



New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Management and Control of Overtime Costs

New York City Health and Hospitals Corporation



Executive Summary

Purpose

To determine whether the New York City Health and Hospitals Corporation (HHC) has effectively managed and controlled its employee overtime costs. The audit covers the period January 1, 2006 through December 31, 2009.

Background

HHC, the largest municipal hospital and health care system in the United States, serves about 1.3 million patients annually. HHC provides comprehensive medical and mental health services through its eleven acute care hospitals, four skilled nursing facilities, six diagnostic and treatment centers, a home health care agency, and more than eighty community-based clinics. In addition, HHC provides medical services to New York City's correctional facilities and operates a managed care health plan. HHC incurred \$126 million in overtime cost in 2011.

Key Findings

- We analyzed overtime payments incurred throughout all HHC facilities and found that many employees are being paid significant amounts of overtime, as their annual overtime pay often exceeds their annual salaries. For example, the overtime earnings for 54 employees totaled \$3.1 million in 2009 and their overtime pay totaled at least 50 percent and as much as 183 percent of their annual base salaries. (See Exhibit A).
- We reviewed the overtime records for 40 employees at two facilities and found many are working considerable overtime, including more than three overtime shifts in a one or two week period and/or ten or more consecutive days without a day off. As a result, there may be increased risks to patient care posed by staff who may not be performing at their optimal level due to fatigue or inattentiveness.

Key Recommendations

- Explore, implement and manage ways to reduce overtime costs. Adopt the best practices of other HHC facilities when deciding to use overtime.
- Establish and implement controls to prevent employees from working excessive overtime shifts and consecutive days.
- Set specific dollar or percentage overtime reduction goals for the facilities and monitor performance in achieving these goals.

Other Related Audits/Reports of Interest

[Metropolitan Transportation Authority: Management and Control of Employee Overtime Costs \(2009-S-88\)](#)

[Port Authority of New York and New Jersey: Management and Control of Employee Overtime Costs \(2009-S-87\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

May 7, 2012

Mr. Alan D. Aviles
President
New York City Health and Hospitals Corporation
125 Worth Street
New York, NY 10013

Dear Mr. Aviles:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of New York City's Health and Hospitals Corporation: Management and Control of Overtime Costs. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Unconsolidated Laws (New York Consolidated Laws Service), Sections 4 (subdivision 9) and 22.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The New York City Health and Hospitals Corporation (HHC), a public benefit corporation created in 1970, serves about 1.3 million patients annually and is the largest municipal hospital and health care system in the United States. HHC is managed by a Board of Directors and provides comprehensive medical and mental health services through its eleven acute care hospitals, four skilled nursing facilities, six diagnostic and treatment centers, a home health care agency, and more than eighty community-based clinics. In addition, HHC provides medical services to New York City's correctional facilities and operates a managed care health plan. HHC's facilities are organized into seven health care networks that were established to improve efficiencies through inter-facility coordination.

HHC's operating budget for fiscal year 2011 totaled \$7.33 billion, including payroll costs of \$2.6 billion for its 36,426 employees. HHC incurred an operating deficit of \$443 million for fiscal year 2011.

In fiscal year 2011, HHC incurred \$126 million in overtime costs. HHC defines overtime as time worked in excess of an employee's regularly scheduled hours. For example, for full-time employees the first five hours of overtime in excess of the regular 35-hour work week is paid at the straight rate. Time in excess of 40 hours per week is paid at the time-and-a-half premium rate. Similarly, for part-time employees, overtime in excess of their regular part-time hours up to 40 hours is paid at the straight rate, with time in excess of 40 hours per week being paid at the premium rate.

Overtime at HHC is divided into two general categories: (1) scheduled overtime, which is built into the employees' regular work schedule and is generally scheduled two to four weeks in advance, and (2) unscheduled overtime, which is assigned as needed, to cover unanticipated employee absences, or to meet special work needs or emergencies.

In administering overtime, the facilities and networks must adhere to Guidelines issued by the Mayor's Office of Operations in May 1997, and HHC's Guidelines for Effective Overtime Management issued in June 1997. These guidelines acknowledge that overtime is a valuable resource that should only be used when it is determined to be in the best interest of the corporation. The guidelines require managers to authorize and monitor all aspects of overtime, such as the necessity for the overtime, proper authorization, ensuring that the employee worked the overtime before approving payment, and determining how to avoid using overtime in the future. Additionally, some departments have developed their own procedures or work practices for overtime.

Audit Findings and Recommendations

Some Staff Work Considerable Amounts of Overtime

Between 2006 and 2009, overtime costs increased 33 percent from \$86 million to over \$114 million. By 2011, HHC records show this cost had risen to \$126 million. HHC needs to ensure that its use of overtime is the most economical and efficient means of meeting its staffing needs. An HHC policy in place since 1997 requires overtime be used only when it is shown to be in the best interest of the organization. Under the policy, before using overtime, managers must evaluate the need for the services, determine that overtime is the optimal way to get work done, and determine what need be done to avoid similar overtime in the future.

We analyzed HHC's 2009 overtime payments and identified 54 employees whose overtime earnings supplemented their base salaries by more than half. Together, these employees earned more than \$3.1 million in overtime during just this one year and their overtime pay totaled at least 50 percent and as much as 183 percent of their annual base salaries. For example, two housekeeping aides at Jacobi Medical Center each earned almost \$65,000 in overtime on top their base salaries of about \$35,400, for a total of about \$100,000 each. Two other housekeeping aides at Lincoln Hospital each earned over \$80,000 in 2009, including almost \$50,000 of overtime each. (See Exhibit A)

High overtime earners were not confined to the housekeeping staff, but rather spread across the full range of HHC operations. For example, for positions related to patient care, we found:

- Three medicine surgery technicians, with salaries of \$35,000 to \$37,000, each earned about \$47,000 in overtime; over 130 percent of their base pay.
- Four pharmacists, whose base salaries ranged from \$96,000 to \$105,000, earned overtime of \$50,000 to \$67,000; a 52 to 64 percent increase over base pay.
- One pharmacy technician with a base salary of \$42,000 earned another \$53,000 in overtime; a 125 percent increase over base pay.
- Nine nurses with salaries of \$69,000 to \$92,000 earned between \$47,000 and \$64,000 in overtime; 51 to 78 percent over base pay.
- A nurse's aide paid \$34,000 earned another \$54,000 in overtime: a 159 percent increase over base pay; and
- Two service aides, whose regular salaries were \$32,000 and \$34,000, earned \$50,000 and \$56,000 in overtime respectively; 157 and 166 percent increases over base pay.

In other areas such as facility maintenance and support, we found:

- A supervisory plumber whose regular salary was about \$89,000 earned almost \$94,000 in overtime; a 106 percent increase over base pay.
- Fourteen other plumbers with base pay of \$84,000 earned between \$50,000 and \$79,000 in overtime; 60 to 94 percent increases over base pay.
- Two carpenters with base pay of \$76,000 earned \$51,000 and almost \$71,000 in overtime; 67 and 93 percent increases over base pay.
- Three electricians whose base salaries were \$96,000 earned between \$64,000 and

\$82,000 in overtime; 67 to 85 percent increases over base pay.

- Eight stationary engineers with base salaries of \$90,000 earned \$47,000 to \$75,000 in overtime; 53 to 83 percent increases over base pay; and
- Two clerical associates whose base salaries were \$41,000 and \$44,000 earned \$55,000 and \$66,000 in overtime; 133 and 151 percent increases over base pay.

We noted that some individual units have developed their own procedures to help limit overtime. For example, managers in the Food and Nutrition departments at Coler-Goldwater and Bellevue each told us they try to schedule part-time employees to work extra hours before assigning overtime work to their full-time staff. Still, HHC does not have any similar corporate-wide initiatives aimed at reducing the need for overtime. For example, management does not routinely analyze overtime trends to identify preventable causes such as excessive absenteeism, unnecessary work assignments or non-productive work rules. Analyses like these are critical to identifying operational practices that contribute to overtime and developing strategies to reduce these costs. HHC does have an array of reports available to track and monitor overtime usage and costs. However, managers generally only review these reports to identify budget variances, not to identify strategies and best practices. We note that even a 10 percent reduction in overtime could save HHC nearly \$11 million each year.

When we questioned why certain employees were working so much overtime, the primary reason cited by HHC officials was that the departments are understaffed and the overtime is needed to ensure sufficient coverage. HHC officials pointed to a reduction of nearly 1,000 full-time equivalent positions in February 2010 as a major reason for these shortages. In addition, a corporate-wide hiring freeze was implemented in December 2008 and, as a result, departments cannot hire additional employees or backfill vacant positions. The other major reason cited by HHC officials was coverage for employee absences, both planned and unplanned.

(In responding to our draft report, HHC officials advised that their workforce reduction has reached 2,500 positions and generates \$200 million in savings annually. They project that these savings will increase to \$300 million annually by the end of fiscal year 2014 when the full reduction of 3,750 positions is achieved.)

When employees work overtime, HHC procedures require managers to document the reasons why the extra work is necessary. We selected a judgmental sample of 40 staff who worked significant amounts of overtime at two facilities, Goldwater and Bellevue, to identify the reasons cited for overtime. During the two-week period we examined, these 40 employees worked 317 overtime events. Staffing shortages were cited as the cause for 183 of the 317 overtime events (58 percent) while employee absences accounted for another 108 overtime events (34 percent). In 24 of these 317 overtime events (8 percent), the reason for the overtime was not documented as required. Specific emergency situations comprised the remaining two overtime events (0.6 percent). These results underscore the fact that much of HHC's overtime is rooted in factors that may be known in advance, affording HHC and its facilities the opportunity to develop possible strategies to manage overtime to help reduce costs.

Excessive Overtime Increases Patient Risk

Excessive overtime is not only expensive in terms of salaries paid to staff at premium rates; performance can also suffer if employees become overtired or inattentive, exposing an organization to additional risks for errors and mistakes. These risks are a particular concern in a patient care environment like HHC, especially when staff are assigned to work multiple overtime shifts or consecutive days without a break. By placing limits on overtime shifts, and the number of consecutive days that employees can work without taking a day off, management can help ensure optimal performance by staff and promote patient safety.

HHC grants its individual facilities the discretion to establish many of the work rules that govern staff scheduling. As a result, some facilities have developed additional procedures governing overtime, while others have not. Two facilities, Coler-Goldwater and Bellevue, have rules that limit staff to no more than three overtime shifts in a week. To determine whether this work rule was being followed, we visited these facilities and examined overtime records and timesheets for 40 employees who worked significant amounts of overtime during a two-week period.

We found that 18 of the 40 employees worked more than three overtime shifts in one or both weeks, in violation of the three overtime shift maximum. In addition, 11 of these 18 employees worked 10 or more consecutive days in a row. For example, at Coler-Goldwater:

- Seven of 20 employees worked between four and six overtime shifts during each of the two weeks we reviewed, including a medicine surgery technician who worked six overtime shifts in the first week and five overtime shifts in the second. In another case, a nurse's aide worked six overtime shifts during each of the two weeks.
- Two other employees had worked more than the three-shift maximum during one of the two weeks we reviewed. These two employees each worked five overtime shifts.
- Four of these nine employees had worked between 13 and 20 consecutive days without a full day off, including two medicine surgery technicians who had worked 19 and 20 days in a row.

We found similar issues at Bellevue, where:

- Seven of 20 employees had worked between four and seven overtime shifts during both weeks, including a pharmacy technician who worked six overtime shifts in the first week and five in the second.
- Two other employees exceeded the three-shift maximum during one of the two weeks; one working four shifts and the other six.
- Seven of these nine employees had worked between 10 and 20 consecutive days, including the pharmacy technician who had worked 20 consecutive days.

Officials at these two facilities agreed with our findings and indicated they would monitor and enforce these restrictions in the future. We believe that HHC should also adopt similar work rules that would apply to all facilities and take steps to monitor compliance in an effort to reduce risk.

One way HHC can reduce the need for overtime by patient care staff is to increase its use of part-time or temporary staffing. We noted that HHC has contracts in place with certain employment

agencies to provide staff, such as nurses and nurse's aides, on a per diem or temporary basis. However we found this option is not being fully used, even though HHC's own staffing plans and patient census analyses show certain units are understaffed. Officials explained that they would rather schedule their own employees to work overtime than use temporary staff, in part because it provides more certainty that staff have the necessary skills, but also because it ensures less disruption and continuity of care for the patient.

While these concerns are valid, they may be less germane to some units or operations where patients may have less complicated cases or experience shorter stays. Further, HHC needs to weigh these goals against the additional risks posed by staff who may not be performing at their optimal level due to fatigue or inattentiveness.

(In responding to our draft report, HHC officials advised that their workforce reduction has reached 2,500 positions and generates \$200 million in savings annually. They project that these savings will increase to \$300 million annually by the end of fiscal year 2014 when the full reduction of 3,750 positions is achieved.)

Auditor Comment - HHC officials make several important points about their overall approach to reducing personal service costs and the resulting impact on overtime expenses, particularly in the clinical setting. They point out the significant cost savings that have been already achieved through attrition and the specific steps they have taken to maintain patient care standards during this process. We agree that this approach is sound, especially when viewed at the broadest organizational level. Nevertheless, we believe opportunities still exist to better manage individual incidences of overtime at a significant savings, especially in non-clinical areas. In fact, most of the high overtime earners listed in Exhibit A to this report serve in facility maintenance and support positions, rather than patient care.

Recommendations

1. Actively explore, implement and manage ways to reduce HHC's overtime costs, including encouraging facilities to maximize the use of part-time and temporary staff before using full-time staff when assigning overtime. Adopt the best practices of other HHC facilities when deciding to use overtime.
2. Review the extent that employees at all facilities are working multiple overtime shifts and consecutive days. Establish and implement controls to prevent employees from working excessive multiple overtime shifts and consecutive days.
3. Set specific dollar or percentage overtime reduction goals for the facilities, monitor the facilities' performance in achieving these goals, and take corrective action if the goals are not achieved.

Audit Scope and Methodology

We audited to determine whether HHC has effectively managed and controlled its employees' overtime costs for the period January 1, 2006 through December 31, 2009.

To accomplish our objective, we interviewed officials at HHC's Corporate Office and at six of the eleven acute care facilities - Bellevue Hospital Center, Coler-Goldwater Specialty Hospital and Nursing Facility, Harlem Hospital Center, Kings County Hospital Center, Woodhull Medical and Mental Health Center and Queens Hospital Center, and their associated networks. We reviewed overtime procedures and guidelines established by the Mayor's Office of Operations, HHC's Corporate Office and any additional procedures and work rules adopted by these six facilities. We analyzed overtime data for HHC and selected and reviewed data at nine departments at Bellevue and Coler-Goldwater.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

This audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Unconsolidated Laws (New York Consolidated Laws Service), Sections 4 (subdivision 9) and 22.

Reporting Requirements

We provided a draft copy of this report to officials in the New York City Health and Hospitals Corporation (HHC) for their review and comments. We have considered those comments in preparing this audit report. Our rejoinder is included thereafter in our State Comptroller's Comment.

HHC officials generally agree with our recommendations and acknowledged that there are opportunities to reduce overtime in certain areas, particularly in non-clinical settings. They advised us that they have engaged in a series of initiatives to reduce personnel costs. However, they also advised that certain factors particular to the operation of hospitals and health centers, including required training and orientation to internal policies and systems, often make the increased use of overtime more advantageous. They stress that, while they have given facilities a degree of latitude to increase overtime expenses, they recognize management's obligation to ensure that these costs are justified and monitored closely. They added that processes are in place for determining and monitoring the need, distribution, and use of overtime.

Within 90 days of the final release of this report, we request that the President of the New York City Health and Hospitals Corporation report to the State Comptroller advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Exhibit A

High Overtime Earners For the Period January 1, 2009 through December 31, 2009

Position	Facility	Compensation		
		Overtime	Base Salary	Total
Supervisory Plumber	Kings County Hospital	\$93,716	\$88,628	\$182,344
Supervisory Electrician	Coney Island Hospital	81,984	96,374	178,358
Supervisory Electrician	Kings County Hospital	71,063	96,374	167,437
Supervisory Electrician	Elmhurst Hospital	64,337	96,374	160,711
Plumber	Kings County Hospital	78,728	84,060	162,788
Plumber	Harlem Hospital	69,587	84,060	153,647
Plumber	Coney Island Hospital	60,867	84,060	144,927
Plumber	Harlem Hospital	58,757	84,060	142,817
Plumber	Kings County Hospital	57,823	84,060	141,883
Plumber	Kings County Hospital	57,569	84,060	141,629
Plumber	Kings County Hospital	55,798	84,060	139,858
Plumber	Kings County Hospital	55,204	84,060	139,264
Plumber	Elmhurst Hospital	54,783	84,060	138,843
Plumber	Kings County Hospital	53,754	84,060	137,814
Plumber	Elmhurst Hospital	51,226	84,060	135,286
Plumber	Elmhurst Hospital	50,796	84,060	134,856
Plumber	Coney Island Hospital	50,759	84,060	134,819
Plumber	Elmhurst Hospital	50,472	84,060	134,532
Stationary Engineer	Elmhurst Hospital	74,844	89,907	164,751
Stationary Engineer	Metropolitan Hospital	65,898	89,907	155,805
Stationary Engineer	Elmhurst Hospital	53,497	89,907	143,402
Stationary Engineer	Woodhull Hospital	49,320	89,907	139,227
Stationary Engineer	Lincoln Hospital	48,467	89,907	138,374
Stationary Engineer	Woodhull Hospital	48,139	89,907	138,046
Stationary Engineer	Coler-Goldwater	47,959	89,907	137,866
Stationary Engineer	McKinney Nursing/Rehab	47,367	89,907	137,274
Carpenter	Kings County Hospital	70,636	76,204	146,840
Carpenter	McKinney Nursing/Rehab	51,283	76,204	127,487
Health System Pharmacist	Metropolitan Hospital	66,970	105,281	172,251
Health System Pharmacist	Metropolitan Hospital	56,069	99,926	155,995
Health System Pharmacist	Metropolitan Hospital	54,589	99,926	154,515
Health System Pharmacist	Kings County Hospital	49,922	96,662	146,584
Staff Nurse	North Central Bronx	64,296	90,785	155,081
Staff Nurse	Kings County Hospital	63,225	92,471	155,696
Staff Nurse	Jacobi Medical Center	54,108	68,768	122,876
Staff Nurse	Lincoln Hospital	52,878	82,642	135,520
Staff Nurse	Jacobi Medical Center	51,413	77,275	128,688
Staff Nurse	Bellevue Hospital Center	49,662	91,514	141,176
Staff Nurse	Bellevue Hospital Center	48,969	79,460	128,429
Staff Nurse	Jacobi Medical Center	47,152	91,813	138,965
Staff Nurse	Harlem Hospital Center	47,106	86,054	133,160
Housekeeping Aide	Jacobi Medical Center	64,812	35,371	100,183

Housekeeping Aide	Jacobi Medical Center	64,449	35,383	99,832
Housekeeping Aide	Lincoln Hospital	49,194	35,430	84,624
Housekeeping Aide	Lincoln Hospital	47,419	35,222	82,641
Service Aide	Jacobi Medical Center	56,268	33,952	90,220
Service Aide	Kings County Hospital	49,741	31,680	81,421
Nurse's Aide	Harlem Hospital Center	54,067	34,022	88,089
Clerical Associate Level III	Jacobi Medical Center	66,439	44,078	110,517
Clerical Associate Level III	Jacobi Medical Center	55,159	41,393	96,552
Medicine-Surgery Technician	Coler-Goldwater	47,882	36,503	84,385
Medicine-Surgery Technician	Coler-Goldwater	47,433	35,638	83,071
Medicine-Surgery Technician	Coler-Goldwater	46,736	35,638	82,374
Pharmacy Technician	Bellevue Hospital Center	52,290	41,702	93,992

Agency Comments



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Alan D. Aviles
President

March 23, 2012

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RE: Audit Report for the Management and Control of Overtime Costs at New York City Health and Hospitals Corporation (Report 2009-N-15)

Dear Mr. Buyce:

This constitutes the response of the New York City Health and Hospitals Corporation (HHC) to your office's February, 2012 audit report 2009-N-15 ("the Audit Report"). We appreciate your staff's efforts in conducting this audit, as well as this opportunity to address the audit's findings and recommendations. In doing so, however, I think it useful to provide some broader context and to highlight certain relevant circumstances and events subsequent to the audit, some of which should serve to assuage the concerns stated in the Audit Report.

A. HHC's Financial Containment and Restructuring Efforts

Preceding and overlapping the time period of the Audit Report, HHC, recognizing that dramatic changes in the evolving healthcare environment were leading its projected expenses to significantly exceed its projected revenues, engaged in an extensive financial containment and restructuring effort referred to as "The Road Ahead". The fiscal challenges that HHC faces are driven largely by the combination of a cumulative \$500 million in cuts to its annual Medicaid reimbursement, an eight-fold increase in pension costs since FY2004 (to roughly \$400 million this year) and a 20% increase in the number of uninsured patients served since FY 2006. Of the 1.3 million patients served by HHC in FY2011, nearly 480,000, i.e., more than one-third, were uninsured.

In light of these challenges, the Road Ahead restructuring plan includes, among other things, a series of initiatives aimed at reducing HHC's largest single expense: personnel services-related costs. For Fiscal Years 2010 through Fiscal Year 2014, we have targeted a reduction of HHC's workforce by 3,750 employees. As noted in the Audit Report, by February, 2010, HHC had reduced its workforce by 1,000 employees. As of now, the reduction achieved has reached more than 2,500 employees.

While this reduction in workforce of more than 6% has been painful, most of it has been achieved with targeted attrition rather than layoffs, and no major facilities have been closed. It is a tribute to our dedicated workforce that we have increased efficiency and productivity enough to thus far preserve HHC's service capacity for meeting the needs of its patients and communities. To place

this difficult workforce reduction in context, the Audit Report estimates that a ten percent reduction in HHC's 2009 overtime costs would achieve an annual savings of \$11 million. However, the 2500 full-time equivalent employee reduction thus far reached is currently saving HHC \$200 million per year; when the 3750 figure has been reached by the end of fiscal year 2014, this savings is projected to reach roughly \$300 million per year.

Most directly affected by this workforce reduction, of course, are the several hundred employees who have been subjected to layoff; but there has also been a direct impact on those employees who remain and those managers who have been tasked with, in many instances literally, doing significantly more with less. Simultaneously with our workforce reduction, HHC has been implementing systematic operations redesign for greater efficiency through a front-line team-based process we call "Breakthrough" which is based upon the process improvement methodology first developed in the manufacturing industry and commonly known as "Lean". Over the past four years, more than 900 week-long rapid improvement events, involving nearly 5000 HHC employees, have produced operational improvements yielding more than \$215 million in combined savings and increased revenues.

This on-going broad and intensive operational redesign for greater efficiency ultimately help us tolerate the continuing attrition of our workforce without sacrificing service capacity, but such fundamental changes in operations cannot be achieved overnight. Accordingly, we have given HHC's facilities latitude in increasing overtime expenses, while our operations are systematically redesigned to function properly with fewer employees.

As your Audit Report rightly stresses, there is an obligation on management to ensure overtime is being monitored closely. HHC does employ an internalized payroll check on overtime hours worked by individual employees and, as more fully discussed below, a monthly variance report of overtime by facility based upon established overtime budgets is sent to our managers.

Your staff recommends that HHC rely more heavily on part-time and temporary staff, rather than overtime. However, the recommendation does not take into account factors that are particular to the operation of hospitals and health centers. First, there is significant variation in patient volume on a seasonal basis and often on a day-to-day basis, especially in the emergency department and inpatient settings. To meet this need for incremental clinical personnel, we principally use a combination of agency (per diem) personnel and overtime. Generally, overtime is preferred both from the standpoint of expense and patient safety.

The hourly cost of agency nurses, for example, often exceed the hourly overtime costs of our own nurses, assuming that they are available and willing to cover the additional hours needed. In addition, there are additional costs associated with meeting regulatory requirements governing the assignment of "agency" or other temporary or part-time staffing in clinical areas. Such staff must have both facility and department orientations before they can work on in-patient care units, and specific training that covers, among other things, OSHA requirements, Joint Commission patient safety goals, and health information privacy and security. In addition, virtually all clinical personnel,

temporary or otherwise, must undergo multi-day training in the use of our electronic medical record, a considerable incremental expense for introducing any new employee into our workforce.

There are also patient safety considerations related to HHC's use of certain evidence-based best practices, established clinical pathways and protocols, and clinical team communication regimens, and permanent personnel are already trained (at considerable expense) in all of these matters. Moreover, the hiring of long-term part-time clinical personnel is often not possible in New York City's highly competitive healthcare marketplace where the demand for nurses, pharmacists and other clinical personnel often exceeds the supply. This is especially true in the categories that require highly specialized and certified training such nursing in areas like the emergency department, intensive care units, obstetrics, surgery, and dialysis.

With regard to overtime incurred in non-clinical positions cited in the Audit Report, especially the trades and housekeeping, we agree that there are opportunities to reduce overtime, even as we are reducing the size of this part of our workforce. Indeed, since your audit was conducted, HHC has outsourced our laundry services, as well as the management of both our plant maintenance (involving the trades) and environmental services (involving housekeeping) in line with industry best practice. Our prior outsourcing of the management of our dietary services to a vendor with specialized expertise allowed us to ultimately reduce the then workforce of 1300 dietary workers by more than 30%, while still reducing overtime, and still meet the food service needs of all our facilities. Projections of the combined personnel services savings that HHC will achieve from the recent outsourcings, including reduced overtime, total an average of \$25 million per year over a nine-year period.

I offer the above as the context within which we view the Audit Report general findings and overall recommendations; and to underscore that HHC's present use of overtime, some three years later, is both responsible and appropriate to its current circumstances. With respect to the Audit Report's findings of overtime use during 2009, which was the specific time period reviewed in the report, I note immediately below certain extraordinary events that year which contributed to the cited examples of allegedly excessive overtime, but which apparently were not taken into consideration in the report's analysis and conclusions.

B. Unique Calendar Year 2009 Challenges

During 2009, HHC had to cope with the following extraordinary events that contributed to the need for overtime and should have at least been noted in the Audit Report:

*

Comment

* See State Comptroller's Comment, page 20.

1. The East Coast Blackout

In February, 2009, what has been referred to as the biggest electrical power outage or blackout in history occurred; 50 million people were affected. As a result, many HHC staff, clinical and non-clinical, remained at their posts for extended tours of duty as transportation difficulties precluded regularly-scheduled replacement staff from relieving them. Additionally, operating on emergency power presented specialized challenges for our staff, and, of course, meant that many specially-trained individuals (i.e., stationary engineers) had to remain on duty for prolonged and multiple shifts in order to be sure that safe patient care was not imperiled.

2. The Swine Flu Epidemic

The H1N1 virus or Swine Flu epidemic was at its peak from March 2009 through November 2009. As a direct consequence, HHC experienced severely overcrowded emergency departments and the need for extended hours at many of its clinics. Increased patient loads and unusual service demands meant, of necessity, that staffing levels had to be augmented (and often through overtime) in order to address this challenging public health crisis.

3. The December 2009 Snowstorm

In December, 2009, HHC prepared for and dealt with a significant winter storm, one which local newspapers headlined with phrases such as, "Records Fall as Snow Blankets the East Coast". The consequences for HHC's operations included, again of necessity, increased overtime for various staff across its facilities. Similar in impact as the Blackout, HHC staff had to remain on duty until relief staff could arrive, and, of course, transportation difficulties abounded. (We note that the Audit Report specifically focuses on Coler-Goldwater during this precise period, when it was clearly not operating under normal business conditions.)

C. Response to the Audit Report's Specific Recommendations

The Audit Report makes three specific recommendations. While I have already addressed many relevant aspects of these recommendations in the discussion above, certain further observations are appropriate with respect to each.

1. Recommendation Number One

Actively explore, implement and manage ways to reduce HHC's overtime costs, including encouraging facilities to maximize the use of part-time and temporary staff before using full-time staff when assigning overtime. Adopt the best practices of other HHC facilities when deciding to use overtime.

Our use of part-time and temporary staff is an extensively deployed, but carefully-considered, option. As discussed above, part-time and temporary staffing is often neither clinically feasible nor economically beneficial.

As to the adoption of system “best practices”, although HHC facilities have significant autonomy in meeting their respective patient populations’ needs, subject to centralized corporate oversight, the ongoing restructuring process includes a focus on harvesting facility best practices across the domains of operations, fiscal and otherwise. We are applying, and will continue to apply, that approach to the use of overtime.

2. Recommendation Number Two

Review the extent that employees at all facilities are working multiple overtime shifts and consecutive days. Establish and implement controls to prevent employees from working excessive multiple overtime shifts and consecutive days.

Overtime, temporary and part-time employees are used whenever it is necessary to maintain appropriate and safe levels of staffing within the Corporation’s facilities. In a real world sense, assignment of overtime or additional assignments are dependent on whether the need calling for it was planned or unplanned. For planned overtime, each facility has a process in place to determine the need and distribution of overtime at a departmental level. Planned overtime is normally on a voluntary basis, and more often than not, the same employees elect to volunteer for overtime due to personal reasons. For unplanned overtime, or in an emergent situation, overtime, including consecutive shifts must remain an option to ensure a safe environment for patients and staff.

Whether the overtime is planned or unplanned, there are established controls in place that allow departments to set and monitor the number of scheduled overtime shifts in a week, as well as the number of consecutive hours an employee can work per shift. In addition, established procedures enable managers to verify and ensure that assigned tasks completed on overtime are consistent with the amount of overtime hours used to complete the assignment or cover the area.

3. Recommendation Number Three

Set specific dollar or percentage overtime reduction goals for the facilities; monitor the facilities’ performance in achieving these goals, and take corrective action if the goals are not achieved.

As stated above, as of March 2012, HHC has achieved a workforce reduction of approximately 2,500 full-time equivalent employees, translating into \$200 million of savings annually. These savings include the planned use of overtime to ease the transition towards reduced staffing levels. There is little question, from a fiscal perspective, that the savings being achieved by reducing the Corporation’s workforce to a leaner, more efficient level is a transformation that fully justifies some flexibility for increased overtime as a transitional measure.

We agree, however, that overtime should be managed against established goals. At the beginning of each fiscal year, HHC's Central Office Budget Division prepares an overtime budget for each HHC facility. The specific budget is developed in conjunction with each of the relevant facilities, and forecasts overtime expenditures based on projected operational changes, including anticipated attrition rates, for the upcoming fiscal year. The Central Office Budget Division then monitors the actual disbursements for each facility against the budget on a monthly basis. In order to reinforce the review of overtime, the division prepares a monthly variance report of overtime disbursements against the budgeted amount for that facility. This report, supplemented by a detailed listing of individual overtime earnings by title and cost center for each facility, is distributed to the relevant facility's Executive Director and Chief Financial Officer.

Overtime disbursements against the budget are also reported to the Corporation's Finance Committee of the Board of Directors on a quarterly basis. Explanations of budget variances, as provided by the facilities, are discussed with members of the Committee, with any major variances being the prominent focus. These quarterly reports to the Board of Directors are at a high level of detail, and are complementary to the more detailed fiscal monitoring/reporting regimen that each Corporate Network undertakes on a frequent basis.

We cite these extensive monitoring measures to emphasize the reality that overtime expenditures, along with all other critical expenditures of the Corporation, remain under close and ongoing scrutiny. In light of these measures, any unjustified variations from the budgeted amounts would not only be detected, but would become the subject of appropriate corrective action(s).

The Corporation acknowledges the significant auditing efforts of your office's staff in fashioning the Audit Report and in issuing its findings and recommendations. Please feel free to contact Christopher Telano, Chief Internal Auditor, with any questions or should you require additional information.

Respectfully submitted,



Alan D. Aviles, President

cc: Antonio Martin
Christopher Telano

State Comptroller's Comment

We were aware of and did consider the impact of these extraordinary events that occurred during 2009, both when selecting our samples and when drawing our conclusions. However, we also note that even though there was a decrease in such extraordinary events in fiscal years 2010 and 2011, HHC's data shows that overtime costs continued to increase to \$123 million and \$126 million, respectively.