patient and minimizing opportunity for error. OPI is a high quality, cost effective vehicle for providing critically essential, high-volume patient care services.

Why can't the work be performed by Corporation staff:

The Corporation does not have staff at each facility on all tours who speak over 190 languages and dialects and who are expert in providing highly specialized medical interpreter services. Given HHC's diverse limited English proficient population, it would be prohibitively expensive, inefficient and a risk to patient care quality and safety to in-source this work.

Will the contract produce artistic/creative/intellectual property? Who will own It? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

No

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

Aleksandra Sas, Associate Director, HHC's Office of CLAS/LEP will have daily responsibility for contract monitoring with oversight by Caroline M. Jacobs, Senior Vice President for Safety and Human Development.

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

Received By E.E.O. _____
Date

Analysis Completed By E.E.O._____ _____
Date *Name*

Waiver of NYS Executive Law Article 15-A M/WBE Goals received on September 18, 2013. (See Attached)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
346 Broadway • Room 500B • New York, NY 10013 • Tel: 212-788-3380 • Fax: 212-788-3689

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

TO: Aleksandra Sas
Associate Director,
Center for Culturally and Linguistically Appropriate Services (CLAS)

FROM: Manasses C. Williams

DATE: Febuary 20, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor **CyraCom LLC** has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:
[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): Central Office

Contract Number: _____ Project: Interpretation/Translation services

Submitted by: Center for Culturally and Linguistically Appropriate Services (CLAS)
EEO STATUS:

1. [X] Approved

2. [ ] Conditionally approved with follow-up review and monitoring-No EEO Committee Review

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

MCW:gsp

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
346 Broadway • Room 500B • New York, NY 10013 • Tel: 212-788-3380 • Fax: 212-788-3689

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

TO: Aleksandra Sas
Associate Director
Central Office – CLAS

FROM: **Manasses C. Williams**

DATE: **February 25, 2013**

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, Language Line Services Inc., has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.
This company is a:
[ ] Minority Business Enterprise [ ] Woman Business Enterprise [X] Non-M/WBE

Project Location(s): HHC – Corporate Wide

Contract Number: _____ Project Number:_____

Submitted by: Central Office – CLAS

EEO STATUS:

1. [x] Approved

2. [ ] Conditionally approved with follow-up review and monitoring-No EEO Committee Review

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

c:

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc
125 Worth Street, Suite 401, New York, NY 10013 Tel: 212-788-3380 Fax: 212-788-3689

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

TO: Aleksandra Sas, M.A.
Associate Director
Center for Culturally and Linguistically Appropriate Services

FROM: Manasses Williams

DATE: February 12, 2013

SUBJECT: EEO CONTRACT COMPLIANCE REVIEW AND EVALUATION

The proposed contractor/consultant, **Pacific Interpreters, Inc.** has submitted to the Affirmative Action Office a completed Contract Compliance Questionnaire and the appropriate EEO documents.

This company is a:

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

Project Location(s): HHC's Corporate Wide

Contract Number: _____ Project: Language Interpreting Services

Submitted by: Center for Culturally and Linguistically Appropriate Services

EEO STATUS:

1. [X] Approved

2. [ ] Conditionally approved with follow-up review and monitoring-No EEO Committee Review

3. [ ] Not approved

4. [ ] Conditionally approved subject to EEO Committee Review

COMMENTS:

c: pt

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

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

TO: Caroline M. Jacobs
Senior Vice President
Office of Patient Safety, Accreditation & Regulatory Services

FROM: Manasses C. Williams

DATE: September 18, 2012

SUBJECT: Waiver of NYS Executive Law Article 15-A M/WBE Goals

---

The New York City Health & Hospitals Corporation is in receipt of your email request dated 9/18/2012 for goals for the **RFP** for **Over-the-Phone Medical Interpreting Services (OPI) for the New York City Health and Hospitals Corporation.**

A review of the submitted data indicated that a **waiver** of the (M and/or WBE) goals for this **RFP**, is appropriate. A review of the scope of work required for this contract indicates that no Article 15A goals are required. The scope of work and method of negotiating the contract did not meet the requirements of Article 15A for establishing M/WBE goals. The Office of Affirmative Action/Equal Employment Opportunity will grant a waiver for the (MBE / WBE) goals on this contract.

Thank you for your cooperation. If you have any further questions, you may contact Martin Everette. He can be reached at (212) 788-3374.

MCW:moe

c: Martin O. Everette

RECEIVED ON
SEP 19 2012
PATIENT SAFETY

Waiver Approval

Over-the-Phone (OPI) Medical Interpreting Services

CyraCom International, Inc.
Language Line Services
Pacific Interpreters, Inc.

Caroline M. Jacobs
Chief Patient Safety Officer
Senior Vice President
Safety and Human Development

What are Over-the-Phone Interpreting Services (OPI)?

- A technique that uses telephones to connect professional human interpreters to individuals who need to speak to each other but who do not share a common language
- Connect remotely via telephone to professionals who are proficient in the languages of both the speaker and receiver and who may also have some knowledge or familiarity with both cultures
- In the healthcare environment, medical OPI services facilitate and support
  - Patient's ability to converse with their health care providers
  - Health care providers ability to converse with patients and their family

Why are Medical OPI Services Necessary?

- 25% of HHC's patient population is limited English proficient
- Critical to patient safety and the provision of culturally competent, patient-centered care
  - Clearly and concisely transfers complex, sensitive medical information in a manner understood by patients
  - Increases patient satisfaction
  - May reduce length of stay and, potentially, readmissions
- Enables compliance with external review agency requirements and federal laws and mandates for the provision of healthcare in a manner understood by patients (e.g., the Centers for Medicare and Medicaid Services, The Joint Commission, NYS Department of Health, Title VI of the Federal Civil Rights Act, local executive directives)

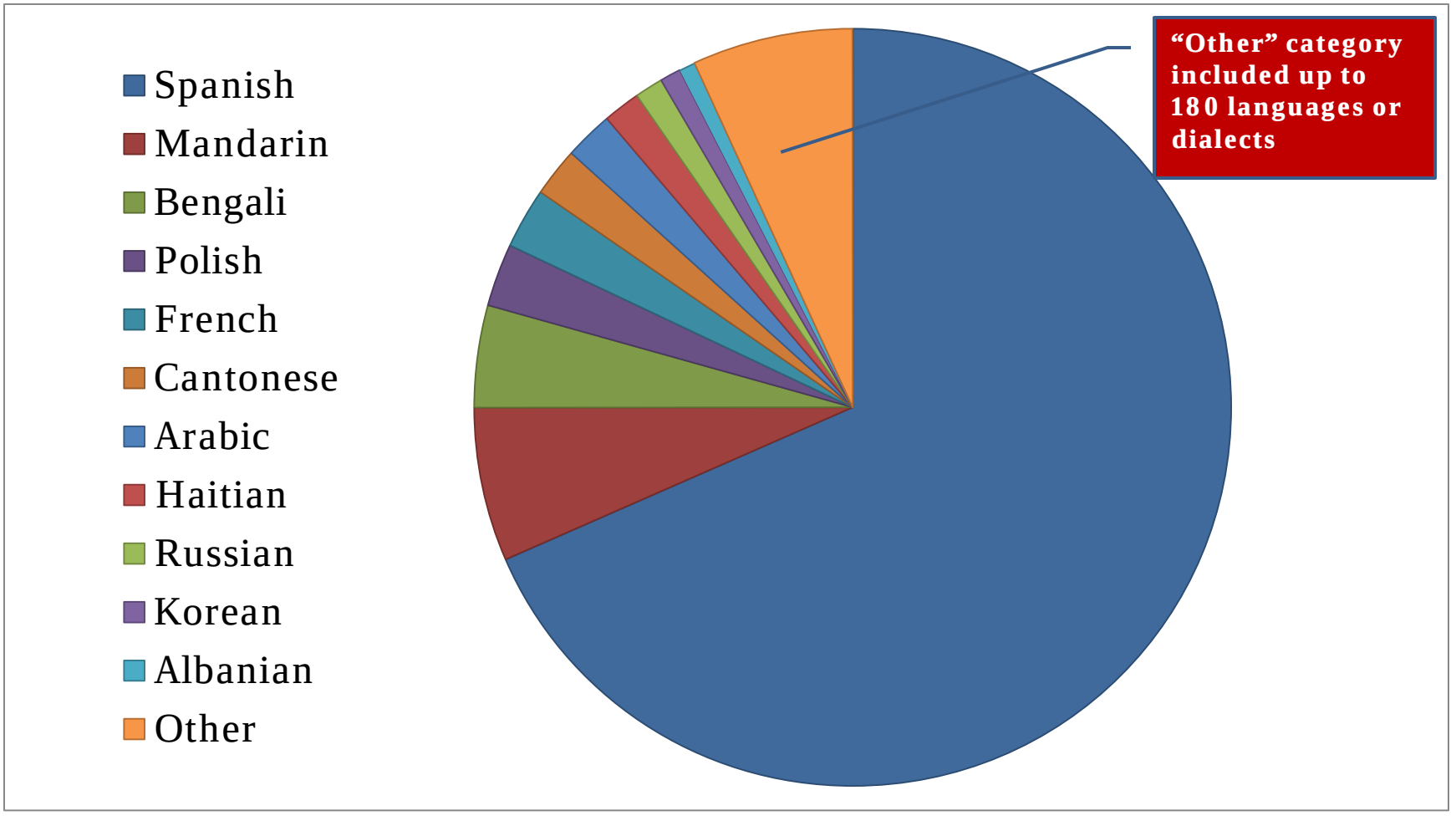
Over-the-Phone Medical Interpreting Service Usage at HHC (FY 12)

- OPI services used for approximately **700,000** interpreter requests in over **190** languages and dialects ranging from 0over 450,000 requests for Spanish to 1 request for Kanjobal (Mayan dialect)

- Over **7,000,000** minutes of medical OPI services requested and provided enterprise-wide at a total cost of **$6,670,000**

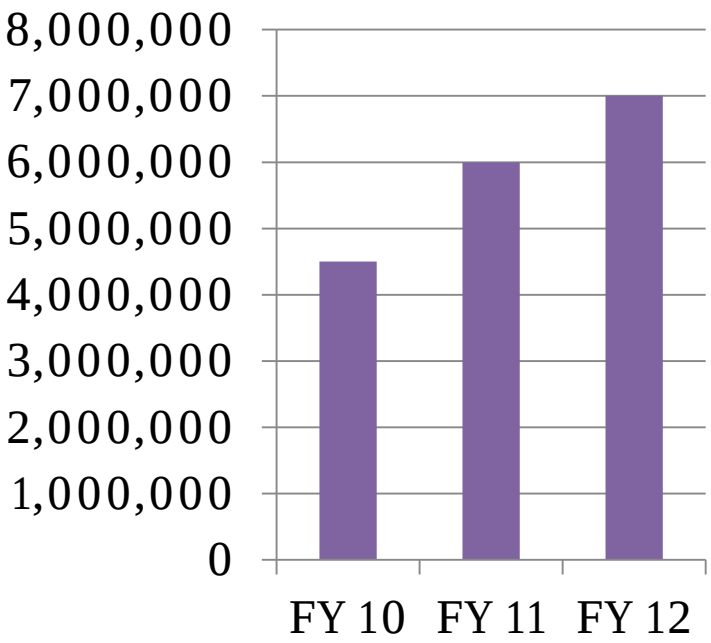
HHC Language Interpretation Statistics

Requested Interpretations by Language FY 12

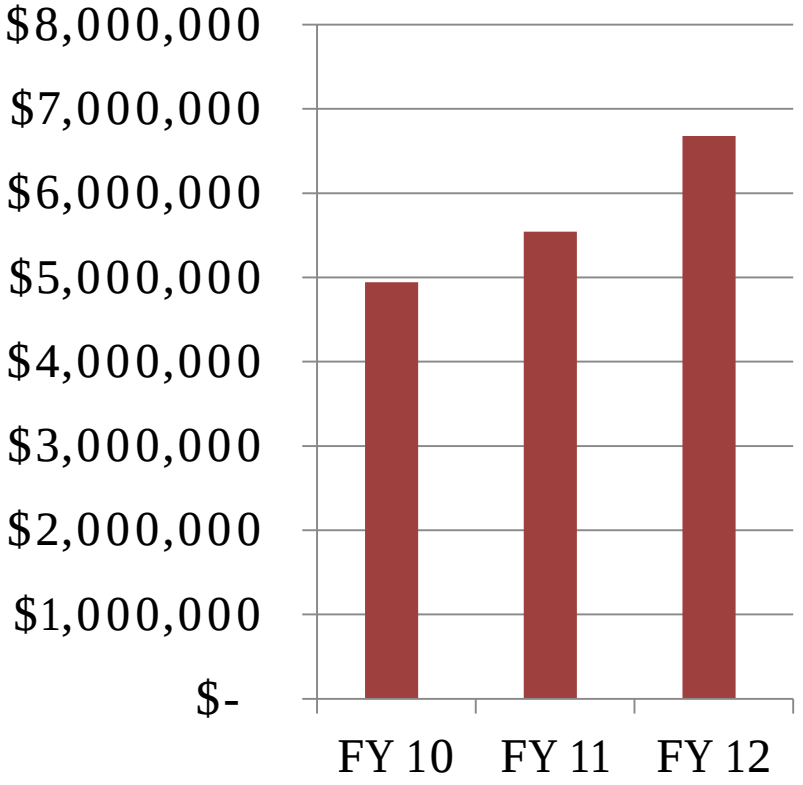


Current State – Growing Volume; Growing Expenditure FY 10 - FY 12

Interpretations in Minutes of Service



Expenditure



Current State

- Current contracts initiated with CyraCom International, Inc. (2002), Language Line Services (2006), and Pacific Interpreters, Inc. (2009). Each contract expires Spring 2013.
- Current flat fee rate is $0.90 per minute of medical interpreting services.
- Determined that we needed to scan the medical OPI market to assure the Corporation was receiving the best value and quality for the expenditure

Selection Process

- RFP issued October 12, 2012
- Non-mandatory bidders conference October 31, 2012 – 13 vendors participated
- Proposal due date – November 13, 2012
  - Proposals received from ten (10) Vendors
- Selection Committee deliberations and clarifications from Vendors
  - November - December
- Vendor notification, December 26, 2012
  - CyraCom International, Inc.
    Language Line Services
    Pacific Interpreters, Inc.

Key Contract Deliverables

- Provision of services by exclusively qualified medical interpreters for 100% of requests
- A 24/7 live operator to respond to HHC interpretation requests and connect each call within an average of 40 seconds, including lesser diffusion languages
- A 24/7 live operator to address HHC customer service concerns and an efficient complaint resolution process
- Monthly and on-demand reports of vendor performance
- Equipment (e.g., corded dual handset and cordless phones)

Contract

- Three years with 2-one year options to renew solely exercisable by the Corporation at a flat fee of $0.75 per minute of interpretation, irrespective of language, day of week, or time of day at an amount not to exceed $ 30, 853,396 for the 5 years

- New rate is a $0.15 per minute decrease over the current rate of $0.90 per minute of interpretation

- Facilities will determine the vendor they wish to receive services from; facilities may choose to receive services from more than one vendor

Contract Monitoring

- Responsibility rests with the Senior Vice President for Safety and Human Development through the HHC Office of Cultural and Linguistically Appropriate Services/Limited English Proficiency (CLAS/LEP)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation ("the Corporation") to negotiate and enter into a sole source contract with Microsoft Corporation to purchase software licenses and related maintenance and support on an on-going basis in an amount not to exceed $34,500,000 for a three year period.

WHEREAS, the Corporation uses a wide array of Microsoft software products and the Corporation is required to purchase from Microsoft the licenses and software maintenance and support needed to run this software; and

WHEREAS, analysis has shown that the most favorable terms and pricing for the Corporation can be obtained by contracting directly with Microsoft Corporation; and

WHEREAS, the accountable person for this procurement is the Senior Vice President/Corporate Chief Information Officer.

NOW, THEREFORE, be it:

RESOLVED, THAT THE President of New York City Health and Hospitals Corporation be and hereby is authorized to negotiate and enter into a sole source contract with Microsoft Corporation to purchase software licenses and related maintenance and support on an on-going basis in an amount not to exceed $34,500,000 for a three year period.

Executive Summary –
2013 Microsoft Enterprise Agreement

The accompanying resolution requests approval to negotiate and enter into a sole source contract with Microsoft Corporation to purchase software licenses and related maintenance and support on an on-going basis in an amount not to exceed $34.5 million for a three year period.

HHC's current Enterprise Agreement with Microsoft expires on March 31, 2013, requiring HHC to negotiate a new agreement for the next three years. This agreement allowed HHC to centralize purchasing of Microsoft products and support. The agreement provides high levels of discount and software upgrade rights for all products covered by the agreement. In addition, the agreement provides payments for the software in a predictable annual payment schedule.

The new enterprise agreement will include the licensing and support rights for all the Microsoft products used by the Corporation today such as Microsoft Office, Windows, SharePoint, System Center, and SQL-Server. Additionally the new agreement contains the Microsoft hosting service Office 365 which includes online access to Microsoft Exchange (email), SharePoint (collaboration web sites), and Lync (video conferencing and instant messaging).

Since FY2010, HHC has spent $31.5 million with Microsoft (including an upcoming true up payment). $27.6 million was with the previous Enterprise Agreement with the remaining $3.9 million being spent on other ancillary licensing and services agreements. EITS is proposing consolidating all licensing under a single agreement for a total spend of $34.5 million over a 3 year period allocated as follows:

- $30 million Enterprise Agreement
- $1.5 million contingency (5%) to allow for possible expanded software use related to significant increases in user counts or additional projects which may require Microsoft Software.
- $2 million EMR/Epic Project - Capital
- $1 million Health Homes Project (Heal17 Grant)

The total spend with Microsoft would be decreased by approximately 5% from $31.5 million to $30 million, excluding the contingency, EMR/Epic and Health Homes projects. The EMR/Epic and Health Homes projects are separate initiatives where the cost of the Microsoft software is included in the budget for these projects.

The proposed agreement will be procured via sole source directly with Microsoft Corporation. After researching several means of procurement it was determined that the best pricing and terms can be obtained by negotiating directly with Microsoft.

CONTRACT FACT SHEET

New York City Health and Hospitals Corporation

Contract Title: 2013 Microsoft Enterprise Agreement

Project Title & Number:

Project Location:

Requesting Dept.: EITS - Central Office

Successful Respondent: **Microsoft Corporation**

Contract Amount: **$34,500,000**

Contract Term: **Three Years**

Number of Respondents: Not Applicable - Sole Source
(If Sole Source, explain in Background section)

Range of Proposals: $ Not Applicable

Minority Business Enterprise Invited: No If no, please explain: No, sole source

Funding Source: X General Care X Capital
Grant: explain
Other: explain

Method of Payment: Lump Sum Per Diem Time and Rate
X Other: explain Annual payment

EEO Analysis: Pending

Compliance with HHC's McBride Principles? Yes No

Vendex Clearance Yes No N/A Pending

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

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

HHC's current agreement with Microsoft expires March 31, 2013 with no renewal options. The proposed contract is a new Enterprise Agreement to replace the previous agreement, which is used across the Corporation,

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

The CRC reviewed this submission on February 27, 2013.

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

No.

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

This contract is a sole source. After researching several means of procurement, it was determined that the best pricing and terms can be obtained by negotiating directly with Microsoft.

Scope of work and timetable:

The agreement is a 3 year agreement that includes software usage rights, software maintenance (termed by Microsoft Software Assurance or SA), premier support, and hosting services for Microsoft Exchange, SharePoint, and Lync (termed Office 365).

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

Since FY2010, HHC has spent $31.5 million with Microsoft. $27.6 million was with an Enterprise Agreement with the remaining $3.9 million being spent on other ancillary licensing and services agreements, which were not part of the Enterprise Agreement. EITS is proposing consolidating all licensing under a single agreement for a total spend of $34.5 million over a 3 year period allocated as follows:

- $30 million Enterprise Agreement with a $1.5 million contingency (5%) to allow for possible expanded software use related to significant increases in user counts or additional projects which may require Microsoft Software.
- $2 million EMR/Epic Project - Capital
- $1 million Health Homes Project (Heal17 Grant)

The total spend with Microsoft would be decreased by approximately 5% from $31.5 million to $30 million, excluding the contingency, EMR/Epic and Health Homes projects. The EMR/Epic and Health Homes projects are separate initiatives where the cost of the Microsoft software is included in the budget for these projects.

Provide a brief summary of historical expenditure(s) for this service, if applicable.

FY2010: Approximately $12.13 million
FY2011: Approximately $9.77 million
FY2012: Approximately $8.7 million
FY2013 True up approximately $920K

Three year total is 31.5 million

Provide a brief summary as to why the work or services cannot be performed by the Corporation's staff.

These purchases are for software, software maintenance, and services that can only be acquired from the software manufacturer.

Will the contract produce artistic/creative/intellectual property? Who will own It? Will a copyright be obtained? Will it be marketable? Did the presence of such property and ownership thereof enter into contract price negotiations?

Yes, the agreement has intellectual property and copyright limitations. Legal Affairs is reviewing the contract.

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

Bert Robles, Senior Vice President / Corp. CIO

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

Pending

Received By E.E.O. _____
Date

*Analysis Completed By E.E.O.*_____
Date

_____
Name

Microsoft Corporation Enterprise Agreement
Presentation Summary

EITS is requesting approval to negotiate and enter into a sole source contract with Microsoft Corporation to purchase software licenses and related maintenance and support on an on-going basis in an amount not to exceed $34.5 million for a three year period.

Background Summary
Today the Corporation uses Microsoft products such as Office, Word, Excel, Windows, SharePoint, System Center, and SQL-Server. Purchasing of these products is consolidated under an existing agreement with Microsoft that expires 3/31/2013. To maintain license compliance HHC plants to negotiate a new agreement for the next three years.

Solution Summary
The new enterprise agreement will cover the products used by the Corporation today. Additionally the new agreement contains the Microsoft hosting service Office 365 which includes online access to Microsoft Exchange (email), SharePoint (collaboration web sites), and Lync (video conferencing and instant messaging).

Financial Analysis
Since FY2010, HHC has spent $31.5 million with Microsoft (including an upcoming true up payment). EITS is requesting $34.5 million spending authority for the next three years. This amount includes $3 million for additional project needs as well as $1.5 million for contingency.

Procurement Approach
EITS plans to contract directly with Microsoft Corporation. Analysis has shown that a direct agreement has the most favorable terms and pricing for the Corporation.

2013 Microsoft Enterprise Agreement

Medical & Professional Affairs/ Information Technology Committee

March 14, 2013

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

nyc.gov/hhc

Background Summary

HHC Requirements

- Maintain License Compliance Across the Corporation

Current Enterprise Agreement

- HHC's current Enterprise Agreement with Microsoft expires on 3/31/2013
- The agreement provides for centralized discounted purchasing for all HHC networks and facilities
- Agreement includes support and upgrade benefits.

In Scope Software Products

- Microsoft Office Suite including Word, Excel, and PowerPoint
- Windows XP, Windows 7, Windows Server
- Microsoft System Center
- SQL-Server, SharePoint, and Exchange (Jacobi only)

Solution Summary

2013 Enterprise Agreement

- MS Office, Windows 7 and Windows 8
- SharePoint Enterprise Edition (Collaboration)
- Exchange Enterprise Edition (Email)
- Lync Enterprise Edition (Instant messaging, video conferencing)

Special Enrollment Programs

- Microsoft has changed the structure of licensing for several products including SQL-Server, System Center, and Windows Server.
- Enrollment programs allow HHC to convert products licensed under the previous structure to the new without having repurchase the software.
- Programs allow for discount levels on future purchases (15% to 40% depending on product).

Office 365 Option

- Promotion being offered by Microsoft for external hosting of Microsoft products including Office, SharePoint, Exchange, and Lync

Financial Analysis

Historical Spend

Description	FY2010	FY2011	FY2012	FY2013	Total Spend
Microsoft Expense	12,128,980	9,772,304	8,712,710	920,000	**31,533,994**

Note: the $920,000 in FY2013 is a true up payment from the FY2010 Enterprise Agreement

Future Spend

Description	FY2013	FY2014	FY2015	Total Spend
2013 Enterprise Agreement	10,050,000	10,000,000	9,950,000	**30,000,000**
HealthHome(Heal17)	-	500,000	500,000	1,000,000
Epic	-	1,250,000	750,000	2,000,000
Contingency (5%)	-	750,000	750,000	1,500,000
TOTAL	10,050,000	12,500,000	11,950,000	**34,500,000**

Benefits

- Total spend decreased from $31.5 million to $30 million excluding contingency
- Epic and Health Home projects are covered by separate budget allocations

Procurement Approach

Recommendation - Direct Agreement with Microsoft via Sole Source

- Microsoft provides software that does not have a feasible substitute in the market.
- A Direct agreement provides the lowest pricing and the most favorable terms to HHC.

Comparison Analysis

- After researching several means of procurement it was determined that the best pricing and terms can be obtained by negotiating directly with Microsoft. .

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3rd Party Validation

- Engaged Gartner and IBM to assist with reviewing pricing. Both confirmed HHC's approach as providing the most favorable pricing and terms.

Questions

Questions?

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Tenant" or the "Corporation") to execute a fifteen year lease agreement with 2857 West 8th Street Associates (the "Landlord") for 24,000 square feet of space at 2857 W. 8th Street, Borough of Brooklyn, to house the Ida G. Israel Community Health Center (the "Center") operated by Coney Island Hospital (the "Facility") at an initial rent of $24/square foot.

WHEREAS, since 1984, the Center provided a full range of primary care services for its patients including pediatric care from newborn through adolescence, gynecologic services, adult primary care, immunizations, dental services, a WIC program, podiatric services, allergy and other medical specialty services as needed; and

WHEREAS, the Center also housed a Chemical Dependency Program which managed approximately 18,000 visits annually; and

WHEREAS, on October 29th and 30th, 2012, the building housing the Center at 2201-2203 Neptune Avenue, Borough of Brooklyn, was substantially destroyed by Hurricane Sandy rendering it unsuitable and untenable for use as a health care facility site and the Corporation terminated the lease effective November 27, 2012; and

WHEREAS, the Center served a primary services delivery area whose residents suffer from a higher rate of medical problems such as diabetes, cancer, heart disease, hypertension and asthma than the general population of New York City, and whose elderly female population exhibits a significant gynecological pathology; and

WHEREAS, there continues to be a need for healthcare services in the area and moving the Center to 2847 W. 8th Street will allow these services to remain within the community.

NOW, THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Tenant" or the "Corporation") be and hereby is authorized to execute a fifteen year lease agreement with 2857 West 8th Street Associates (the "Landlord") for 24,000 square feet of space at 2857 W. 8th Street, Borough of Brooklyn, to house the Ida G. Israel Community Health Center (the "Center") operated by Coney Island Hospital (the "Facility") at an initial rent of $24/square foot.

EXECUTIVE SUMMARY

LEASE AGREEMENT
IDA G. ISRAEL COMMUNITY HEALTH CENTER

CONEY ISLAND HOSPITAL

OVERVIEW: The President seeks authorization from the Board of Directors of the Corporation to execute a lease with 2857 West 8th Street Associates (the "Landlord") for space at 2857 West 8th Street, Borough of Brooklyn, to house the Ida G. Israel Community Health Center (the "Center") operated by Coney Island Hospital ("Coney Island").

NEED/
PROGRAM: The Ida G. Israel Community Health Center (the "Center") is the primary caregiver for the service area, which includes approximately 50,000 residents. Coney Island is also a Health Provider Shortage Area ("HPSA"). The Center's former site, 2201 Neptune Ave, was destroyed by Hurricane Sandy. The new site for the Center, 2857 West 8th Street is approximately one half mile away from the clinic's previous location. The Center's second floor location at West 8th will make it more storm resistant. The new site will contain approximately the same floor area as the Neptune Avenue location and is in the same Primary Service Delivery Area. The block that the Center will be located on houses many City Services including the Human Resources Administration, Department of Motor Vehicles, and NYPD's 60th Precinct. The Center will be accessible by mass transit. Based upon recent statistics, the population being served is made up of significant groups of Hispanic (18%) and African-American (23%) residents. Other growing populations include Asian Indian, and former Soviet Union refugees. The community's residents suffer from a higher than normal rate of medical problems such as diabetes, cancer, heart disease and hypertension. These numbers are significantly higher than the general population in New York City. There is also significant gynecological pathology among the elderly female population and the younger population has a higher than normal incidence of asthma.

The Center will continue to provide a full range of primary care services for its patients, including pediatric care from newborn through adolescence, gynecologic services, adult primary care, and immunizations. In addition, the Center will provide full dental services, a Women, Infant, and Child (WIC) program, podiatric services, allergy treatments and an assortment of other medical specialty services as needed. The Center will continue to house a successful Chemical Dependency Program.

UTILIZATION: A total of approximately 42,000 billable visits were provided at the Center in FY 12 of which approximately 18,000 were provided by the Chemical Dependency Program. In addition, the grant funded WIC program provided an additional 18,000 face-to-face encounters in FY 12. The total visits for the Center is anticipated to increase given the new convenient location, its proximity to public transportation and the fact that many medical/dental providers in the area will not re-build after being impacted by Sandy.

TERMS:

The Tenant will have use and occupancy of approximately 24,000 square feet on the second floor of 2857 West 8th Street (the "Premises"). The initial term of the lease will be fifteen years. The base rent will be $24 per square foot, or $576,000 per year. The base rent will be escalated by 2.5% per year. The lease will contain three five year renewal options exclusive to the Tenant. The base rent for the option periods will be set at 95% of fair market value.

The lease will commence on execution but the first six months of the lease term will be free of rent. Additionally, Landlord shall provide a credit in the amount of $360,000 which may be used by the Tenant as free rent or applied towards the renovation costs.

The Landlord will complete renovations to the Demised Premises in accordance with plans and specifications prepared by the Landlord developed from the space program provided by the Tenant. The Landlord will prepare all schematic, design development, construction documents, specifications and construction estimates, and implement all filings, obtain all permits, certificate(s) of occupancy, comply with all applicable codes, rules and regulations. The renovations will be completed at an estimated cost of $7.2M (calculated using a $300 per square foot project cost, including FF&E). The project cost estimate is a preliminary estimate subject to modification as more detailed cost estimates are developed. The Corporation's Chief Financial Officer must approve the project estimate and receive FEMA reimbursement pre-approval prior to project commencement. The Corporation anticipates FEMA reimbursement of a substantial portion of the project costs. Once more detailed estimates of cost have been developed, the Facility will return to the Corporation's Capital Committee and the Board for approval of the budget for the construction of the project.

The Landlord shall solicit at least three bids from firms for the design work and the construction work. The Tenant shall have the right to submit as many as two additional design and two additional construction firms to the Landlord to be added to the list of bidders solicited. The Landlord will be reimbursed on a monthly basis for work installed during the construction period with 10% withheld pending completion of the work. The construction schedule for the renovations will be established during the design phase of the project. If the Landlord fails to achieve substantial completion within thirteen (13) months after lease execution, the Tenant shall receive a rent credit equal to one day of free rent for each day of delay.

Utilities including electricity, gas, water and sewer will be separately metered and paid directly to the public utility by the Tenant.

Real estate taxes are included in the base rent. The Tenant will pay its proportionate share of real estate tax increases above the 2014/2015 base year.

The Landlord will be responsible for all exterior maintenance and repairs and all exterior and interior structural maintenance and repairs to the building and premises, including replacement of the roof and main utility feeder and waste lines serving the building. The Tenant will be responsible for non-structural repairs and maintenance.

FINANCING: The Center's programs are financed by revenues from payors including Medicare, Medicaid, HMOs and self-paying patients, as well as special operating budget funds from the New York City Council in the amount of $800,000, $250,000 in NYCDOH funding for Child Health Centers, and $268,000 in grant funds for the WIC program.

SUMMARY OF ECONOMIC TERMS

SITE:	2857 W. 8th Street Block 7279, Lot 162
LANDLORD:	Steven Samuels 2857 W. 8th Street Associates LLC
PREMISES:	24,000 square feet, 2nd Floor
INITIAL TERM:	Fifteen years
OPTIONS:	Three five year options
BASE RENT:	$24 per square foot; $576,000 per year
RENT COMMENCEMENT:	Rent will commence approximately thirteen (13) months after lease execution and not until the work at the site is substantially completed.
ESCALATION:	2.5% per year
MAINTENANCE:	The Landlord will be responsible for all exterior maintenance and repairs and all exterior and interior structural maintenance and repairs to the building and premises, including replacement of the roof and main utility feeder and waste lines serving the building. The Tenant will be responsible for non-structural repairs and maintenance.
UTILITIES:	Utilities including electricity, gas, water and sewer will be separately metered and paid directly to the public utility by the Tenant.
LANDLORD's WORK:	The Landlord will complete renovations in accordance with plans and specifications prepared by the Landlord developed from the space program provided by the Tenant. The Landlord will prepare all schematic, design development, construction documents, specifications and construction estimates, and implement all filings, obtain all permits, certificate(s) of occupancy, comply with all applicable codes, rules and regulations. The renovations will be completed at an estimated cost of $7.2M (calculated using $300 per square foot project cost, including FF&E). The project cost estimate is a preliminary estimate subject to modification as more detailed cost estimates are developed. The Corporation's Chief Financial Officer must approve the project estimate and receive FEMA reimbursement pre-approval prior to project commencement. The Corporation anticipates FEMA reimbursement of a substantial portion of the project costs. Once more detailed estimates of cost have been developed, the Facility will return to the

Corporation's Capital Committee and the Board for approval of the budget for the construction of the project. The Landlord will be reimbursed on a monthly basis for work installed during the construction period with 10% withheld pending completion of the work. The construction schedule for the renovations will be established during the design phase of the project. If the Landlord fails to achieve substantial completion within thirteen months after lease execution, the Tenant shall receive a rent credit equal to one day of free rent for each day of delay.

TAXES: Real estate taxes are included in the base rent. The Tenant will pay its proportionate share of real estate tax increases above the 2014/2015 base year.

SAVITT PARTNERS

March 13, 2013

Dion Wilson
Office of Facilities Development, Real Estate
NYC Health and Hospitals Corporation
346 Broadway, 12 West
New York, NY 10013

Re: 2857 West 8th Street, Brooklyn, NY – 2nd Floor

Gentlemen,

Pursuant to your request, I have evaluated the referenced property for the purpose of establishing the fair market rental value of the 2nd floor as medical office space. My evaluation is subject to the assumption that:

- this unit is zoned and legal for use as a medical office
- the unit is accessed through a common lobby & elevator
- the unit is built to current code and with handicapped access

The tenant will occupy space on the 2nd floor of this commercial building. The building is located one half mile away from the clinic's previous location, 2201 Neptune Avenue, which was destroyed by Hurricane Sandy. While this building also sustained damage on account of Hurricane Sandy, it is currently being renovated for tenant occupancy. Public access to the building will be code compliant and ADA accessible. The unit will be accessed via a common corridor on the ground floor and elevator to the 2nd floor.

The tenant will occupy approximately 24,000 RSF. The initial term of this gross lease will be fifteen (15) years. The base rent will be $24 per RSF and escalated by 2.5% per annum compounded in subsequent and all years after. Tenant will benefit from three (3), five-year extensions and rent during those periods will be at 95% of fair market value. This is typical of rent escalations. Tenant will further benefit from a 7.5 month free rent period, the cash value of which can be used by Tenant as either free rent or credited towards Tenant's portion of its construction obligation.

Landlord will be building on behalf of Tenant and subject to Tenant's plans and specifications. Landlord, as its base building obligation, will replace building façade and the windows on the 2nd floor, will demise the premises according to Tenant's plans and specifications, provide a new public lobby & corridor with an ADA compliant elevator as previously described, bring electrical service to Tenant's panel for distribution by Tenant, provide two (2) ADA compliant bathrooms, new exterior roof-mounted HVAC units adequate to service the premises (inclusive of gas service) and provide water and sewer service to the building for Tenant to "tap" into.

The balance of construction will be provided by Landlord's contractors in accordance with Tenant's specifications. The cost of Tenant's finishes will be at Tenant's expense.

All utilities (electric, gas, water, sewer) will be on separate meters and billed and paid directly by Tenant to the appropriate public utility. The cost of installing the meters will be borne solely at Landlord's cost & expense. Real Estate taxes will be Tenant's proportionate share over a 2014/15 base year.

The rent, escalation, Landlord and Tenant work distribution and cost is consistent with commercial lease and rent structures and the rent is consistent with newly built space within the given geographical area. We have provided comparable rents for medical office space at other Brooklyn based locations for comparison.

In the event that I can provide any additional information or be of any further assistance to you, please do not hesitate to call.

Thank You.

Very Truly Yours,

Michael E. Dubin
Partner

Brooklyn Properties

Address	*Building Type*	*Neighborhood*	*Sq. Ft*	*Construction required*	*On-site Parking*	*Public Transit*	*Asking Rents PSF*	*Est. Annual Rents*	*Notes*
2571 E17th Street	Class B/ Office/ Medical	Sheepshead Bay	9,200	open space; new construction	Street Parking	B,Q lines Sheephead bay Stop 3 blocks from location	$30	$276,000	3,800sf on the 1st, 2,700sf on the 2nd and 3rd floors
1825 65th Street	Retail/ Storefront/ Office	Borough Park	7,000	Yes	Street	N line 18th avenue stop 1 block from location	$35	$245,000	***Lease out for signature.*** *LL showing until lease signed. LL will not contrib-ute to build out. T has to work out C of O cur-rently under public assembly.*
1355 84th Street	Class B/ Office/ Medical	Dyker Heights	10,000	No	Yes	D, M lines 79th St. & New Utrecht 5 min walk	$38	$380,000	**Ready to go**
1090 Coney Island Ave	Class B/ Office	Midwood	10,800	No	Yes	Q line Avenue H stop	$23	$248,400	On-site parking is $150 per spot.
3044 Coney Island Ave	Class B/ Office	Brighton Beach	7,500	Open Space	Street	B,Q lines Brighton Beach stop few blocks from location	$29	$217,500	4 free executive spots on site. Ownership can make 20 plus spots avilable off-site @ $200 per spot
3101 Emmons Ave	Class C/ Office	Brighton Beach	7,500	open space; new con-struction	Street	B,Q lines Sheephead bay Stop	$32	$240,000	7,500 over three stories
1494 Ocean Ave	Multi Fam-ily/ Residential	Midwood	6,000	Yes	Street	Q line Avenue J stop few blocks from location	$30	$180,000	Residential property
902 Quentin Road	Class A/ Office	Gravesend	8,164	yes owner will build to suit	Yes	B,Q @ E16th St.; F @ MCDonald Ave	$35	$285,740	***Built to Suit - new construc-tion***
3046 Brighton 1st	Class B/ Office	Brighton Beach	11,500	yes owner will build to suit	Yes	Q line 1 block from location	$30	$345,000	***Built to Suit - new construc-tion***
2275 Coleman Street	Class B/ Office	Marine Park	10,545	No	Street	2/5 to Bklyn College + Q35	$29	$305,805	Modern, built office. $15 workletter.
1530 E 15th Street	Class B/ Office	Midwood	17,400	Yes	Street	B, Q King's Hwy stop	$30	$522,000	White Box w/ HVAC
1100 Coney Island Ave	Class B/ Office	Midwood	9,600	Yes	Street + Garage	B, Q lines Newkirk Ave	$23	$220,800	White Box

RESOLUTION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve a Capital Project for Harlem Hospital Center to Relocate and Modernize the Dental Clinic for a total project cost of $6.25 Million.

WHEREAS, the Harlem Hospital Center Dental Clinic resides in the Women's Pavilion (WP) which is planned for eventual demolition; and

WHEREAS, the existing WP building infrastructure and clinic space cannot support the proposed modernization of the Dental Clinic; and

WHEREAS, Harlem Hospital Center has been granted HEAL 21 funds in the amount of $3,858,653 to be used for the relocation and modernization of its Dental Clinic; and

WHEREAS, Harlem Hospital Center has been awarded an additional $1.8 million in City Council funds for the purpose of purchasing equipment for a 23-operatory dental clinic which will be used to partially fund this project; and

WHEREAS, the proposed dental clinic equipment will provide a state of the art sterilization facility will correct existing deficiencies and conform to current codes and standards allowing the process to return to operation within the dental clinic thereby increasing efficiencies; and

WHEREAS, funding for the balance of this project above the HEAL 21 grant and City Council funds will be provided by Harlem Hospital Center Expense funds and existing Capital funds remaining in Capital Project #13200703; and

WHEREAS, the revision to Operating Procedure 100-5 requires that construction projects with budgets of $3 million or more shall receive approval of the Board of Directors through the Capital Committee; and

WHEREAS, the proposed total project budget, inclusive of all contingencies, is estimated to be $6.25 Million; and

NOW THEREFORE, be it

RESOLVED, that the President of the New York City Health and Hospitals Corporation (the "Corporation"), be and hereby is authorized to approve a Capital Project for the Relocation and Modernization of the Dental Clinic at Harlem Hospital Center in accordance with the budget attached at a total project budget of $6.25 Million.

RESOLVED, that the approval of this resolution shall be in lieu of an approval by the Capital Committee of a Work Order for the funds authorized in this resolution.

EXECUTIVE SUMMARY

PROJECT APPROVAL
RENOVATION

HARLEM HOSPITAL CENTER DENTAL CLINIC RELOCATION AND MODERNIZATION

Authorizing the President of the New York City Health and Hospitals Corporation (the "Corporation") to approve a Capital Project for Harlem Hospital Center to Relocate and Modernize the Dental Clinic for a total project cost of $6.25 Million.

Harlem Hospital Center plans to relocate its existing dental clinic to the Kountz Pavilion from the Women's Pavilion (WP) in order to vacate that building which is slated for demolition. The existing equipment is approaching 25 years of service and frequently requires extensive maintenance to remain in service. Moreover, the existing sterilization processing facility is no longer functional requiring all dental instruments and equipment to be processed through a facility located in a separate building resulting in prolonged turnover time between reuse, the need to purchase additional instruments to be used during the process and increased likelihood of loss of instruments through attrition.

In June, 2012, Harlem Hospital Center was awarded a HEAL 21 grant from NYS-DOH in the amount of $3,858,653 for this project. These funds, together with a City Council FY 12 award of $1.8 Million for new dental equipment, form the basis for proceeding with the design and construction of a 23-operatory dental Clinic to be located on the mezzanine floor of the Kountz Pavilion. Additional funds for the balance of this project will be provided by Harlem Hospital Center Expense funds and existing Capital funds remaining in Capital Project #13200703.

The new dental clinic will relocate to the mezzanine floor of the Kountz Pavilion encompassing approximately 8,900 square feet. Included will be 12 general dentistry, 6 oral surgery, and 5 pediatric/orthodontic operatories. Each of these operatories will be outfitted with state of the art intraoral digital xray equipment which will provide for better patient flow and higher efficiency of dental staff. Two digital panorex rooms are anticipated to shorten length of visits. The clinic will include a dental laboratory and a code-compliant equipment sterilization suite, allowing faster turn-around and reuse of dental instruments. In addition to registration/reception and waiting areas, departmental offices and services, conference/training and library space will be located on this floor. A new pump room for compressors, vacuum pumps, and amalgam separators will be located in the building basement. Oxygen and Nitrous oxide will be delivered to the operatories through a central system located in the MLK Pavilion.

The clinic currently accommodates approximately 22,500 visits annually and it is anticipated that this number will rise 10 - 15% year over year for each of the first 3 years following occupancy. This increase will be enabled by the efficiencies of the new digital equipment and a decrease in the length of visit times by an average of 25%.

NYS-DOH approved the initial Certificate of Need (CON) for the Dental Clinic Relocation in January, 2009. Due to a change in location in the current project, a revised CON application was submitted upon receipt of the HEAL 21 grant and approval was obtained in January, 2013. The current schedule anticipates construction completion in December, 2013 and occupancy in early 2014.

March 14, 2013

Dear Capital Committee Members,

On January 10, 2013, the Capital Committee tabled consideration of a resolution for nine million ($9 million) to relocate the existing Harlem Dental Clinic from the Women's Pavilion into the Kountz Pavilion, pending response to questions relating to the dental clinic and the Harlem Major Modernization project. The following represents a response to those questions.

DENTAL CLINIC PROJECT (SOURCES AND USES) -BUDGET REVISION

- Since being presented in January, the project's initial budget has been reduced to reflect a more limited scope. The reduction in cost is attributed to a repurposing of existing furniture, office equipment and fixtures into the revised project scope and a reduction in space renovation.
    - The revised project cost is estimated at $6.25 million (inclusive of contingency), and is composed of: $3.86 million in HEAL 21 Grant funding (for which no debt service will be incurred); $1.86 million in General Obligations ($1.8 million in City Council funds and $56,000 in Mayoral funds); $401,057 in HHC bonds, and $130,000 in Other Than Personal Services (OTPS) funds committed by the facility for non-capitally eligible activities associated with project's preparatory work.

HARLEM MODERNIZATION COSTS AND ITS RELATIONSHIP TO THE DENTAL CLINIC PROJECT:

Why the Dental Clinic was not part of the Major Modernization:

- In the campus Master Plan of 2006, the Dental Clinic was to be relocated from the Women's Pavilion to the second floor of the existing Ron Brown building. The relocation required a series of sequential moves that had not been properly funded, and an alternate plan was developed to relocate the Dental Clinic into the Kountz Pavilion.

SHOULD THE DENTAL CLINIC HAVE BEEN INCLUDED AS A COMPONENT OF WHAT WAS PURCHASED AS PART OF THE HARLEM MODERNIZATION PROJECT? Yes.

- The Master Plan sought to:
    - Modernize portions of the Martin Luther King Pavilion (incomplete);
    - Construct a New Patient Pavilion (completed);
    - Relocate occupants of the New Nurses' Residence and raze the building (completed);

- Construct a new 400 car Parking Garage to include an integrated EMS station (incomplete);
- Relocate occupants of the Women's Pavilion (which includes the dental clinic) and raze the building (incomplete).

THE INITIAL MODERNIZATION ESTIMATE WAS NOT VALIDATED TO SUPPORT A $225 MIILION BUDGET

- Best practice recommends continuous revisiting and reconciliation of project scope at various stages of design and construction, to assure their alignment, and that project assumptions remain valid. In this case, both budget and project assumptions were not validated at later stages of the process.

THE PROJECT'S BUDGET IS $325 MILLION; $292 MILLION HAS BEEN EXPENDED

- There remains in the modernization budget, approximately $31 million in project funding;
  - $10 million dedicated to the relocation of current occupants of the Women's Pavilion, inclusive of the building's demolition;
  - $4.6 million in dedicated funding to integrate the previously demolished EMS station,
  - $16.4 million for a new parking garage.

- **THE INITIAL ESTIMATED COST FOR RELOCATING OCCUPANTS OF THE WOMEN'S PAVILION AND ITS DEMOLITION EXCEEDS $25 MILLION - THE EXISTING BUDGET IS $10 MILLION**

- **THE COST OF A MORE MODEST 200+ CAR GARAGE INCORPORATING THE DEMOLISHED EMS STATION EXCEEDS $25 MILLION**
  - There remains an additional $8 million unfunded appropriation by Congressman Rangel that has not been honored, however, HHC has taken measures to attempt to utilize that funding. An application to build a parking facility for the $8 million in lieu of a parking garage is currently pending with the U.S. Department of Transportation.

- **OMB WILL NOT ALLOW A COMMINGLING OF THE REMAINING $31 MILLION FOR USE IN COMPLETING THE WOMEN'S PAVILION**

MORE EFFECTIVE AND TIMELY COMMUNICATION WITH GOVERNANCE

- At the earliest stages, governance should have had clear comprehension of the implications of the project's budget constraints. Prospectively, more effective communication with governance will be implemented.
- The current Breakthrough initiative now reviewing construction processes will seek to include review of more effective communication methods with governance to assure construction related decisions, especially those impacting services, are clearly communicated.

Respectfully submitted,

Alfonso C. Pistone

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Assistant Vice President
Office of Facilities Development

3/14/2013

HARLEM HOSPITAL CENTER

DENTAL CLINIC RENOVATION/EXPANSION - Comparison of January 10, 2013 and current March 14, 2013 cost estimates.

Item	January 10th Scope Estimate	March 14th Scope Estimate
Renovation & Demolition in Kountz Pavilion (including general conditions)	$4,860,589	$2,952,898
Asbestos Abatement or Removal (allowance)	$0	$25,000
Subtotal Construction Cost	$4,860,589	$2,977,898
NYSDOH Certificate of Need for Design Contingency	$486,059	$81,205
NYSDOH Certificate of Need for Renovation Construction Contingency	$486,059	$295,290
Other Project Construction Contingency		$295,290
Planning Consultant Fees	$72,909	
Architect/Engineering Fees	$413,150	$342,458
Construction Manager Fees	$388,847	$327,569
Furniture, Fixtures, and Dental Equipment, including Telecom/Data	$2,292,387	$1,861,000
Project Costs for relocations, make-ready, clean-up, painting, telecom/data)		$65,000
Total Project Cost	**$9,000,000**	**$6,245,710**

HARLEM HOSPITAL CENTER
DENTAL CLINIC RENOVATION/EXPANSION

Scope Description	COST
Renovation/Demolition	2,952,898
Asbestos Abatement Allowance	25,000
Design Contingency	81,205
CON Renovation Contingency	295,290
Other Project Construction Contingency	295,290
A/E Fees	342,458
Construction Manager Fees	327,569
Furniture & Equipment	1,861,000
Other Project Costs	65,000
TOTAL	**$6,245,710**

Funding Sources	
HEAL 21	3,858,653
City G.O.	1,856,000
HHC Bonds 2010	105,767
Future HHC Bond Financing *	295,290
OTPS Expense	130,000
	$6,245,710

** Earmarked for the additional 10% in construction contingency.*

3/13/13

PROJECT FACT SHEET

Harlem Hospital Center
Dental Clinic Relocation and Modernization Project

Overview: Harlem Hospital Center proposes to relocate its dental clinic from the 2nd floor of the Women's Pavilion (WP), to the mezzanine floor of the Kountz Pavilion at an all-inclusive cost of $6.25M. The existing dental clinic currently occupies the 2nd floor of the WP, located on 137th Street between Lenox and Fifth Avenue. The WP was constructed circa 1930, as a Women's and Pediatric facility. Over the years, its age and interior configuration has made it increasingly less functional for clinical service.

In deciding whether to renovate within its existing WP location or to relocate the service elsewhere on campus, the WP's physical condition, interior configuration, and budgetary constraints were considered. The WP requires extensive renovation to comply with current building codes, and would require additional renovation to make its interior configuration appropriate for continued clinical use. Current budgetary resources are inadequate to address those issues. The WP will eventually be razed once sufficient funds are available. In the interim, the facility is taking interim steps to vacate the WP. The dental clinic represents the first of the current WP occupants to vacate.

In contrast, relocating dental clinic services to the mezzanine floor of the Kountz Pavilion on 136th Street near Fifth Avenue provides an ability to streamline services and reduce patient wait times by increasing efficiencies as a result of having each operatory fully outfitted with intraoral x-ray equipment, upgrades to existing digital x-ray technology, and faster turnaround of operatories due to availability of sterilization equipment. These improvements will decrease the length of time of each patient visit, therefore providing opportunity for scheduling more patient visits per session.

Remaining WP Occupants include; Network Data Center, Medical Records, Human Resources, Occupational Health Services, Behavioral Health Adult Outpatient Programs and Administrative Offices, CPEP Mobile Crisis, Chemical Dependency, Residency Training, Fire Life Safety, Physician Assistant School Program, Electric, Carpentry, Locksmith Shops.

Statistics: FY 2011 patient visits totaled 22,380, an increase of 14% over FY 2010. Currently, the clinics are functioning at full capacity. In the new Kountz Pavilion location, with the availability of digital intraoral X-Ray equipment in each of the 23 proposed operatories, and the addition of two new digital panoramic X-Ray rooms. It is expected that volume will increase between 10-15% year-over-year in each of the next three years; adding roughly 3,000 visits the first year, and additional 3,000 to 3,500 in each of the next two years. Projected annual patient visits after the 3rd year would be in the range of 30,000 - 35,000.

Currently, the average new patient appointment scheduling is 3 months. This will be reduced to 3 weeks or less with the additional capacity available as a result of greater efficiency and shorter visit times. It is anticipated that typical visit times will be decreased by 30 minutes.

Construction: The project architect of record is Perkins Eastman. It is anticipated that the services of a construction manager will be contracted to coordinate and supervise construction.

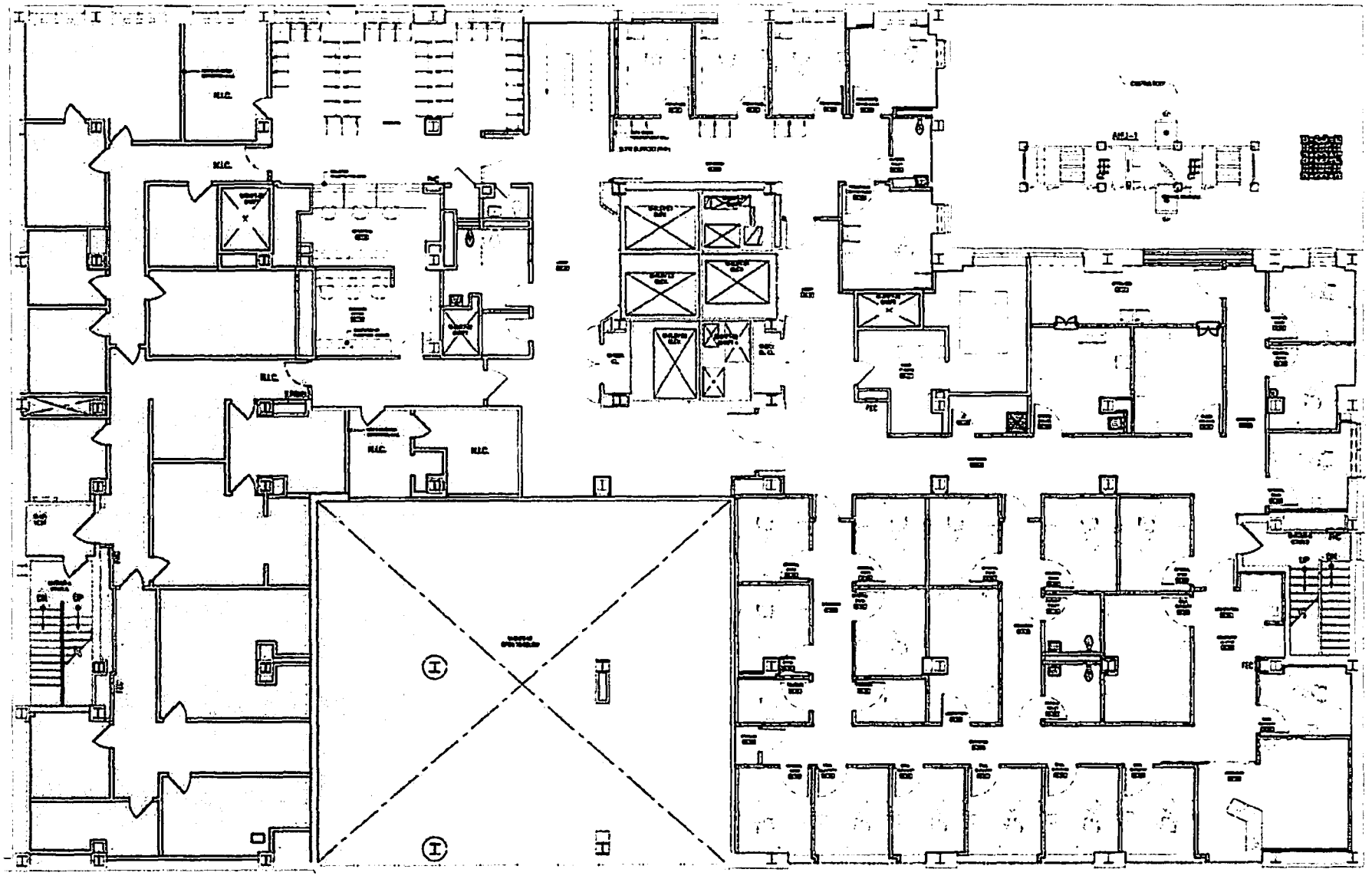
Projected Schedule:

- Relocation of programs on Kountz Mezzanine to take place within two weeks of Capital Committee and Board of Directors project approval.
- Purchase of Dental Equipment within two weeks of project approval.
- Demolition to commence April 1st with a duration of 30 days (IQCC contractor).
- Bid to be advertised no later than April 1st with bid opening in 30 days.
- Award of contracts May 30th, 2013 and start of construction in June 30th, 2013.
- HEAL 21 Funds to be expended no later than December, 2013.
- Completion of construction and installation of dental equipment December, 2013.
- Testing, Inspection, certification and regulatory approvals completed February, 2014
- Occupancy of new clinic in March, 2014.

Project Budget: $6.25 Million

PROPOSED DENTAL CLINIC RELOCATION

KOUNTZ BUILDING—MEZZ LEVEL



NOT IN SCOPE

RESOLUTION

Reappointing Margo Bishop as a member of the Board of Directors of MetroPlus Health Plan, Inc., a public benefit corporation formed pursuant to Section 7385(20) of the Unconsolidated Laws of New York ("MetroPlus"), to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws.

WHEREAS, a resolution approved by the Board of Directors of the New York City Health and Hospitals Corporation ("HHC") on October 29, 1998, authorized the conversion of MetroPlus from an operating division to a wholly owned subsidiary of HHC; and

WHEREAS, the Certificate of Incorporation of MetroPlus designates HHC as the sole member of MetroPlus and has reserved to HHC the sole power with respect to electing members of the Board of Directors of MetroPlus; and

WHEREAS, the Bylaws of the Corporation authorize the Executive Director of the Corporation to select a Director who is a member of the MetroPlus "mainstream" Health Plan, subject to approval by the Board of Directors of the Member; and

WHEREAS, the Executive Director of MetroPlus has selected Mrs. Bishop to serve an additional term as a member of the Board of Directors of MetroPlus;

WHEREAS, the Board of Directors of MetroPlus has approved said nomination;

NOW, THEREFORE, **be it**

RESOLVED, that the HHC Board of Directors hereby reappoint Margo Bishop to the Board of Directors of the MetroPlus Health Plan, Inc. to serve in such capacity until her successor has been duly elected and qualified, or as otherwise provided in the Bylaws of MetroPlus.

EXECUTIVE SUMMARY

Pursuant to the Certificate of Incorporation of MetroPlus, HHC has the sole power with respect to electing members of the Board of Directors of MetroPlus. The Bylaws of MetroPlus authorize its Executive Director to select a Director who is a member of the MetroPlus "mainstream" Health Plan, subject to approval by the Board of Directors of HHC.

The Executive Director of MetroPlus has nominated Margo Bishop to serve another term as a member of the MetroPlus Board.

Ms. Bishop has been a participating member of the MetroPlus Health Plan since 1988. She has been an active member of MetroPlus' Member Advisory Committee for over eight years and a MetroPlus Board member for five years. MetroPlus is very pleased that she has agreed to continue to serve on the Board, and is particularly interested in the perspective that she, as a member, will continue to bring to the Board.