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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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HELD AT: COUNCIL CHAMBERS - CITY HALL

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Chairperson

COUNCIL MEMBERS: Mark Levine
Diana Ayala
Francisco Moya
Antonio Reynoso
Mathieu Eugene
Alan N. Maisel
Steve Levin

A P P E A R A N C E S (CONTINUED)

Mitchell Katz
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Chad Scherer (SP?)
Vice President for Policy and Director of the Medicaid Institute
United Hospital Fund

Carrie Tracy
Community Service Society of New York

UNKNOWN: Quiet, please.

CHAIRPERSON RIVERA: Good afternoon, everyone. I am council member Carlina Rivera, chair of the Hospitals Committee. Before I give an overview of today's hearing, I would first like to introduce my fellow members of the Hospitals Committee. Joined with me here today is council member Alan Maisel and council member Antonio Reynoso. We have a lot of important work ahead of us over the next four years, and I look forward to serving with this distinguished team. Later on, I hope to be joined by council member Diana Ayala, Francisco Moya, Mark Levine, and Mathieu Eugene, also members of the Hospitals Committee. Today the committee is holding a hearing to examine the implementation of the New York City Health + Hospitals One New York Transformation Plan. I would like to start off by congratulating Doctor Katz (SP?) who will testify here today on his recent appointment as president and CEO of Health + Hospitals and would also like to express my appreciation to the entire Health + Hospitals team, doctors, nurses, and all staff, for the work they do to provide healthcare

services to our city's residents. Health + Hospitals is the largest municipal health system in the country. It serves 1.2 million New Yorkers each year, providing medical, mental health, and substance abuse services. Health + Hospitals operates 11 acute care hospitals, five long-term care facilities, a certified home health agency, and a network of federally qualified health center clinics, including six diagnostic and treatment facilities. Its mission is to provide quality comprehensive health services to all New Yorkers regardless of their ability to pay. In effect, Health + Hospitals is the default system of care for Medicaid patients, the uninsured and other vulnerable populations, and is integral to a system of safety net hospitals. Half of all uninsured hospital stays and uninsured emergency department visits in New York City happen at HealtH + Hospital facilities, and approximately 70 percent of patients served by Health + Hospitals are uninsured or enrolled in Medicaid. In the last decade, however, the financial strength and viability of safety net hospitals has continually declined as a result of major changes in the healthcare marketplace. Federal and state funding that helps

cover the cost of caring for the uninsured is projected to decline by almost a billion dollars once the federal government begins phasing out its subsidy to hospitals that treat large numbers of uninsured patients, known as disproportionate share hospital, or DISH, funding. Meanwhile, nearly one million city residents remain uninsured, and our public hospital system treats a large proportion of these individuals. In order to address these challenges, in April 2016 Health + Hospitals released a report outlining the city's plan to address its growing forecast at Health + Hospitals financial shortfall. The plan laid out four goals. One, providing sustainable coverage and access to care for the uninsured. Two, expanding community based services with integrated supports that address the social detriments of health-- determinants of health, excuse me. Three, transforming Health + Hospitals into a high performing health system. And four, restructuring payments and building partnerships to support the health outcomes of communities. The committee looks forward to hearing about the implementation of this plan as well as other strategies Health + Hospitals is pursuing to address

its projected financial shortfalls while continuing to provide quality, affordable healthcare to patients throughout the city. Tackling this difficult problem is crucial to maintaining the viability of our great public hospital system. I'm going to administer the oath before we begin. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee and to respond honestly to council member questions?

DOCTOR KATZ: I do.

CHAIRPERSON RIVERA: Thank you. Let's begin.

DOCTOR KATZ: Good afternoon. Chairperson Rivera, members of the committee, council member Reynoso, council member Maisel, council member Moya, nice to see you. I'm Mitch Katz. I'm the president and chief executive officer of Health + Hospitals. This is my first council hearing. I'm incredibly honored to be before you. I'm a Brooklyn boy. I'm a product of the New York City Public School System. My family received their care at Coney Island Hospital and a Kings County hospital, two of the hospitals in our system, so I know how incredibly important public hospitals are. At heart,

I'm a primary care doctor. In fact, my medic-- my New York State medical license just came through last week, so I'm now in the privileging period, so if any of you need a primary care doctor I will be available at Gouverneur in about a month. We're always looking to increase our population of city insured patients who are seen in our system. I'll also work as an in-patient doctor on a rotating basis in our hospitals. I am unabashed about my love of public hospitals, of the people who work in public hospitals, of the patients who come to public hospitals, and the-- the mission for them. I've been so happy in visiting through the different hospitals and clinics at what a mission-driven group of doctors, nurses, pharmacists, social workers, and other professionals you have. I mean there's so much for New York City to be proud of. Every day, people's lives are saved in the intensive care units, in the emergency rooms, in the ORs. But there are problems. There are problems with access, with people not being able to get prompt appointments, there are problems with wait times, there are problems with people not being able to be seen in the right setting because we don't have enough outpatient capabilities, and many of these

same mission-driven people are frustrated, and they're frustrated for the right reasons. One of the things that has pleased me is I've seen no whining. What I see is people saying, doctors and nurses, please help us to have the system that would enable us to take care of our patients the way we want. You are lucky to have a system full of healthcare professionals who want and are ready to do the right thing. They just need a system that is as good as they are. There has been some progress in recent time that I want to give credit to especially the interim CEO, Stan Bresnoff (SP?), for helping to improve billing and revenue collection for which 107 million in the last fiscal year was produced. Also doing a good job of managing personnel expenses over the last three fiscal years for an estimated savings of 400 million dollars. That's good, but there's a whole lot more that we can do, and there's a whole lot more that we need to do. For me, the top three things that matter are expanding and invigorating primary care, improving access to specialty care, and fiscal solvency. And I would argue that those three things are all related. You could see them all as really one plan of how together we're going to make

Health + Hospitals a ongoing success. In terms of primary care, the special sauce of primary care is longitudinal relationships. When I see a patient I've never seen before, I can't easily judge whether this is the day that they've had more pain than they've ever had before or this is a typical day. I don't know about their full history. I haven't been their doctor. So naturally, when you see someone for the first time you're more prone to order more tests. When you know people well, you know exactly what they need because you understand them, their history, their family, their culture. You understand what the precipitors (SIC) are. They're here with an asthma attack. The first question you might ask is how are things going at home? Right? Because you already know that they have a difficult family situation. Beyond the-- when you develop longitudinal relationships with people, that in and of itself is healing. A lot of people suffer from illnesses that don't have a simple medication, but as a primary care doctor I always have something to offer. Right? I can always comfort someone, I can always hug someone, I can send them a greeting card for their birthday, I can call them up on the telephone, there's always

something a primary care doctor can do, and those things are healing. You also don't have to be a doctor to do them. One of the most therapeutic things I ever saw was when, in the heat of the AIDS epidemic in San Francisco, a middle-aged Latina receptionist saw a young patient come to the AIDS clinic where I was working who was petrified. And while she was not a doctor, she was not a nurse, she was a mother. And she saw that look. She went around the desk, she put her arm around him, she told him she was always available if he needed something. That's what you get in primary care. You get longitudinal relationships between the people that you see, and that makes a huge difference. I want that for everybody who has a chronic disease and needs a provider. When it comes to specialty care, as a primary care provider I can do so much, but what if my patient needs to see a cardiologist? What if they need to see an endocrinologist? It's no good if that's going to be six months away. I need to be able to promptly refer my patients. We had a lot of success in Los Angeles creating an e-consult system where I as a primary care doctor, I would write a con-- a consultation. I might say I'm seeing a

gentleman who is 57 years old and has congestive heart failure. He's still short of breath on the following medicines. What would you try next? And I would send that, that would go to the cardiologist, and within two days I would get an answer. So that patient didn't have to go for a visit. The-- the visit is saved for a patient who absolutely needs to be examined by a cardiologist where an internist examination is not sufficient, but the patient gets better care. I was very pleased when I came here to find out that New York City is doing e-consults. We currently have them at four facilities, but it needs to be the way we do all of our consultations. That has to be the underlying system so that we can decrease the number of visits to those people who have to be physically seen, and then you'll see a dramatic drop in our wait times. We're happy-- I was certainly happy to learn that we had a successful health plan, Metro Plus. It gives us an opportunity to enroll patients, gives us an opportunity to include city workers, and it-- and it has absolutely grown in size. But it cannot reach its potential under the current situation because even when patients enter Metro Plus, if we don't have primary

care doctors, they're going to get referred outside of the H + H-- the Health + Hospitals system. So even today, about 55 percent of the patients who are in Metro Plus are getting their primary care by doctors outside of our own system. This is a health plan we own. We're-- it's a fully owned subsidy-- subsidiary. You use those as a way of making it easier for insured patients to get care, but we're sending people out. That-- that has to change. So that brings me to our financial situation. As the largest provider of uninsured patients, the Health + Hospitals will always need help from the city. There's no-- if you're taking care of people who don't have insurance, by definition, there's not going to be a revenue source. However, that amount has to be predictable. It can't suddenly be that we have much larger needs. The city has to be able to plan for it, has to know what the expenses are, and it has to be an affordable amount. Now, some of the problems that we've had are due to the (INAUDIBLE) cuts in disproportionate share hospital dollars. I'm very glad that there is a reprieve for two years, and I thank counc-- the council members for advocating on our behalf as well as other elected officials, the

mayor, the congressional delegation. It pushes the problem two years into the future. Doesn't really change it because the cut gets larger when it happens, but it's a critical two years, and I think we could together really use those two years, with the amazing people that I've met, with the very positive union relations with organized labor, with the incredibly supportive community, we can during those two years really bring Health + Hospitals into solvency. I'm a big believer, and I'm sure many of you have heard the old adage of the nuns who ru-- ran the Catholic systems, that without-- there's no mission without a margin. Right? I think that there's nothing wrong with running systems like a business, if by a business we don't mean profit. We don't mean sending people away. We mean looking for opportunities where we, Health + Hospitals, can take on things so that we actually can generate revenue and that revenue can cross-subsidize for the care of uninsured people. And that-- that is something that I very much want to do with all of you. First step I think has to be, because it's the thing I can do fastest and I think that will set the tone for how I want people to see our work together, is to reduce

administrative expenses. So I've already-- with my staff, we've reduced consultants by 16 million dollars. Basically, I went through with my excellent staff, including our CFO, what consultant contracts do we have. There are in times when you need a consultant, when you need a very specialized piece of knowledge, when there's something that you need four hours, six hours, 12 hours, teach us how to do this. We don't know how to do this. Help us to learn. But you cannot transform an organization with consultants. It does not work. To transform organizations, you have to work with the people who are in the organization. They already know what needs to be done. They're just waiting to be asked. They're waiting for their voices to be respected. I will also be looking in general at how to decrease other administrative expenses. Things like can we get out of rental leases and move offices into empty hospital space? I love having administrators in hospital space. You always want to connect administrators to your clinical mission. That's what we are. Right? I like to look at every opportunity to decrease administrative expenses, and I think my staff have now you know heard me, maybe to the point

of their nauseum, but I'll keep saying it. You know, what I am interested in is doctors, nurses, pharmacists, social workers, and the people who support their functions. Those are our front line people. They're the ones interacting with our patients. Those are the people we need to grow and develop, and of course we need a computer system to support them, we need finance people to support them, but the focus of the organization has to be what does the patient need and how are we going to provide that? One of the things that makes me optimistic about our work together is that there is a huge opportunity to bill insurance. Not people. And bill insurance for insured patients. I think that Health + Hospitals was slow to turn the switch on billing. You know, it's not unusual in public systems, right, if you go back before Lyndon Johnson in the creation of Medicaid and Medicare, before that low income people didn't have insurance. There was nobody to bill. But over the time since the creation of Medicaid, creation of Medicare, creation of the CHIP program for kids, then the ACA, we keep increasing the number of people who have insurance. That's a good thing. But it only works if you bill. If you

don't work on the billing portion, then now what happens is you have less federal subsidy because the government says well, but the people have insurance, but you're not actually collecting the revenue. And so there's no way to make your system run effectively. Billing is not one thing. Billing also involves coding effectively. So sometimes I've already heard here, as I've heard in other systems, oh, well we send-- it's not worth billing because we never get paid. Well, if you don't put the right code on the bill, it turns out you never get paid. But if you put the right code on the bill, it turns out you do get paid. So you know these are things that other systems which have had to rely on insurance learn. I certainly don't aspire to be you know charging nine dollars and 75 cents for putting on a band aid, but I do want to fairly recoup, for insured patients, the dollars that we deserve from insurance. We have to stop sending pat-- paying patients away. So when I was coming here and I was reading the reports, I saw a lot about well, we need to recruit and attract patients, paying patients. And I am interested in that. But I-- I was somewhat surprised to learn that every day at Health +

Hospitals we send patients away who are paying patients. We say to them oh, you have an insurance card. Well, you don't need to come here. You could go to X across the street. It doesn't-- that instinct doesn't actually come from the worst place. It comes people thinking mission, you know we're here for low income people, we're here for the uninsured, and that's great, and I want to welcome every uninsured person. But there's nothing wrong with us also seeing people who have insurance. There's nothing wrong with our sending insurance companies a bill that is correctly coded so that we have enough money to take care of everybody else. We have to invest in resources, into hiring physicians that are revenue generating, and I'll o-- I'll offer you one example that I think will set the tone. There is a procedure called cardiac catheterization. It's where you may know people who've had it. It's a fairly common procedure done to diagnose coronary artery disease. Dye is sent up in the veins, it lights up the heart, you can see if there are any blockages. When I was a-- in medical school in the early 1980's, that was as much as we could do. Then by the 90's people were doing what's called angioplasty.

Angioplasty means that in addition to shooting the dye, you also put a wire up that same vein, and then you open the cardiac arteries, the same arteries, and you open up the-- the cardiac arteries. We are still, at Health + Hospitals, doing the-- the catheterizations without the angioplasty. I wouldn't let any of the six of you have that procedure. I would tell you well, but if you have that and it turns out there's a blockage, you're going to have to have the procedure again. Now, we don't run sleepy community hospitals. Not every hospital can do angioplasty. Right? I understand that. But we're running level one trauma centers. We're running places like Jacobi with amazing vascular laboratory capabilities. If you dig a level deeper and you say why has this been allowed to happen, what I'll tell you again, as many things I've learned in Health + Hospitals, it doesn't come from a bad place. What people discovered is well, we don't have to do angioplasty because lots of hospitals will take our patients who need it. Well, there's a reason that lots of hospitals will take our patients who need angioplasty. Because it pays well. We can't survive if we are only willing to do those things that don't

pay well. Behavioral health services do not pay well. I'm thrilled to do them. I'm happy to do more of them. I'm-- I see it as something we do for mission because it's the right thing, but I would also like to do those things that reimburse us well so that I have enough money to cross-subsidize those services that don't reimburse us well. So I think making sure that we are investing our resources into hiring the physicians that are revenue generating, doing those specialized services, and the last of the seven points in the plan is that continuing to convert uninsured people who qualify for insurance. So I think New York has had good success in doing that. There have been several initiatives supported by this council and the mayor, but there are still-- we're running about 400,000 uninsured patients, and that is not uninsurable. That is uninsured. So there is still a tremendous opportunity to connect those people to insurance, either through Medicaid or through the basic health plan, the exchange, where we could make a dramatic change in the amount of revenue. So let me stop there. I have never woken up in the morning as early, as happily as I have since I got here. It's been a phenomenal two weeks.

I-- I already feel-- I mean I'll always-- I mean I've always been a New Yorker. This is the only place where I don't have an accent. But the-- but I-- I can already feel deeply connected to Health + Hospitals and the people here, and I'm really looking forward to working with all of you to make the system a-- a growing success. Thank you.

CHAIRPERSON RIVERA: Thank you. I want to first acknowledge some of my colleagues who have joined us, Council Member Mark Levine and Council Member Francisco Moya. So thank you, Dr. Katz. Thank you for being here. We-- we are feeling I guess optimistic whenever there's a new chapter in H + H, and you're certainly bringing a new energy and a new vision based on some of the work you've done in California and of course the roots that you have here in New York. So you know when the One New York Plan came out it was at a different time. It was-- the political climate was very different, and we are looking at kind of what are you thinking as working and what is not working for One New York. So you've been I guess a CEO for how long?

DOCTOR KATZ: Here for two months.

CHAIRPERSON RIVERA: Two-- two months, right (SIC)?

DOCTOR KATZ: I was seven years ran the Los Angeles system and 13 years ran the San Francisco system.

CHAIRPERSON RIVERA: Alright, so as someone who's also been on the job for about two months, I'm gonna…

DOCTOR KATZ: We have that together.

CHAIRPERSON RIVERA: Yeah. So I'm-- I'm excited. You know, like I said, this is-- this is a new year, and there are a lot of people in this room who have been working around this issue for a very long time who I'm sure are going to be welcome assets and people who I hope you will consider as resources. So you've had two months. I know it's been probably-- you said you've been-- you've been-- you-- you seem happy.

DOCTOR KATZ: I am happy.

CHAIRPERSON RIVERA: I'm sure it's been challenging.

DOCTOR KATZ: It's been incredibly fun and terrific people.

CHAIRPERSON RIVERA: Great. Alright. So in terms of what you're looking at for One New York, I just want to ask about public engagement a little bit. So with changes and transformation, what has engagement been like? What have your past two months been like? For me, I know you're p-- I'm sure you've had countless meetings, you've met with people from organized labor, community-based organization, advocates, the mayor's office, multiple agencies. So I want to just get a-- a big picture as to how has it been meeting and talking with employees, community advisory board members, and of course the consumers about the changes that are coming to H + H.

DOCTOR KATZ: Well, tha-- thanks so much for the question. I-- first, definitely the best thing is going out to the different facilities. I mean it's an amazing time you know for meeting people, staff, patients. I was in Staten Island at Seaview yesterday like talking to patients, talking to staff there. It's where you can learn what is really working and what isn't working. I've been to-- to meet with the-- a very important group, in my opinion, which is the Gotham Board, because part of our-- the work in building primary care is our

federally qualified health center network. I've not yet been to some of the other advisory meetings, but I-- I fully intend to go. I think one of the great things about New York City, and it is very different than Los Angeles, is how strong the neighborhood spirit is. Los Angeles is-- is you know is a place everybody drives. Nobody lives anywhere, right? Everybody lives in their cars. One of the things I love about going to the hospitals is how many people I've met who were born in the hospital like you were at-- at Bellevue, people who were-- who grew up in the neighborhoods who really feel a connection to the people who that they care for. So you know I-- I'm-- I love meeting with people. Right now my kids are in Los Angeles until they finish the school year, so evenings are-- are happily spent with community groups.

CHAIRPERSON RIVERA: That's a great reminder that we don't have cars, so that's why a close hospital is so, so important. And of course, we're all going to work together and make sure that we have everything else we need for a very fair New York. You know New Yorkers are very honest when they want to tell you about what our needs are. So in the

One New York plan you outline pretty much four areas that you're really trying to focus on. So I'm going to try to keep the line of questioning with those four areas, but of course I'm going to ask my council members to chime in because I know we have a very busy schedule today with a lot of overlapping committees.

DOCTOR KATZ: Sure (SIC).

CHAIRPERSON RIVERA: So we understand that patient utilization has been a concern for some time, and it's been declining in recent years. Can you provide us with patient utilization rates for the past two fiscal years with a breakdown by facility? I know that's very technical, but why I'm starting with that question is because quickly I want to emphasize the increased transparency that we're hoping to have with H + H.

DOCTOR KATZ: So in ter-- so I-- I didn't-- you know I didn't bring detailed data, but I'm happy to share whatever we have. Maybe start you know big picture with what I've seen. In terms of waits for appointments, hugely variable. One of the things that I found distressing when I was at Bellevue is that the wait for a behavioral assessment

for a kid is currently months. Which frankly has nothing to do with money because kids are fully insured, right? So it's-- it's a question of the system, and I think it is related to the issue that we-- the cost control has been focused on attrition. The problem with attrition is that what you really want to do is grow in those areas where you need to grow, especially around things where there's a clinical need, where there's a revenue, and decrease on the administrative side where you can afford to have less. So what I-- what I would say is you would find places in Health + Hospitals where you could get a primary care appointment within a reasonable period of time. The gentleman to-- to my left is a good recruit to Health + Hospitals, promptly chose our health plan, and sought an appointment as a regular person with no special arrangements, called our call center number to get a primary care doctor, and your appointment was how much after you called?

UNIDENTIFIED: Two months.

DOCTOR KATZ: Two months. So I'd say that's where we currently are.

CHAIRPERSON RIVERA: That's the average wait time.

DOCTOR KATZ: Well, that's-- it's-- it's as real as it gets. He called-- he joined the health plan, he chose Health + Hospitals, he called the call line, he got a two month wait. What it should be for a new patient appointment I would say would be a maximum a month. That would be the-- the maximum time that you would ideally want. But again, I'll say these are reven-- that's a revenue producing service. If you're trying to get yourself out of a fiscal problem, you need to focus on increasing capacity for revenue services. When I looked at the utilization data for our federally qualified health centers, utilization is down. But it's not down because people don't need our services, and it's not down because people aren't working hard, it's down because there are fewer providers because we have been on attrition. And again, what I'd say is that attrition is a good way around certain kinds of administrative expenses because it's-- you-- it's never good to lay people off. It always causes heartache. But if you just-- attrition isn't equal. Right. So you could be in a situation where attrition hurts you. For example, if you have a clinic and you lose say two doctors who are generally

the-- the doctors in a clinic, the doctors or the nurse practitioners who are the revenue generators, and you keep everybody else, you'll actually be worse off. Because now you have no revenue generators, you have fewer appointments, and you have the same expenses, practically. So I-- we have to get off the attrition and into business plans where we say okay, we need to hire. If we can hire x number of revenue generating physicians, nurse practitioners, and the support staff it's going to bring in this amount of revenue because we're going to lower the time it takes from two months to three weeks, it's going to mean more people choose us, and here's what the ultimate revenue would be.

CHAIRPERSON RIVERA: So really quickly, I want to remind anyone here if you'd like to fill out a witness slip to testify you can fill one out with the sergeant in the back. So I want to get back to the-- the wait time and some of the scheduling. Would you say that the average wait time for appointments for a returning consumer or patient is the same? And what about for specialty clinics?

DOCTOR KATZ: Well, I'll start with the second. Certainly, the specialty is way too long.

It-- I-- I want to just before anybody themselves has a heart attack from-- from my saying the numbers, Health + Hospitals, like any good public system, will always get in people who need to be seen today. Right. So I mean that is part of the ethos of public systems. So there is always a huge difference between what it means when you call and say I need an appointment versus if I'm a primary care doctor as I-- in the system and say call the ophthalmologist, you have to see my patient. He's a diabetic, and today he says he's lost half of his visual field. Right, that person doesn't go through the call center. But if you went through the call center for some of the specialties it would certainly be on the order of months. It could be four months, it could be six months depending upon what the specialty is, which I would say is totally unacceptable, and frankly, it's not good for generating revenue. Because you can't convince people who have choices to choose a system if you're going to tell them that it takes four months to get to see a specialist. For re-- returning visits, again, from what I hear, I'd say this is a general message of Health + Hospitals, it's a heterogeneous system. So some of-- one of the

clinics that I visited in Harlem, Renaissance, they've had a lot of success in decreasing cycling time, and they can get a new patient appointment in within 10 days, and they said they could do a return visit within two to three weeks. So they're doing super well, but then there are other clinics that are full and are either closed to new patients or where it could be months to see a returning. So it's not-- it isn't any-- there isn't one standard, but it's all not where it should be. It-- it all needs work and change.

CHAIRPERSON RIVERA: So how do you-- how do you plan to cut the patient wait time? Are there-- are there serious scheduling system changes coming?

DOCTOR KATZ: Yes. Well, I'd say first on the primary care, it's a workforce issue. We have to hire more primary care doctors and more nurse practitioners and physician's assistants. And-- because any one primary care doctor can only see so many people. When it comes to specialty, it's a different issue. Because a lot of-- with specialty, everybody does not actually need the visit. What they need is specialty advice. In the American medical system, it's hard-- in most systems, say

Medicare, my parents, right? They can't get any consult because they're Medicare people. Nobody's going to do any consults (SIC) as a private doctor because they won't get paid. One of the advantages you have in Health + Hospitals is we have salaried doctors, so I can have my salaried specialists responding to e-consults. They don't need to see the person, they can do many more e-consults. So in general, what we found in the full implementation in Los Angeles and the pilot data here is you can eliminate about a third of the visits do not-- are not needed, and when you eliminate a third of the visits you make dramatic shortenings without costing anyone more money. It's one of the few wins for everyone. It's better for the patient because they don't have to travel, it's better for the specialist because they only see the patients that really need specialty, it's better for the primary care doctors like me because we learn more by reading the consult. So I think that we-- I've charged our staff and Doctor Dave Chotski (SP?) that his job is to take the successful demonstration project of e-consult and make it the system for Health + Hospitals. So if L.A. was doing 16,000 a month, this system will need

probably to do about 30,000 a month. Right now we're more like 1,200 over a period of months. So huge room to grow.

CHAIRPERSON RIVERA: To ask about the social determinants part of One New York, it identifies a number of social determinants. It includes poverty, unemployment, homelessness, food insecurities. How-- how can a system address such a wide array of issues? And that can impact the health of its patients?

DOCTOR KATZ: Well, the-- thank you, Chair Rivera. I think that one of the effective interventions is clearly case management. And as you know, we've-- Health + Hospitals has started an aggressive case management program with the goal of seeing 32,000 people. And you know this is-- the-- the people that you're talking about are the people that I've taken care of my whole you know career. The people I most love to take care of. They have a variety of issues. They have mental health issues, they have addiction issues, they're living in poverty, they're living in substandard housing, they're homeless. They need a lot of services. Medicine is only sometimes the smallest issue. What

they really need is help. They need help getting their benefits, they need help finding a place to live, they need to know where the food bank is, someone has to get them on SNAP, and those things are best done through case management. I'm pleased that we're doing the program. I think beyond the case management though I'm pushing my staff to really look at health worker models. I think that encouraging the hiring of peers, whatever peers means for the person, so the-- the right peer for someone recently released from jail is somebody else who was previously in jail, right? The right peer for a middle-aged woman diabetic who's struggling with her sugar control is another middle-aged diabetic woman who's been able to control her sugar. Right? I'm a big believer that a lot of the things that we have medicalized would be better dealt with by hiring community health workers, some people call them navigators, in Los Angeles we tend to call them promaturas (SP?) because it fits that tradition, but they are wise people from the community who help others to navigate systems because they've been through similar challenges.

CHAIRPERSON RIVERA: And I think a lot of us here would be-- are very happy to hear about like comprehensive holistic care, and so I did want to ask you quickly about behavioral health and some of the trends that we're seeing in some of the private facilities in removing some of the psychiatric beds. What-- what do you see as the future of-- of behavioral health and psych beds in H + H?

DOCTOR KATZ: Well, the need is absolutely there in behavioral health for expansion. It's in both the-- the people who need maybe not necessarily-- and I'm-- I'm working with my staff to try to create a middle level. There is the true acute psychiatric hospitalization, the locked ward. The locked ward in my opinion should really be only for those people who are so suicidal, homicidal, unable to care for themselves that they're not safe elsewhere. But then I think one of the holes in our system has been okay, well there are people who don't meet that standard but really can't take care of themselves, and they need milieu therapy, they need someone to make sure they take their medicine, perhaps they're currently living in the shelter system, perhaps they're riding next to me on the

subway, they're in the wrong place. They need more of an intermediate level, and I really want us to look at our current hospital footprints and think we have some empty hospital wards. Can we create what are treatment facilities, right? And it would be reimbur-- it's a reimbursable service under Medicaid through the state providing intermediate level of care for people with serious mental illness who don't need to be in a locked facility but also are-- are not able to really access outpatient treatment. And then the next group is to really make sure that we have the appropriate outpatient treatment for those people who are in stable housing situations, don't need 24 hour a day care but need you know very low barrier, drop-in, culturally appropriate, near where they live, low expectations in terms of forms and bureaucracy. I mean one of the things I've learned in taking care of people with mental illness is they will come if you make it easy but not if you create a lot of demands. You have to do this first, you have to do this first, you have to fill out this form. So I think across the board there's a whole lot we can do together.

CHAIRPERSON RIVERA: So I'm going to-- Antonio, I know you have a-- a-- a couple questions, but I wanted to ask if-- if you don't mind, if I can ask Council Member Moya who I know has to step out.

COUNCIL MEMBER MOYA: Thank you to my colleague for allowing me to go in front of him, and thank you Chairwoman for giving me the opportunity to jump ahead of my colleagues. I just have to head back to Queens for something. But thank you, Doctor, for coming here and testifying in front of us. Like I like to tell everyone, I was born at Elmhurst Hospital, I worked at Elmhurst Hospital, and I'm proud to have represented Elmhurst Hospital for the last eight years as an elected official. I'm glad to see a couple of things in your testimony. I have just a couple of concerns that-- that I'm seeing. One, I'm really happy to see that there is a elimination in the 16 million dollars in what has been going through the consultants. Sort of that outsourcing that has created a problem. But it was a concern for me when I saw that you know as we were seeing that a hospital like Elmhurst that is busting at the seams, Queens has lost so many hospitals, it's a high immigrant community, when there was the

opportunity to save jobs at Elmhurst, last year we saw the elimination of jobs through this administration when they promised us when we were in Albany fighting to make sure that we had put in the enhanced safety net hospitals in our budget, and part of that requirement was that we would not eliminate jobs, that ad-- this administration went out there and eliminated over 600 jobs throughout that system. Hurt a lot of employees that are the front lines, yet we're still hiring people at higher levels that are doing the same work that some of these people that were there for years are no longer there. So as we go and we continue to advocate, I'm a big advocate for-- for H + H, you know I'm-- I'm a big supporter, but I need to make sure that we have guarantees that when-- when we as legislators-- legislat-- are fighting to protect a hospital system that right now is in the red, that also the-- the workers that are there are not going to be the first ones eliminated because of the outrageous spending that has happened in years past. And so that's kind of what I want to see as we move forward in this is that it's not just this great picture of yes, we're reducing this waste here, but that those jobs aren't going to continue to

get lost and that we don't say well, that was because of attrition, and the realities were that that was going to happen regardless. And that's-- that's been my concern from the very beginning. So I hope that that's something that you take with you as we're moving forward with this. You have a lot of-- of my support. I-- I-- I work very closely with-- with-- with the folks at Elmhurst Hospital, I'm very supportive of that, but I really want you to be mindful of the fact that that is a very, very important point that we are continuing to save the jobs of those folks that are truly the front lines of this hospital system.

DOCTOR KATZ: Thank you, Councilman. I-- I entirely understand, and I agree. I-- I will say that-- and I think part of us, our work together, when I started in Los Angeles it was also a deficit. It was 226 million dollars, which at the time seemed to me like a lot of money before I came to New York City. So but when I left, not only were we in surplus, but we had added 1,500 public sector jobs. So one thing I do know is that-- that you have to take financial problems seriously, but you can both

grow out of financial problems, sometimes more easily than you can shrink out of financial problems.

COUNCIL MEMBER MOYA: Right (SIC).

DOCTOR KATZ: So I do not take it as-- you know I'm a public sector guy. I mean this is what I do. This is what I believe in. I think it's u-- up to us to work together you know to make it happen.

COUNCIL MEMBER MOYA: Great. Thank you. Thank you, Chairwoman, and-- and thank you to my colleagues for allowing me to cut in front of you. Thank you.

CHAIRPERSON RIVERA: Council member Reynoso, if you want to ask your questions now. It's the least I can do.

COUNCIL MEMBER REYNOSO: No. You have more questions though?

CHAIRPERSON RIVERA: Of course, but it's okay.

COUNCIL MEMBER REYNOSO: Thank you, Chair. Is (SIC) doing amazing work already. Thank you so much for-- for this hearing, and just want to thank the doctor for being here. Doctor Katz, thank you so much.

DOCTOR KATZ: Thank you.

COUNCIL MEMBER REYNOSO: Welcome back home.

DOCTOR KATZ: Thank you.

COUNCIL MEMBER REYNOSO: We-- we are very happy that you're back here. Given your record and the work that you've done in other locations, we-- we have high hopes for you, and sometimes that's not a good thing, but I feel like you're-- you're up to the challenge, and-- and I'm excited to see success. Grow out of a financial problem, that's-- that's a-- a great way to put it, if-- if need be. What we're looking for here ultimately is that we don't shrink to-- to-- to-- to-- to not exist, and-- and it's a-- it's services that are extremely important to our communities, and I want to talk about a couple of things in general, and then I'm going to talk about Woodhull Hospital, which is the hospital that's in my district or across the street from my district. It's still-- it's still mine. I-- I-- I own it. I-- I want it to be a part of my district. But we have some issues there that I want to discuss and a lot of potential also that I want to discuss. In-- in one of your-- in your-- one of your HH facilities where

you have the least amount of-- of-- let me just get the question out so I could-- yeah, one of your most underutilized HH facilities currently has more than half of its beds empty. Given the amount of funding that we get related to in-patient revenues, which is about 70 percent that Health + Hospitals gets, that-- that's a concern. I-- is there an opportunity there to reallocate space for a-- a revenue generating use or to-- to not just sit there empty? I-- I just really want to go through how you're thinking about reallocating resources in locations where we might not be doing the best--

DOCTOR KATZ: Great (SIC).

COUNCIL MEMBER REYNOSO: --work.

DOCTOR KATZ: Well, thank you, Council Member, and I love it when elected officials take ownership for their hospitals in their district-- (CROSS-TALK)

COUNCIL MEMBER REYNOSO: (INAUDIBLE)

DOCTOR KATZ: --or even their hospitals that are right across from their district, so I hope-- I hope everybody will do that. So yes, I think what-- the way I look at it is you want to-- if you have empty space, use it.

COUNCIL MEMBER REYNOSO: Yes.

DOCTOR KATZ: And wh-- again, there's also tremendous value in looking at administrative space because you can get people more connected to a mission when they have an administrative job when they actually work at a hospital. It's a really positive thing because then their identity becomes that hospital. So I think looking at you know the instructions that I've given you know my facility staff is I would like to get out of every rental lease I have that you can put my people into hospitals that we're not currently using. I think the issue part of my interest in creating intermediate care centers for people with serious mental illness is first, I think that's a much better place for them, but it's also a very good use of facilities as a treatment program. Right? So I think that looking at-- at the facilities, and then the last thing I just want to mention, not so much for the council members but for the public, is sometimes I feel like there's a little bit of misperception that a half empty hospital is costing money. Right. So what I always remind people is none of the Health + Hospitals hospitals are under

200 patients. Usually the viability of a hospital is about at 100. Right? We're not-- if you get much below 100, a hospital starts to get hard to maintain all of the functions. So if you have a 10 story building and you're not using the top two floors, I mean I would say you should use the top two floors, find something, but there's no added expense if you're not staffing them, if you're-- you turn off the lights. Right? You don't-- you don't abandon a building because your top two floors are empty if you're working good programs elsewhere. You just have to make sure that your-- that your staffing fits how many patients you're running, that you're not run-- that you're not staffed for 800 patients and you have 200. But as long as you-- you get the staffing correct, it's not in and of itself a drain.

COUNCIL MEMBER REYNOSO: That's good-- that's good to know. It's a concern when we see underutilized space. We've seen it in other systems like the Department of Education where it actually does mean that, so we got to be very careful and ask these questions. The-- the issue with the-- the uninsured and-- and Medicaid and how important that is to our systems, to our HH system, what I-- what I

want to get to is the billing situation. One of the experiences that I had in Woodhull Hospital where I had my child, it was born in Woodhull Hospital December 16th. I'm very proud of that. I think it has one of the best maternity wards in all of the city, and I challenge anyone to go tour it and tell me otherwise, but-- but I did have an issue where I felt that my private insurance, or city insurance, was-- was foreign to them. They were very adept and-- and educated on how to deal with Medicaid patients and figuring out a way to get people insured, but when they brought me into the room and find out that I didn't need Medicaid and I-- and I was insured, a lot of billing issues happened. I ended up getting charged in one-- in my emergency care insurance instead of my-- my general insurance, and I just felt like people really couldn't get a grasp on it, and it took me about three months to finally figure that out after getting billed a couple of times, and I just really want to make sure that in cases where we have folks that are not under Medicaid going to these hospitals that-- that's important, that we-- we give them the best experience possible and that they don't feel that they have to go through a lot of-- the

finance office every other-- every other visit to try to-- to-- to figure out how to make that happen. Just maybe a training that-- that-- you know, I-- I imagine that the person that was helping us gets 100 patients that are Medicaid and then one person that's on-- on general insurance, and-- and it becomes complicated, but I do want to make sure that that's not another barrier for someone to continue to go to Woodhull and that that doesn't happen. So just want to talk about what you're doing there to-- to make sure your staff understands that it's not only about uninsured or Medicaid patients.

DOCTOR KATZ: Well (SIC)-- (CROSS-TALK)

CHAIRPERSON RIVERA: And if I could-- if I could just-- (CROSS-TALK)

DOCTOR KATZ: Yeah, please (SIC).

CHAIRPERSON RIVERA: -- ask to couple with that, because you mentioned missed opportunities from failing to bill properly.

DOCTOR KATZ: Uh-hm.

CHAIRPERSON RIVERA: So I want to just ask you also directly how much revenue has H + H lost out on just-- just on average over the last two

fiscal years because of this failure to properly bill?

DOCTOR KATZ: Yeah. Well, I (INAUDIBLE) my-- my CFO a chance to see if he-- if he wants to offer a number. I will tell you how I view it conceptually, that even today we're not fully billing for our services. Part of the problem is that for a system that historically has not billed, I-- it's not like any of us can send a memo and say start billing. Right? It begins with registration. The-- when the person comes in, does someone say could I see your insurance card? When they-- when they see the insurance card do they get a prior authorization if it's-- if it's not one of the ones that-- that doesn't require that? Right. Do they actually send the bill? Does the bill go to the right place? Is the-- is the-- is the bill coded? Right. So if you don't put the right diagnostic code, you will not. I mean here is-- you know, this is-- this is as recent as our governing body meeting, and now this is a problem solved. We, I was told and I know to be true, that we spend for our five skilled nursing facilities, we spend about 21 million dollars purchasing drugs for patients who are in our skilled

nursing facilities. And by the way, just so you-- you understand that I-- I-- I-- I both appreciate the things that are working and things not working. Purchasing is working in Health + Hospitals. Health + Hospitals has learned to be a good purchaser. So that-- that-- that's the positive. So we are purchasing the drugs for the right price. 21 million dollars. We are only getting five million dollars of revenue for 21 million dollars of drugs. That's impossible. That's impossible because we're talking about skilled nursing facilities where there are almost no uninsured patients. There are just a few, because generally if you're sick enough to get into a skilled nursing facility we manage to qualify you. So despite the fact that overwhelmingly everybody is covered, we're bring in on 21 million dollars of paid prescriptions that are purchased at the right price, we're only getting five million. So under a new arrangement of billing, we'll actually fully cover the cost of all of the people who are insured. So the reality is at this moment we are subsidizing insurance companies. Until that switch is turned, because we-- again, and it's not any one thing. Probably sometimes we're sending the bill to the

wrong person, the wrong plan. Right? Sometimes we're sending the bill but without the diagnostic code, so they reject it. It is true and a reasonable defense of Health + Hospitals that it's not as if billing in America is an easy thing. Right? I mean take medications. Part of the problem is there are I think 80 different Medicare Part D plans. Right? So somebody could have Medicare this-- this Part D plan, that Part D plan. It is-- it's not as if it's super easy, and this is a different critique of American medicine. So you take an institution like Health + Hospitals that existed to serve people who didn't have insurance historically and never really developed the expertise, but I-- I think to-- to get back to what you're asking, Council Member Reynoso, it's totally doable. Right? Other hospital systems have learned it. It's not nearly as difficult as it is to do the kinds of things that our doctors and nurses are doing every day in our emergency rooms and our wards. This is all known stuff. It's just that what we will have to do, and I ask your patience and that of the city because you can't just send a memo, because you have to fix every step of the process from registration through you know the collection

and-- and the appeal. Right? If you get denied, then you have to look for the code. That it is a one to three year process before we will see all of the revenue that we are rightfully entitled to. To our CFO, what-- that was the-- obviously the-- the high level. Is there something more granular you can offer?

CHAIRPERSON RIVERA: And if you could just state-- (CROSS-TALK)

PLACHIKKAT ANANTHARAM: (INAUDIBLE)

CHAIRPERSON RIVERA: --your name for the record.

PLACHIKKAT ANANTHARAM: Sure, my name is P.V. (SIC) Anantharam. I am the CFO for the Health + Hospitals System. I was just going to elaborate that the last review that we did about the lost revenue opportunity was anywhere in the range of between 130 to 290 million dollars. That's a low range and a high range, and I think it-- it points to your experience, frankly, is what gives us belief that we can actually do better for the system in terms of mitigating the gaps that we have. The-- the transition that we've been through for the last five years of moving from (INAUDIBLE) service systems to

managed care systems is going to bring those issues much more to the fore, so we have engaged a group to come in and help us train all of the front end workers in terms of patient registration, collecting appropriate information, not just at the point of contact but also when the c-- the scheduling is actually being done and even in the emergency rooms. We will actually have individuals with iPads and electronic equipment that allow those kinds of informations to be gathered, but training and is-- is very critical, and we are going to be embarking on a process of making sure everybody at the front end is being trained properly. We have changed the structures from individual hospitals to a network-based hospital, so every hospital used to behave differently in terms of how it encountered patients, so all of that is changing, and Doctor Katz has-- has also confirmed and-- and required that all of the front end staff report directly up to finance so we maximize the potential and opportunity to collect all that we can. We expect that a lot more commercial patients will come to our doors, because that's really how we have to get out of this pickle.

CHAIRPERSON RIVERA: So is the 130 to 290 million range you said for last year or is that ex-- is that-- (CROSS-TALK)

PLACHIKKAT ANANTHARAM: That-- that's--

CHAIRPERSON RIVERA: --the range annually?

PLACHIKKAT ANANTHARAM: Yes, that was the initial assessment that was done suggested that that-- that much opportunity to improve.

DOCTOR KATZ: But-- but just to add, that is-- that is not our total opportunity. That's for doing what we currently do. Right. So it doesn't say well (SIC) we have to start doing those things that reimburse better. We have to convert people who are uninsured to insured. Right? So it's within the, right, the model that we've been doing there's that much money. So imagine how much money there is if we are actually start doing the services. A-- another aspect of this that I don't has been fully appreciated is when we enroll someone in Metro Plus, if we don't-- if we can't do angioplasty, we still pay for it. We have to, right, because it's-- they need the procedure. So we're then paying other providers, often at quite high rates, for them to

have these specialty services. When we gain the ability to do that, we hold the money ourselves. So there is a tremendous-- so the-- the estimate is really about assumi-- what-- what could we get if we just kept doing business the same way we are but fully billed for the business. But you know my hope for our work together is of a much larger you know ability to generate dollars.

COUNCIL MEMBER REYNOSO: S-- th-- I'm concerned about long-term care in-- incentives, I guess. We get most of our money from like emergency or one shot deals or you're in, you're out. What is the incentive here to build a system that is looking into the health of a person more broadly? And-- and maybe keeping them out of the hospital has value or-- or teaching them how to stay out of the hospital has value, and then maybe there's opportunities in that-- in that part. Educating patients as to how they can stay away from the hospital, right? Doctor Fishkin (SP?) from Woodhull Hospital always talks about this, is that we don't want the person that has diabetes to get here at the tail end. We want them to come in the front end. Teach them how to-- how to live life the right way so that-- so that we don't see them in

the emergency room a year later. Just-- but-- but the incentives are not there to do that work. That Woodhull has (INAUDIBLE) paid more for the-- the-- the emergency care person that comes in at the tail end than it does at teaching people how to live the right lifestyle. So-- b-- so what-- what can we do to (INAUDIBLE) proper education and information to patients and it not I guess cost us?

DOCTOR KATZ: Right. Well, tha-- thanks so much for raising that question because it's so important. Right? I mean the reality is the U.S. doesn't have a healthcare system, it has a sickness system. Right? And it-- it reimburses for sickness, and the sicker the higher the reimbursement. What we do-- what we need to do as health people, as-- as elected representatives, is always do the right thing for the people we serve. Right. So you know prevention is the right thing, and we should do that, and early intervention is the right thing, which was what he's focused on. He's a wonderful doctor, and I-- I love the bicycle ride as a bicycler. So I think that-- that there-- that part of how we do it is to develop the capability to generate a surplus that can be used for other things. And you know in--

I'm very-- one of the things when I look back that I'm proudest of my seven years in L.A. was we-- that our health department housed 4,000 people. And we did that supportive housing. They were all people from our emergency rooms, from our hospitals. It was on the basis of surplus. From delivering acute healthcare. So now of course those were the better years of the A.C.A. when reimbursements were somewhat better, but I think the model is still the same. We always should do what's right for the people we care for. But if we would run Health + Hospitals more like a business, more looking for what the opportunities are, we would find that we had more opportunity to do preventive and early intervention. I hope-- (CROSS-TALK)

COUNCIL MEMBER REYNOSO: (INAUDIBLE)

DOCTOR KATZ: --we can do that together.

COUNCIL MEMBER REYNOSO: It's a-- it's a goal that can be achieved here.

DOCTOR KATZ: It can be done.

COUNCIL MEMBER REYNOSO: Okay. And my-- my last one, question, is rebranding. So unfortunately, some of these hospitals have reputations that precede you and even many of us

here, and-- and it's very difficult to get-- to get away from the stigma of-- of what they were or what they've done. Woodhull is a perfect example of that. I think it's a-- a-- a hospital that's really come of age. It has great leadership. The facility itself has-- has expanded and grown and-- and-- and improved. The service is improving, but it's still Woodhull Hospital to a lot of people that are more born and raised in that area, and its reputation of the past really-- really hurts it. And whether or not we can have a conversation on whether-- on-- on if rebranding makes sense in these hospitals. The name itself is-- is-- is difficult to-- to get away from. The reason I think it had this-- it has this reputation, the reason I know it has this reputation, is its emergency room and the-- the plight of our district during the 1990s and the early two-- and the early 2000s and the drug epidemic (INAUDIBLE) long after everyone else was recovering we were starting the crack epidemic, for example. And also the high rates of asthma entrance because we are one of the most polluted districts in the city of New York. We have the highest entrance into Woodhull Hospital for asthma rates than anywhere else in the city of New

York. Because of that, we saw an emergency room that probably couldn't handle all that work and-- and maybe some cases in which people could've gone to a place where they would've gotten more attention and it would've been less chaos. The emergency ri-- room right now in Woodhull Hospital is too small. You're cramming four and five people into a room that shouldn't have more than two. It-- it's-- I think we redid it in the waiting area, but where they actually operate is exactly the same. So I really want to have a conversation about why a certain hospital is-- has the reputation it has by looking into the history and looking into the community and asking those questions and then being able to have a conversation about whether or not a rebranding makes sense and whether or not a-- a re-- just redoing the entire emergency room makes sense at Woodhull Hospital. And just if that's in your-- in your-- I just want to know your thoughts on that oppor-- on the possibility of that happening.

DOCTOR KATZ: It can be done. It absolutely can be done. I think the best news is that-- and I've looked very carefully at-- at the quality and outcome data of Health + Hospitals.

COUNCIL MEMBER REYNOSO: Yes.

DOCTOR KATZ: Is that the quality of the medical and nursing care is actually not at issue. Right? I mean across the board, Health + Hospitals is better than community standard. The problem is that the patient experience is not very good. And that's what people remember. Right? So if somebody is rude to you, someone tells you to sit back down, someone makes you wait three or four hours, there are no appointments, what you remember is that. But what-- what I always find interesting about those things is it's so much easier to fix those things than it is to recruit mission-driven doctors and nurses and social workers and pharmacists, and that we've done. So we have the right people. We have the right ingredients. Some of our facilities are you know brand new and beautiful. Some of them are older and need a lot of work. Some of them are in between. Not unusual in a large municipal system. People in my experience will-- if people are nice to them, right? I-- I can't overestimate how much you know niceness, friendliness, welcoming matters. Part of the loyalty that we have, and I do think many of the hospitals have tremendous loyalty, comes because

people feel they won't be judged for being poor at our hospitals. That if the people who know well, they could go somewhere else, but they're worried if they go somewhere else that-- that someone's going to make them feel like it's a crime to be poor, it's a crime to be homeless. And they come to us because at least they know that we will accept them. But there's no reason we can't ha-- we can't accept them lovingly and also answer the phone on time and smile at people when they come in. It's not that difficult, and I think that it's just-- it got a little bit lost in the shuffle. It can be challenging to work in public hospitals. It's challenging when there's a long line. I feel my job is to make the system as good as the people in it. And we can do that. It's entirely doable.

COUNCIL MEMBER REYNOSO: But back to the reputation portion of it though, the people inside Woodhull Hospital are absolutely amazing. The midwives are second to none in-- in-- in-- in Woodhull Hospital. The doctors in the maternity ward, in the-- in the women's health unit, are unbelievable. But we need people to get into the Woodhull Hospital to see the facility, to see the

doctors, to see the midwives. Once they're in, they-- they'll forget about it. They'll-- they'll lock them in every time. But they got to get in, and the-- the name discourages that from happening.

DOCTOR KATZ: I got it (SIC).

COUNCIL MEMBER REYNOSO: And just whether or not you're-- you're willing to have a conversation about that.

DOCTOR KATZ: I-- I'm completely open to working with you. I don't-- I don't even know the history of that particular name. I-- but I-- I think what you're-- what you're right most deeply about--

COUNCIL MEMBER REYNOSO: Uh-hm.

DOCTOR KATZ: --hospitals are important symbols in their community. And they have almost mythic like meanings to the people who live around them. And you have to understand you know the history of the hospitals. You know, again, to reflect for a moment on-- on Los Angeles, Los Angeles had to close a public hospital, M.L.K., which was-- had been known as Killer King after a very negative set of articles, and while I was there we, under a public private partnership, we reopened M.L.K., and people said patients wouldn't come back, and they

did. And po-- the buzz is very positive. So it can be done. You can reboot, you can rename, you can rebrand, you can-- you can bring people in, you can have tours. Let's talk about you-- you-- you have the best feel of your neighborhood. I'm a Brooklyn boy but not from your neighborhood. I'm more south, so let's-- let's-- let's talk together how to make it happen.

COUNCIL MEMBER REYNOSO: Thank you, Chair.

CHAIRPERSON RIVERA: So I wanted to go back to your-- your testimony. You did mention you outed me as proudly born in Bellevue Hospital, and they-- there's also a reputation there, too, but we won't get into that. I'm very proud to be born at Bellevue and serve on the Bellevue Community Advisory Board. In your testimony, you mentioned that you are hoping that there's going to be a two-year turnaround and a chance at solvency, and I want to hear a little bit about how-- you've touched on it a-- a little in answering our questions, and I want to thank you for that, but what is your-- your plan overall to-- to hit this two year goal? If that's-- (CROSS-TALK)

DOCTOR KATZ: Sure, so--

CHAIRPERSON RIVERA: --in fact what it is.

DOCTOR KATZ: Thank you, Chairperson. So the-- what I would like to be able to do with you, with the council, is to be able to give dollar amounts to what I see as the seven point plan. How much money is realistic from decreasing consultants and administrative expenses, how much is due to better billing, how much is due to converting people, and to-- I-- I've always found that large numbers, when they seem insurmountable the first thing you have to do is break them into portions. Right? So I don't want to focus on okay, well how we going to fix this whole gap? I want to say okay, well we're going to-- let's break it into pieces, let's fix this part with this amount, this part with this amount. So I feel like just in the-- in the two months I have learned from the great people in Health + Hospitals a huge amount. Enough to understand and to believe that this is a solvable problem. What I next need and what you have to expect from me and hold me accountable is exact dollar amounts for each of the seven things. And that's what currently we're working on together in Health + Hospitals. So I can

bring you and I can tell you okay, by converting-- i-- if you-- we're currently serving 400,000 people who are uninsured. If you converted 100,000 of those people to insurance, that'd be huge. Huge. And they're entitled. So they-- it's such a-- the reason it's a huge opportunity, just for-- for people in the audience, is that what they would be converted to is either the basic health plan or the exchange if they're not Medicaid qual-- qualified. And those plans come with a huge federal subsidy. So by those people being on a sliding scale, not being enrolled, the subsidy is lost. Right? So we're essentially leaving federal dollars on the table by those people not being enrolled. So, right, I mean th-- that's such a huge opportunity. So what I want to do is to take the seven things, be able to come back to you and say okay, in each of the next two years I think w-- these incomes will grow this amount of time, and at this point-- and again, we will always require a city subsidy. Because there will always remain a group of people who are uninsurable. And we're absolutely committed to those people, we want to provide great care to those people, we want to be a system that cares for everybody, but that's what the

subsidy should be-- the city subsidy should be for is the people who are uninsurable. And then what we should do is be able to care for the other people by effective billing. And there is no reason that I can see, if again we're at the-- the macro level, that should work. Right? A city subsidy plus Medicaid with some level of DISH (SIC) enhancement plus effective billing would lead to a solvent Health + Hospitals. But because I can't turn that switch, I think instead what-- what you have to hold me accountable for is in each of the seven steps how much can I bring in next year, how much can I bring in the year after, and at what point do we arrive at a subsidy that is affordable and represents good value for the money that you're giving us?

CHAIRPERSON RIVERA: How are you going to work to insure those people? Like how are you going to work to make sure that people are getting enrolled, that they're taking advantage of Metro Plus, how are you going to work to reach the numbers that you think that you're not getting to?

DOCTOR KATZ: Well, again, it's-- it-- it's not any one thing. But I can tell you depending upon which part of Health + Hospitals you're talking

about, you have to ask each of those people. Right? Because we-- (CROSS-TALK)

CHAIRPERSON RIVERA: Uh-hm.

DOCTOR KATZ: --we cannot insure them without their help. So the two things you have to do is to make sure that someone explains, so for example New York City should be proud of the fact that it has always provided a progressive sliding scale. But if you've come to us for many years and because we provide a progressive sliding scale you haven't had to pay, how would you know or who would even help you that you're now going to enroll into this other insurance? Your-- your needs are being met. Right? And you're-- so you're paying zero or you're paying 10 dollars, and nobody has explained well, but you would get even more benefits if you were to enroll, and-- and let's help you. So I-- I think part of the difference I'm seeing is that New York City did a very good job I think broadly speaking getting people into Medicaid, which is the easier step than getting-- see from (SIC)-- because Medicaid doesn't require that the person go onto the website or call a navigator through the basic health plan or the exchange. It's open at all times. Right? So the

exchange and the basic health plan have specific enrollment periods. There's a (SIC)-- so it is trickier. So I think that it's (SIC) that group that-- that probably represents the largest opportunity. There is some still Medicaid that we could get if every person were at the time that they're coming in get the proper counseling. That means having the staff, it means having the staff who again are-- are knowledgeable about this, who see it. There is-- I mean one of the urban beliefs is that it doesn't matter because we are here for the uninsured. I mean that-- you know I-- I-- and again, this doesn't come from a bad place. But i-- if-- i-- until people in Health + Hospitals at a deep cultural level ha-- the narrative has to go from you know we-- we see everybody without sending bills to we are excellent billers so that we can provide phenomenal care to both the uninsured and those who have insurance, that narrative has to change, and-- and as-- as you know as experienced people, culture is the most challenging thing to change about a large organization. Anybody can send a memo, anyone can say here's our strategy, but to really change the culture that has e-- that has existed in this

particular way-- I can't tell you how many doctors have told me stories of sending family members to Health + Hospitals facilities and where when they go and show their insurance card the person says you don't need to come here. You have insurance.

CHAIRPERSON RIVERA: So I'd like to turn it over to any of my colleagues who has a question. Council Member Levine.

COUNCIL MEMBER LEVINE: Well, thank you so much, Chair. You're off to an incredible start. You're-- you're-- you're already a-- a-- a pro and with a lot of experience based on how well you're chairing the hearing, and I look forward to partnering with you with the health portfolio as well. And Doctor Katz, great to see you, and-- and you have rightly been focusing on this large pool of New Yorkers who, while they don't have insurance, are eligible for insurance. The community clinics like FQHCs confront a similar challenge, and as far as I can tell, the better run of them have a pretty intense protocol in place to sign someone up for insurance on the spot if they show up for services and they are uninsured and eligible. Now, granted, if someone's coming into the emergency room with a--

an-- an issue that has to be addressed in a time-sensitive way, you're not going to pause and sit them in front of a computer screen. I get that. But I got to imagine out of I think you said the number is about 250,000 patients a year that you see who are uninsured and eligible, that many of them are coming to you in settings where you could spend-- I don't know how long it takes, but let's say 20 minutes, I-- I don't know, and sit them in front of a computer screen, is-- is that another cultural challenge you have to overcome? Is that a-- a resource issue or am I making it seem simpler than it really is?

DOCTOR KATZ: N-- n-- no, Council Member, I think you're-- you're-- you're right and accurate. It's both of those things. I think another part of that is that there's no-- right now we haven't constructed a system to make it that that's the easiest choice for the person. Right? To be able to enroll in insurance. We've kind of made it easier to pay 10 dollars, which might be the same copay that they would pay if they had insurance, but the difference in terms of what our system and city would receive is huge. Right? So that's what I mean, if the-- if people-- if they have been coming for us for

six years and you know let's say predates the A.C.A., when y-- when-- when having a sliding scale is-- that is very progressive is absolutely the right thing because there's no other choice for people. But now that we have the A.C.A. we don't want to be undermining the A.C.A. by having-- making it-- making it so that it's easier just to pay the 10 dollars. It's not that we want people to pay more, they'd actually probably pay less or the same, but we don't want to lose that subsidy. But the systems for doing that, again, not so easy because you do-- you c-- we can't do it on our own. The person has to do it with us. And so I think you know helping people to understand you know why they are better off if they are insured, why-- and many people, for example, don't understand that in the-- many of the exchange plans they actually won't pay anything. Right? So people-- because you say I'll sign you up for insurance, oh, I can't afford insurance. Right? So people don't realize, right, that actually under the A.C.A.-- I mean the-- all of you know that, right? But the-- to the average person, well how am I going to pay for insurance? I'm a-- I'm a low income worker. Right? I clean hou-- I clean houses. You

know I can't a-- to trying to-- to teach that thing, and as you say, you know it can be regular-- obviously not going to do it before treating somebody in the E.D., right, so you-- you have to do it at the right moment.

COUNCIL MEMBER LEVINE: I-- I-- I hear you on that, but gosh, I have to think that most people, if you sat them down and said we're going to sign you up for insurance now, and you explain to them this is going to allow you to get service beyond an H + H facility, if you're traveling, if you're in (SIC) another part of the city or for whatever reason you need to go elsewhere, this will allow you to access services that-- even in a world where we tend to provide medical care to the uninsured, it's-- there are, as you say, consultations or preventative c-- services or more costly higher end any kind of di-- discretionary procedure. I think even with that disparity in the copays and some of what you're offering, it-- it-- it's pretty easy to argue that it's in the interest of any New Yorker to get health insurance. And even if a small number would say you know what? I've run the numbers, and I would rather be uninsured, okay, we lose a small number. But--

but are we at least presenting people with the opportunity or maybe even the imperative to sign up to capture those who will go through with it?

DOCTOR KATZ: Councilman, I'd-- I'd say in honesty, well no. Not-- not the way I would like it, not the way you're describing it, not everywhere. So yes-- yes, the way you're describing it, the way we would like it, in some places, but no, we need to be everywhere with that message because the (SIC) huge opportunity. We're like throwing away money by not being able to do that.

COUNCIL MEMBER LEVINE: Ab-- absolutely, and look, in the ideal world people are going to show up to you already insured. You should be providing medical services first and foremost. You shouldn't have to worry about this. For the reasons we mentioned, you don't have that luxury, but I'm also interested in figuring out what we as a city can do to make sure that when people show up to one of your facilities this is already taken care of.

DOCTOR KATZ: Uh-hm.

COUNCIL MEMBER LEVINE: And the citywide number is that-- that we're quoting is 667,000 uninsured New Yorkers. And some of them are

undocumented, and so we have that challenge, but does your experience in San Francisco or Los Angeles tell you that there are other city departments, maybe it's the Health Department, maybe it's the HRA, ACS, are there other times we're touching New Yorkers where we could deal with this? Did-- did Los Angeles or San Francisco have good protocols in place to make sure this was already taken care of before they showed up to the hospital?

DOCTOR KATZ: I'm not s-- you know, I'm not sure that Los Angeles or San Francisco was ahead of New York City in this area. I would say that both Los Angeles and San Francisco were ahead in the health service system. That when people came without being covered, getting them covered. So I don't want to blame the broader city efforts. I think what I take from what you're saying, the most important thing that I think is-- is critical is you have the numbers right, you're good on numbers. 250,000. We-- okay, so let-- let's agree we wont get 250,000. But that's a lot of people. Right. If we got 100,000 of the-- the 250,000 that we believe are currently getting our services and insurable, that would be huge. Right? Because again, all of those--

it's not just that one visit. Right? If those people were to enroll in Metro Plus, we're talking about a federally subsidized monthly amount that's going to come for each of those people, and as you say, they're going to get more things. So it is in their interest to do it. I do think that in L.A. in the same way and in San Francisco the lives of people who live at poverty are difficult. People-- people have other things, there are transportation issues, there are form issues, there are literacy issues, but they're all surmountable. None of them are beyond surmountable, and I think-- I think what we do need to do, and I-- I'd love to work with you on both parts-- what are the-- what are the other places that New Yorkers are touched, because you're right, the absolute best is if people come and they're already you know covered, and in fact, maybe if they came-- if they were already covered they wouldn't need to come. Because maybe they would've gotten great primary care at one of our centers. And then we do have to do better once they're in front of us. Because the-- then you have them. It's-- that should be a relatively easy time. We sh-- we have to do better on those.

COUNCIL MEMBER LEVINE: Absolutely, and I'm going to go back to the Chair. I'll say I-- I really think that we as a city, as a city council, have to solve this, and I-- I look forward to working with Chair Rivera, Chair Ayala, actually Chair Levin (SP?) as well, we'll brief him on what we were talking about, but on this notion that when New Yorkers touch city agencies if they're not insured we take that opportunity to do it so that by the time they do need medical care that that issue's already settled. Thank you, Madame Chair.

CHAIRPERSON RIVERA: Sure, you're-- you're welcome. I'd like to acknowledge Council Member Steve Levin for joining us. I just want to ask a couple questions, and then I'll let you-- it's okay? Okay. So I want to talk a little bit about the investment that we have already made for-- for H-- into H + H as a council. So One New York reported that the city's investing 100 million in capital funds over the next four years to expand and upgrade the community-based health centers and clinics, and you mentioned a little bit about the infrastructure that exists in some of our facilities and how they do need an upgrade. So 10 million dollars in council

capital funding was allocated in fiscal year 2018 for health clinics. So what capital improvements are planned with this funding?

DOCTOR KATZ: Thank you, Chairperson. So I did a little bit of-- of research on sort of what our capital needs are, what our-- our resources are, and I have to say re-- remembering that I'm a primary care doctor, not a real estate person, that I-- I'm not as strong, right, on real estate issues. What I know is none of the money has-- or what I'm told is none of the money has yet been spent, and there is not-- so but it-- it o-- it hasn't been frittered away, right, it's-- it's sitting there, that it is-- that it's specific for primary care centers, and that it-- it is based on the city's process to determine which of the centers you know will be renovated. And to be honest, that's as much as I you know currently understand about that fund. It's sitting there waiting for decisions on which centers, and I haven't yet been to all of the centers, so I-- you know I've-- I've seen some that I think are in great shape and some that I think could use some work.

CHAIRPERSON RIVERA: So are you saying that you think that by visiting all of the centels--

centers you're going to have a better grasp of where the money should be spent? Is there not a plan already in place to upgrade some of these infrastructure projects?

DOCTOR KATZ: I-- my understanding is that there isn't yet any-- that this 100 million I'm told is not yet programmed against any specific centers.

CHAIRPERSON RIVERA: So in January 2016 the city added 337 million to H + H's budget to bridge an immediate gap and is continuing to contribute 180 million annually. What is being done to ensure that we don't result to the same emergency measures in the future?

DOCTOR KATZ: Right. Well, I think that-- that's really where the-- the seven point ways we're going to fix this budget come in. I think that it is-- it is a viable plan. It-- it makes sense that-- that given the number of people who are uninsurable that we should be able to care for all of the people who cannot be insured with a subsidy like what the city has traditionally provided, if we are successfully billing. Of course, if-- if we have decreases in federal dollars and we're not doing

billing, then we will continue to have those large amounts. Because really those amounts are going to pay for people who we could be billing for. Part of the switch from DISH to the current system is to empower individuals to have insurance. Right, and I very much believe in that. I don't believe that people should come for charity care. I think people should be empowered, you have insurance. Middle class people have insurance, low income people should have insurance. And they should get to choose where they want to go, and their dollars should follow where they go, but that does require billing. So my belief is with the DISH dollars put off, we-- we're actually running a bit ahead of-- of projections now. The O.M.B. will be helping us within-- your council has our budget hearing on March 15th. We're working very hard with O.M.B. to be able to produce the numbers, but it will certainly, from what I-- from my sense of how things are going in revenue cycle, it will be better than what people have seen before. But O.M.B. has not yet quantitated that.

CHAIRPERSON RIVERA: I do have some questions on-- ahead of the preliminary budget hearing that we're having for fiscal year 2019 and

the relationship with OMB, and-- and I mentioned this at the start of the hearing that transparency has not been something that we have looked forward to as a council. So before I get to those questions, I do want to see if any of my council members have something they'd like to ask. Council Member Levin?

COUNCIL MEMBER LEVIN: Thank you very much, Chair Rivera. Thank you so much for your testimony and for the-- the good work that you do for New Yorkers throughout the five boroughs. My name is Steve Levin, Chair of the Council of General Welfare Committee. So we had a hearing yesterday around the opioid epidemic among New York City's homeless population, and in preparing for that hearing, reviewing the-- New York City's plan for combating the opioid epidemic from last year, you know H + H is identified as really the backbone in terms of healthcare delivery to-- to connect New Yorkers to long term care, and as you know, people struggling with addiction may not be ready to go into long-term treatment like methadone or buprenorphine at some point in time. At some point in time they might be ready for that. And what we need to do as a city, because we're combating a you know a-- a significant

uptick in overdoses due to the prevalence of fentanyl that's out there now, we need to make sure that we're ready to connect people with those resources when they're ready.

DOCTOR KATZ: Uh-hm.

COUNCIL MEMBER LEVIN: And so to that end, I wanted to ask what-- so a couple of questions. How many physicians or nurse practitioners or physician's assistants are prescribing buprenorphine right now that are affiliated with H + H?

DOCTOR KATZ: Okay, so I'm looking at the exact numbers because I don't want to say it wrong. So we have 60 who are currently waivered, and we have 225 who have done their training and are waiting for their SAMHSA to send them the--

COUNCIL MEMBER LEVIN: So there are only 60-- (CROSS-TALK)

DOCTOR KATZ: --certificate (SIC).

COUNCIL MEMBER LEVIN: --right now that are currently waivered.

DOCTOR KATZ: There are only 60 who are both trained and have their SAMHSA statis-- certificate.

COUNCIL MEMBER LEVIN: So I just want to make clear what that is. So that's actually out of-- so just to be-- just to give you a-- a snapshot of the-- there are about 1,900, I believe, physicians in New York City, physician's assistants. You know those-- there's 19-- because you could be a nurse practitioner, physician's assistant, or a physician-- 1,900 that are-- that currently have a waiver. So of that 1,900, only 60 are affiliated with H + H. And if H + H is going to be the backbone of healing NYC, which is-- they're identified as the backbone, that number has to come way up. So I appreciate two-- an- - an additional 200 some odd having done the training. Have you thought about how you're going to get more physicians affiliated with H + H to be-- to be trained and-- and get that waiver?

DOCTOR KATZ: Well, yes, and-- and I want to start, Council Member, by just thanking you for your advocacy for these patients. I mean I've taken care of them my whole life. I've lost several patients to overdose. This is incredibly-- (CROSS-TALK)

COUNCIL MEMBER LEVIN: You know.

DOCTOR KATZ: --important.

COUNCIL MEMBER LEVIN: Yeah.

DOCTOR KATZ: Right. The-- I wish the federal government would also make it a little easier.

COUNCIL MEMBER LEVIN: Sure.

DOCTOR KATZ: Right, I can't-- you know just worth saying because other people are listening, you know this stuff, that I can, without a waiver, prescribe all sorts of medications.

COUNCIL MEMBER LEVIN: Yeah.

DOCTOR KATZ: Right. And there actually isn't even a single other medicine where even if I needed to be trained I would be limited in the number that-- of people that I could prescribe it for.

COUNCIL MEMBER LEVIN: Yeah.

DOCTOR KATZ: In fact, it's-- it's counter to all of how we think of medical practice, which is that you want people who get really good at something.

COUNCIL MEMBER LEVIN: Yeah.

DOCTOR KATZ: Right, so you'd want is-- right, so the whole-- so I mean the-- right, we have to at least acknowledge that the environment was not set up correctly.

COUNCIL MEMBER LEVIN: Right, and--

(CROSS-TALK)

DOCTOR KATZ: Right.

COUNCIL MEMBER LEVIN: --they've been working to try to address that on a federal level for a number of years.

DOCTOR KATZ: Right. So but what I-- but we need to do what we can do.

COUNCIL MEMBER LEVIN: Right.

DOCTOR KATZ: Which means there needs to be a massive increase in the number of people who can prescribe.

COUNCIL MEMBER LEVIN: Yeah.

DOCTOR KATZ: From talking to people, I sense openness. I don't-- you know the doctors, nur- - nurses are good about doing this. I think it's interesting compared to other settings. I think Health + Hospitals could train more nurse practitioners.

COUNCIL MEMBER LEVIN: Sure.

DOCTOR KATZ: You don't only have to be a physician--

COUNCIL MEMBER LEVIN: Right.

DOCTOR KATZ: Right? So there is a lot more opportunity here.

COUNCIL MEMBER LEVIN: And I-- I heard from a doctor affiliated with another hospital who said that Bellevue, which is our flagship hospital, only has like five or six hours a week.

DOCTOR KATZ: Two days, yeah.

COUNCIL MEMBER LEVIN: So it should be-- I mean the-- the consensus around the room that I was in was 12 hours a day, six days a week.

DOCTOR KATZ: I'm with you.

COUNCIL MEMBER LEVIN: Or 24 seven for that matter. I mean--

DOCTOR KATZ: I am-- I am with you that it is-- that there is a huge need to expand.

COUNCIL MEMBER LEVIN: I'd like to make a recommendation. There was an article that was published in the New England Journal of Medicine two weeks ago by a physician in-- in Boston. I'll-- I could get you her name, and it was covered in the Boston Globe, who wrote a very moving personal testimony about-- about what happens when you don't have the waiver. And she had an elderly patient who had gotten addicted to opioids, and she wasn't able--

she was her primary care physician, she had the relationship, she wasn't able to prescribe it. She referred her to a-- a-- a colleague, a friend of hers that was able to do it. That patient ended up dying of an overdose. A grandmother (INAUDIBLE) And that personal testimonial about what it means to be able to do this-- and-- and-- and she was very candid about her obstac-- you know why she w-- why she didn't get the waiver in the first place, which was-- you know and she was very candid about the challenges of dealing with the population that might be coming in with other issues in-- in addition to the addiction, but you know-- and the addiction on top of it. So I'll get that-- that article. I'll-- I'll shoot you an email with that article or you could find it.

DOCTOR KATZ: I can find it (SIC).

COUNCIL MEMBER LEVIN: I would recommend you just mail that out to every-- to every N.P., P.A., and physician in the H + H system.

DOCTOR KATZ: And one thing I have to that regard, I've made it clear that you know that would be an appropriate use of over time. Right, so because it does come up with physicians, and it's in

a good way. People don't want to cancel a clinic session. Right, so I mean there are other ways--

COUNCIL MEMBER LEVIN: Uh-hm.

DOCTOR KATZ: --to make sure that people get in their training. So--

COUNCIL MEMBER LEVIN: And one other--

(CROSS-TALK)

DOCTOR KATZ: --I will (SIC)--

COUNCIL MEMBER LEVIN: --question or one other recommendation came up yesterday. D.O.H.M.H. has project relay.

DOCTOR KATZ: Yes.

COUNCIL MEMBER LEVIN: It's the program that they're working on in getting peer counselors when there's an overdose in an emergency room. They're working with five emergency rooms in the city. They're working on getting another five into the program. None of those emergency rooms are H + H. And I asked them why, and they said well, you know H + H is in charge of doing that. There needs to be programs where if an overdose comes into your emergency rooms that you are able to have a peer counselor 24 seven using that time that somebody's in

your care to present them with long-term treatment options.

DOCTOR KATZ: Uh-hm.

COUNCIL MEMBER LEVIN: And so I strongly encourage you, they have five E.R.'s. It's like Sinai, Maimonides, Montefiore. Missing from that list were any H + H, and-- and that was disappointing, so.

DOCTOR KATZ: Well, thanks for advocating-- (CROSS-TALK)

COUNCIL MEMBER LEVIN: Strongly recommend.

DOCTOR KATZ: --both for these patients and for us.

COUNCIL MEMBER LEVIN: Thank you. Thank you, and I-- I do (SIC) want to thank Chair Ayala who-- who-- we co-chaired that hearing together, and that's a long hearing, so. Thank you very much, Chair. Thank you.

CHAIRPERSON RIVERA: Alright, I'm going to turn it over to Chair Ayala for a question.

COUNCIL MEMBER AYALA: Good afternoon. So I-- I actually represent eighth-- the eighth (INAUDIBLE) district, which is broken up in between

East Harlem and the South Bronx, so I'm right across the street from Lincoln Hospital, so it's not quite mine, but most of my constituents do use that as their hospital of choice, and then I have Metropolitan Hospital in East Harlem. Metropolitan has been for many, many years you know avoiding talk of closure, and so there's-- there was a lot of anxiety there last year, and we've been working with the hospital. I-- I-- I try to attend as many cab meetings so that I have you know access to the administration (INAUDIBLE) we're working together, and I noticed that one of the issues that they have, and it-- it's a-- it's a very popular hospital in-- in my district, used primarily by you know uninsured constituents, but one of the issues I think, or one of the challenges that they've had consistently is the lack of equipment that allows them to be competitive. And so often times people will come in for a special-- some sort of specialty treatment and will have to be referred out for something as simple as maybe they don't have the appropriate echogram machine or sonogram machine, and I wonder as part of you know the-- the work that we're doing in the next two years and the plan, is there like-- is there a

plan for that calls for capital improvement to these facilities to make them viable and to kind of rebrand. Kind of to speaking to what Council Member Reynoso's you know was speaking about, you don't need to change the name, right, to rebrand the environment and to make it feel different for individuals. A lot of these facilities, you-- you walk in-- you know Metropolitan being one of them, and you can tell that it's pretty-- you know, it's pretty old. And so I-- I wonder, because I-- I know that that's one of the challenges that they've been having in the last few years.

DOCTOR KATZ: Council Member, I-- I was-- when I went to Metropolitan, what my first thought was wow, this place has a really vibrant feeling to it. Which is interesting because it's not-- it's an oldish building. But the-- the feeling of the people working there is clearly very tied to that facility, right? And there is tremendous neighborhood loyalty to-- to that hospital.

COUNCIL MEMBER AYALA: Remember that, you better not touch that hospital. Just remem--

DOCTOR KATZ: Right. So-- so yes, I mean let's figure out-- you know I mean we-- we can't do

everything everywhere, but we can make sure that people are getting the services that they commonly need. I mean I think you-- it-- it's one of those things where you want to set the point in a sensible way, right? I mean there-- none of our hospitals do everything. Right? And so I mean there are things that Bellevue, which is probably our most you know quartenary (SIC) like hospital, has to send out. Because we don't-- we don't do it. But you don't want it to be something common. Right. You-- you want it to be really the unusual thing where either the cost of the equipment is so astronomical, right, like I-- I had a hospital in Los Angeles that said to me we need a PET scan. And I said why do you need a PET scan? They said well, our other-- one of my other hospitals-- they have a PET scan. Like that's actually not a good reason to have a PET scan. Okay? Right, I mean we-- right, so we're stewards of public money. It has to be sensible. But I'm happy to work with you in any of those areas.

COUNCIL MEMBER AYALA: I appreciate it.

CHAIRPERSON RIVERA: So I just really quickly want to thank everyone who's still with us. All of the advocates and the labor leaders. You

know, this-- this is specifically a hearing on this plan, and I wanted to make sure that you heard from Doctor Katz himself on his-- on his vision and-- and what he plans to do over the next year or so. So I just have a couple more questions. I-- I want to again thank you for your patience. I wanted you to hear from Doctor Katz if you hadn't met him yet. He's been very open to having meetings and visiting, so make sure you get on his radar after this. Of course, I'm going to invite you to stay to hear--

(CROSS-TALK)

DOCTOR KATZ: Of course.

CHAIRPERSON RIVERA: --from everyone's te-- to hear everyone's testimony. So just a couple of weeks ago, H + H dev-- they announced that they're going to develop a care management program over the next year. One New York stated that expanded care management will save Health + Hospitals an estimated 19 million annually by 2020. Given that the latest program will not be up and running until 2019, what are the new cost savings for this program?

DOCTOR KATZ: I don't have better cost savings data for you. What-- what I'd say is to me, and this might be a little different than the plan,

the reason you do care management is because it's the right thing for the people. Some of the studies of care management have shown dollar savings, some of them have not. And you know, again, to me, the reason people need care managers is because they're living in very difficult circumstances and they're coming for healthcare for things that cannot be treated with a pill, an injection, or a stethoscope. And you need to give them the appropriate treatment. If that also then results in lower-- in lower savings, I say even better. But I-- I-- I'm-- I'm a little-- and I realize it's a little different than the previous plan, but I'm a little weary of-- that's wary, not weary. I'm a little wary of this-- of-- of seeing that the purpose of care management is to save money. Because the research has not been overwhelming that there are actual savings.

CHAIRPERSON RIVERA: So you know one thing that I-- I think is going to be really important in terms of-- of serving people who have mental illness, who are chronically homeless, is the creation of supportive housing. I'm hoping to promote that development in my own district and citywide, and I want to know I guess from you and

based on your plan, how can investing in something like supportive housing help a struggling public hospital system?

DOCTOR KATZ: Well, I think a-- a lot of ways, and I thank you so much for-- for scoping out that-- that piece of work. I'm a huge advocate for supportive housing. I've spent a lot of time in both San Francisco and Los Angeles doing supportive housing. I think that for the seriously mentally ill, and I think it ties to some of the earlier themes, many of them would-- as much as I believe in housing first, many of the people who are most psychotic would benefit from three to six months of transitional housing where they got good milieu treatment. Not locked, but good milieu and medications. And I think during that time we could them stabilize them to make the transition into supportive housing easier, and (INAUDIBLE) we got them the right set of benefits, a little less expensive for the city. I'll have to look-- I'll look to you and to others. I'm just beginning to understand the-- again, the real estate issues of New York City, and I get that it's-- it-- it's a little-- having done this in San Francisco and Los Angeles,

which I thought were difficult places, it seems like this is up a whole other notch of difficulty in terms of finding places, but it is totally the right thing. And I commend you for staking it out because it is-- right, the-- the whole-- my whole involvement with supportive housing came from how dissatisfying I found it when people would come into the hospital and then would be discharged homeless. And you know to me, right, it's just such a wrong message. It-- people can't survive with chronic illness, and then they wind up going back and forth between in-patient acute psychiatry, you know this, or-- or Rikers, right, and the city-- th-- spends money because of course Rikers is expensive and in-patient psychiatry is expensive, and meanwhile, that investment in housing, which is so much less, doesn't happen. So anything I can do to help you, anything we can do together. I've already met with the corporation for supportive housing. They would love to help us. I know they've been active in other projects. I know they're doing one in the Bronx now. Right, I think the-- you know New York City has-- I mean from someone on the West Coast has-- was really the first to make substantial movement as a municipality's

supportive housing. I remember when I was in San Francisco reading the initial New York City studies on supportive housing. So anything that I can do, I would love to be part of.

CHAIRPERSON RIVERA: I think that some of the-- the council members that came in here today expressed some concern over their own facilities, whether across the street or in their district, and I think when it comes to the private hospitals who I have every intention of bringing before us and asking very similar questions as to the services they're providing, and their focus on the bottom line, is that there is a ton of speculation in New York City. So when you have you know hospitals that have been described as empty, people are always looking at that as more of a land use portfolio and a development opportunity. So in order to look at some of the-- the spaces, maybe there's a couple floors in some of the buildings that aren't being utilized as they were previously because of how healthcare is really going through a transformation, what are the public and private partnerships that you're looking at? For-- for example, I recently met with-- and this is just one example-- Planned Parenthood is looking to expand

some of their services, bring what-- what they consider they are the experts in providing not just reproductive rights education information, but also abortion care and abortion services into really an expansion in terms of locations. Are you looking at public and private partnerships? I mean this even goes to some of the supportive housing.

DOCTOR KATZ: Sure. Well, I think that there are tremendous synergies in what you're saying and that we should look for all of the opportunities. When I was at Seaview last night I was there for a public hearing about using an empty Seaview building for a residential substance treatment for women, which I thought was terrific. And you know, so you know to me, we should always-- done by a-- a private nonprofit. I'm blocking on the name. Camelot? Yeah, so Camelot. Thank you. So I mean I think there-- there are a lot of opportunities for us to use-- use space and also you know then partner, right? Perhaps we come up with-- with a partner, whether they're a substance treatment provider or Planned Parenthood, and they're doing a scope of services and then referring patients who need medical care to us. Right? So there are lots of ways that

you can work this so that you take best advantage you know to-- of your-- both your space and of your potential.

CHAIRPERSON RIVERA: Diana, just let me know if you have any questions, okay? So One New York includes a plan to seek federal funding for a program that delivers coordinated healthcare services to the uninsured, and I just would like to know how might this change under the current federal administration and whether you foresee this political climate in some of the pending cuts and the looming changes and overall just threats from Washington and how it affects your plan.

DOCTOR KATZ: Well, Chairperson, you-- you know how difficult the federal environment is right now. You know, I-- I think it's important that it stay on our books because it's important that we continue to make clear that the federal government should be helping us. And in that sense, I don't want to say the number is off, because they should be helping us. I think the likelihood of our being able to get additional federal support at the current time is unfortunately pretty low. But we-- we want to--

we want to leave it there as our way of saying that they really should be helping.

CHAIRPERSON RIVERA: Right, and I know that the-- the council's going to do everything they can to support efforts to really-- really fund our public hospital system. And my last question, because I do want to get to all of the advocates here, and again, thank you so much--

DOCTOR KATZ: Thank you.

CHAIRPERSON RIVERA: --is-- is going back to I guess our role as legislators, and a piece of legislation, state legislation, on enhanced safety net hospitals. So state legislation to create these enhanced safety net hospitals, to increase Medicaid reimbursement for hospitals that primarily care for Medicaid and uninsured patients, we know was vetoed twice by the governor. How much of an impact would this bill have on H + H's bottom line?

DOCTOR KATZ: We don't have an exact formula, but best estimate, four million dollars a year.

CHAIRPERSON RIVERA: Okay. Well, thank you. Thank you for that. We're going to do everything we can to-- to assist you in your-- your

new role here at-- at Health + Hospitals holding you accountable. I know the-- the advocates and-- and the labor leaders in this room certainly will hold me accountable in making sure that we bring you back to answer some of these questions. In terms of the preliminary budget hearing, we-- we have-- we have some questions, but you know what? I-- I really want to make sure that we're getting to the advocates, and so I want to thank you again for your testimony, for bringing your team, for everyone here from H + H. I hope that you'll return, not just for the budget hearing but for any questions that weren't asked and that we desperately need answers for, maybe coming back in a few months and talking about the financial health of Health + Hospitals.

DOCTOR KATZ: Great. Thank you so much.

CHAIRPERSON RIVERA: Thank you.

DOCTOR KATZ: (INAUDIBLE) Yeah, I can sit back there, right?

CHAIRPERSON RIVERA: You can. You can.

DOCTOR KATZ: Right (SIC).

CHAIRPERSON RIVERA: The people's house (SIC). Good (SIC)? Let me make sure that I-- alright. (BACKGROUND VOICES)

DOCTOR KATZ: Oh, wonderful. (BACKGROUND VOICES)

CHAIRPERSON RIVERA: (INAUDIBLE) Alright, let's do this. We have (INAUDIBLE) Okay, so I'm going to call up to the next panel, Judith Cutchin. And-- and you c-- please correct me if I mispronounce your name. As someone who has a lifetime of people mispronouncing her name, I appreciate it. Kevin Collins, Anne Bulve, and Anthony Feliciano. Thank you, sir. (BACKGROUND VOICES) Oh, I think they're fine. I think they waited long enough. How you holding up? Did you eat? You should go (INAUDIBLE)

ANNE BULVE: Okay, I'll start. My name is Anne Bulve. I'm a registered nurse. I've just recently retired from Bellevue Hospital after 40 years of service. Presently, I'm a member of the C.P.H.S. Board of Directors as well as N.Y.S.N.A. Secretary to the Board. I'm here to advocate for obviously the survival and the flourishing of New York City Health + Hospitals. Back in 1969 a law was passed Chapter 1016, which basically established Health + Hospitals, otherwise known now as New York City Health + Hospitals, to provide health and medical service that are essential and-- they're

essential to the public and should be provided by governmental function. Originally, this law was intended for all hospitals within the state of New York but ultimately only became the responsibility of the public sector. Operationalizing this law is the mission and vision of New York City Health + Hospital, outlining its focus to access to care for peoples, specifically in terms of looking at regardless of ability to pay, just simply regardless. And the system reinforces the position of care as a right and not a privilege. In that light, the services required need to be subject to the needs of the community, not planning behind the closed doors of administration, and I've been personally witness to the fact that the Community Advisory Boards, whose existence are established by this chapter, this-- this law that was established back in 1969, have been not part of-- of the planning process. What I've seen in terms of the Council of Cabs is is that they're being told as opposed to being solicited for what they could offer in terms of opinion. One example in recent years was literally overnight the closure of N.C.B. with regards to their O.B. service. With the-- with the outreach of the community and the

advocacy that it provided with the help of organizations like C.P.H.S. as well as the providers like (INAUDIBLE) and Doctor's Council, we were able to work through that issue and to help get it re-- reinstated. Another example in terms of looking at healthcare needs is what's been mentioned, is behavioral health. One of the things that I've seen local to Bellevue Hospital is that there's been closures of Cabrini, St. Vincent, and now Beth Israel, and the impact that that has had on the behavioral health population that Bellevue sees, it's becoming overwhelmed in terms of the emergency room there. You have stretchers side by side and patients waiting for beds, and the problem is is that in terms of they can-- ambulances can be put on diversion, but it's just simply a word because there's no place for these patients to go. And this is not just true in Bellevue, it's true throughout the corporation where you have-- or the system, as it's known now-- where you have behavioral health patients, psych patients coming. And the private sector has really turned its back on behavioral health in the sense that these bed closures are not going to be reopened anywhere else. And when you look at another example of that would be

Columbia Presbyterian, their Allen pavilion, they're closing their psychiatric division, reducing now 30 beds, or they're attempting to reduce 30 beds accordingly. And as was mentioned, this obviously has impact on social determinants of health with regards to housing, and actually also has impact in terms of the general welfare of the individual, in terms of compliance with their own other healthcare needs as well. So we need to really be looking at what are we doing with regards to behavioral health. There's other specialties that also go along with the public sector the private sector is not jumping to the opportunity to take advantage of, and that-- one of them is level one trauma status. And that's an extremely expensive framework and service to be provided, and-- and I've-- it's my belief that New York City Health + Hospitals does a really good job in terms of providing that service. But there needs to be resources available to facilitate that as well. But I think in all of this, and I-- and I think it has been mentioned in the questioning that was done, is with all the talk of privatization and outsourcing services through the years, one of the big issues, especially surrounding dialysis initially, and I

remember when Christine Quinn was health-- head of the health committee and she had a hearing on that, the CFO of Bellevue at the time said the reason that we had to privatize is that we couldn't get the reimbursement. And-- and jokingly, I remember being one of the people to testify next, I says well, if I just told you I couldn't do my job, then how many nanoseconds would I still have my job? So the point is is that we have to hold people accountable to do the services that need to be provided. We almost lost out on Medicare Medicaid monies because of poor central office control of finances, and it took the mayor's office to help us re-- to help New York City Health + Hospitals recruit those finances. Once again, the idea of accountability. In closing, I'm very proud of the colleagues I've worked with through the years. New York City Health + Hospitals is a jewel that needs to be further polished, not crushed and destroyed. Hopefully, moving forward this new leadership that's now in central office of New York City Health and Hospitals will further support and develop the exemplatory (SIC) services provided by New York City Health + Hospitals and provide the transparency that is necessary to work with the

community, and politicians represent the community, so you are the community. So and to-- in order to facilitate what we need to have done for a healthier New York, and you know healthy people 2020, healthy people 2020 in New York City. Thank you.

CHAIRPERSON RIVERA: Retired registered nurse. Do you have another title that you'd like to put on record? You're-- you're a board member, correct?

ANNE BULVE: I'm a board member of C.P.H.S., and I'm an N.Y.S.N.A. Board of Directors. I'm also full time faculty at St. Francis College in Brooklyn now.

CHAIRPERSON RIVERA: Okay.

ANNE BULVE: Yeah.

CHAIRPERSON RIVERA: Alright, well just wanted to get that on the record that you're busy.

ANNE BULVE: Thank you.

ANTHONY FELICIANO: Good afternoon. My name is Anthony Feliciano. I'm the director of the Commission on the Public's Health System. First, I want to congratulate Councilman Carlina Rivera in her appointment to this committee, hospital committee. I think a very needed and necessary committee that

needs to continue doing what it needs to do moving forward. Also want to welcome Dr. Katz in terms of ensuring hi-- this leadership in terms of working with communities, community-based organizations, and-- and front line workers around really improving and strengthening the public health system. You know, I hope that this hospital committee along with other committees in the city council will work closely with underserved communities and community-based organizations to change this narrative that we have in New York City. A two-tier, two-type of healthcare system. You know, we're talking about where the publics serve all and the others serve a few. And-- and there are real, true safety net private hospitals. We know that. And they also take the brunt of thi-- this (INAUDIBLE) taking care of communities that are very underserved. What I want to touch on, it is clear for us that the cost of large lawsuits to the public hospitals and the-- is a lot of how the privates are profiting as well. You know, there-- New York Health + Hospitals absorbs not only a social cost but also a-- a cost that gets evaded by the many privates, and you can see that example with just Bellevue and NYU next to each

other. They're adjacent to each other, and there's plenty of studies that have been done and that's in the-- my testimony that shows the-- the disparity in terms of who's-- who's serving who. We know like in New York State, you spoke (SIC) about it before (INAUDIBLE) It was set up to actually be distributed to hospitals according to the level of need providing that charity care, but the money doesn't follow the patient. And so we know there's an unequal, unfair distribution of those dollars. And so there's been plenty of analysis also that shows that. Thi-- this situation is very unacceptable. You know, the private provider must be forced to do their fair share, so I'm hoping that this hospital committee actually when bringing the privates really address that inequity. We talked about the city council being able to push for fair distribution of the state and federal funding, particularly mount more pressure on Governor Cuomo since he vetoed twice a bill that would not just help the public hospital, will also help other safety net facilities, not only in New York City but also throughout the state. And so that needs to be critically passed, and-- and I think the city council with this committee has a-- and the

health community and others pushing that forward. I think there's also-- to make a priority to create a more comprehensive uninsured care program that builds off of Action Health NYC. Action Health NYC and the mayor's task force on immigrant healthcare access recommended a direct access program for the uninsured immigrants, and-- and nothing has come since it. And the Action Health NYC pilot was cancelled. So a real funded (SIC) uninsured program would have a big impact on H-- on H + H, as I think is it (SIC) important for (INAUDIBLE) put that back on their radar. I think there's (SIC) also needs to be a more assertive role by the city in studying some more local healthcare priorities. To-- to (INAUDIBLE) local health needs and demand that all providers work cooperatively to meet those needs for the people of New York, particularly underserved communities, low income communities of color. The city (INAUDIBLE) some type of local health planning body. Originally there was some push to-- to try to develop some legislation around this, and I-- and I look forward to see if we can revisit that. That would analyze healthcare needs, really provide a little bit a more assertive voice from the community around how those

resources are being used. In carrying out those functions also, we-- you've mentioned before about One City and the Envision 2020. These were two reports released by the mayor's administration and H + H. But they fall short in the following ways, and I'm hearing a little bit from Doctor Katz about what they're trying to address, and I see some slight direction change, but I still feel like there needs to be a little bit more addressing understaffing of H.H.H. facilities. That report did not do that. It didn't identify resources and funds to really expand primary care. It details long-term solutions to (INAUDIBLE) issues without looking at wait times and both medical, and I'm hearing Doctor Katz looking forward to addressing those issues. But it also didn't better connect and integrate (INAUDIBLE) project required even under the state's Medicaid (INAUDIBLE) to see how those connect. There seems to be we have H + H and then one city in terms of district, not a real connecting of where things are going to integrated (SIC). Particularly if you want to transform the healthcare system. I think we (INAUDIBLE) health advocates and other CBOs (SIC) have seen an inconsistency when it comes to H + H

(INAUDIBLE) include community and labor in decisions around our public hospitals. I'm not going to say that they haven't been convening, but it's been from advocacy of pushing for that, and it's been very inconsistent. So ongoing efforts to restructure H + H has to be-- is based sometimes also on a false premise that HHH is too costly or inefficient and that the solution to financial (INAUDIBLE) is to cut costs, and so we need to readdress that by bringing more community-based organizations, advocates, and even the patients in terms of the decision-making process. You know, I will say that we have to stop using financial problems as an excuse to reduce healthcare staff or closing vital services. You know, we talk about vulnerable hospitals, Metropolitan and others, making sure that not only the rumors don't come true in terms of a closing of those hospitals, is that the community is involved in that decision. And so it has to be conducted with a real, meaningful public input before any changes are decided or implemented. (INAUDIBLE) perfect example where-- where the service was closed, but then (INAUDIBLE) working relationship, the community-based organizations there and labor was able to sit down

and talk about how to market the labor and delivery services, and we saw drastic changes when there was an actual partnership or collaboration. You know so finally, it needs to be insurances (SIC) for all of us how that decision make process is done. I get concerned when staff gets cut at-- at Health + Hospitals. I understand that there was (INAUDIBLE) heavy in management, but how those decisions were made, how those roles are going to be substituted, what is actually going to be done, that wasn't part of I see the assessment. And so it concerns me when decisions get made without even understanding or being transparent how those decisions were made. And see, we're talking about H + H being rebranded. Now, with H + H it's more than just being rebranded. It is-- it is truly about changing the way decisions get made and where communities are involved in those decisions. Thank you.

JUDITH CUTCHIN: First I would like to say congratulations on your new role. My name is Judith Cutchin. I'm the elected president of the New York State Nurses Association, Executive Council for H + H (INAUDIBLE). I'm here today to represent the 9,000-- nearly 9,000 registered nurses that provide

the right care in our H + H system. I have a great deal of direct experience myself of the vital role played by the public hospitals in providing care and services to the people of the city of New York. My family receive their care from H + H, I myself receive my care, I was born at Kings County Hospital, I've worked a-- as a front line wor-- nurse at Woodhull Hospital for the last 27 years. The New York City Health + Hospitals system is undoubtedly facing a serious financial crisis, which projected operating deficits that reached as much as 1.8 billion in the fiscal 2020. These deficits could be further affected by ongoing efforts of the Republican Party, congress, and President Trump to slash Medicare, Medicaid, and repeal and undercut Obamacare, all to pay for the huge tax cuts for the rich. It is clear to us that the problems faced by H + H are not because it is an inefficient public system or because its labor costs are too high or because its quality of care is not as good as the private hospitals. The reason that H + H loses money is because it carries the largest share of providing care for people and communities and types of service that are not profitable and that the private

hospitals have no interest in taking. New York City H + H not only provides a very high share of care for uninsured and Medicaid patients that are not reimbursed, but it also provides very high shares of costly level one advanced trauma services, in-patient psych services, substance abuse, chronic health conditions that are not fully reimbursed. We provide services to communities of color and other populations that the private sectors won't even touch. They're not interested in those patients because of the lack of insurance. In taking these vital roles, we are not only losing the money because of that, we are enabling (SIC) the private hospitals to make huge profits on the more lucrative services that they advertise on T.V. 24 hours a day, seven days a week. Nurses and other front line providers know what needs to be done to fix the financial problems of H + H, and we believe that Doctor Katz and the new leadership of H + H also know what needs to be done. That includes you. First, we must not cut services to-- and slash our staff. This will not fix the budget problems. The quality of care that we provide at H + H is of high quality. If we slash the staff, that will decline. Patients who have

insurance will leave and go to other financial-- or insti-- institutions, which will further cause financial problems for H + H. Second, we need to invest in expanding services so that the quality of care is maintained and improved so that more services are available and that the wait times for patients to be seen get shorter. I am the head nurse in the ambulatory clinic in specialty, and wait times can be up to four hours. This goes to patient experience. It goes to staff experience as well. People will resign, people leave, patients don't come back. This will bring more patients-- if we do expand and-- and-- and put the time in, thi-- this will bring more patients into the system, allow us to keep them because they know they will be receiving the high quality care that we provide. Third, we need to stop wasting money on expensive consultants and outside contractors and for-profit entities that make money from taxpayers and don't do anything to improve the situation. We also need to look at what it working in H + H and what is not working. Where equipment is lying around, what can-- can we move it to another facility to use if this facility is not? Because that is a big waste. We use the (SIC)-- and then we

could take that money to hire more nurses and direct caregivers to be able to improve our services. Fourth, we need to stop listening to industry insider consultants for advice on how to address patient care in our community. Instead, we need to start listening to our patients, our nurses, our doctors, our staff, and other direct care healthcare workers and including them in the governance process as we go about fixing the problems in H + H. NYSNA, which is New York State Nurses Association, we support the efforts of Doctor Katz to expand and improve our patient care and services in the whole entire H + H network. In conclusion, I would urge the members of this committee and the council to support these efforts as well as to (INAUDIBLE) urge to look at H + H as a business that needs to be fixed by cutting costs and downsizing. Healthcare is a right, it is not a business. Cutting costs and slashing services is the wrong approach. It is an approach that will fail. It is an approach that will only make the problems worse and worsen our entire public and private healthcare system (INAUDIBLE) Thank you for giving me the opportunity to testify today.

KEVIN COLLINS: Good afternoon, and thank you for having this hearing. I am Kevin Collins, the executive director of Doctors Council SEIU, and we represent thousands of doctors in the Metropolitan area, including in every New York City Health + Hospitals facility, the Department of Health and Mental Hygiene, correctional facilities such as Rikers Island, and other city agencies. Our member doctors are committed to ensuring that H + H remains a quality safety net system for all New Yorkers. The front line doctors in the public hospital system have been at the forefront of providing care to all those who walk through our doors, regardless of their country or origin or insurance status. We welcome the new president and CEO of H + H, Doctor Mitchell Katz, and look forward to working together with him. Doctor Katz met with us and nearly 100 of our members just last week. He stayed for nearly two and a half hours, giving a presentation and answering questions. Most importantly, he listened. And Doctor Katz welcomed comments and suggestions on the issues doctors and patients face at Health + Hospitals and how we can make improvements. It is fair to say that doctors find a renewed sense of energy and hope.

Doctors Council supports empowering front line clinical staff to problem solve and grow our system. We support spending less money on consultants and administration and more on clinical care. Our doctors are happy to work together on solving the H + H issues so that instead of shrinking we can grow. The system may be faced with many challenges, but that creates opportunities for all of us to work together to improve the system for our patients and communities through an engaged and motivated workforce. And while we recognize that H + H's budget crisis needs special attention and that we are faced with a changing healthcare landscape, we strongly believe the answer is not to close, consolidate, or privatize facilities or lay off workers. If we want to keep the public hospital system to be a glowing example that serves all New Yorkers with quality care. New funding models are needed that respect the services and the care provided to underserved communities. We also need to ensure that communities and local stareho-- stakeholders are engaged in the future of H + H. The Blue Ribbon Commission Report stated clinical restructuring should reflect through community

assessment taking into account geographic access and other patient needs and include a process for community input and engagement. Community groups and the constituencies who rely on public health services must be consulted in this process. Recognizing in-- the need for innovation and best practices, these are critical for patient care and the fiscal health of the system, Doctors Council SEIU and H + H jointly launch an innovative partnership known as the Collaboration Councils. The purpose of these councils, both at the facility level and system-wide, is to provide front line doctors greater engagement with administration and a venue for direct dialogue to develop results-driven projects that will improve the quality of care and patient experience within H + H. Collaboration councils have already proven effective in helping enhance labor management communication. The collaboration councils synergize with the goals in the mayor's transformation plan. We believe they could serve a forum to look at new models such as integrating government and community-based social services with healthcare services in particular hospitals. We need to think about creative ways to engage with New Yorkers and bring

new patients into the system. We encourage the city to explore synergy between H + H doctors and the school health (SIC) program and to potentially pilot a program that allows H + H doctors to visit schools. As you may know, there are very few doctors working in the school health program today. This pilot could center around one public hospital in a high-needs community or several schools in the vicinity. Over the last couple of years, we've been extra focused on efforts to ensure equitable funding at the federal and state level. For some time now, we have called for adequately funding for our safety net hospitals by making them eligible for higher Medicaid reimbursement rates and ensuring that resources go where they are needed most and that the money should follow the patients. Yet money has continued to flow to large private facilities and hospitals despite their poor record of caring for the uninsured. We ask our council members and city hall to recognize this disparity and call on the governor to create a more equitable state funding formula in the state budget by ensuring that resources go where they are needed the most. Thank you for the opportunity to speak today.

CHAIRPERSON RIVERA: Thank you. I-- I just wanted to-- to thank you all. I know you mentioned a couple of things here, and you mentioned some of the beds that they were removing from some of the private facilities, and I wanted to just go on record that I know that the Certificate of Need program itself is incredibly complicated, and also besides the bureaucracy that surrounds it, a lot of people really don't understand how it can happen without real public input. So I know it is worth investigating, and it is on my radar, so I just wanted to let you know. The other thing was the formula you mentioned. I know that charity dollars, the way they're distributed, the way that safety net hospitals receive it, and that the fact that they're not a priority is an issue, and we're going to address that in-- in the coming months. Thank you for bringing up DSRIPP. For anyone that doesn't know, it's the Delivery System Reform Incentive Payment Program. That's very, very important, especially here in-- well, here in New York State. The wait times, the consultants, which Doctor Katz address a little bit, I know he's going to expand on that in the coming months as well, and really the

collaboration councils also, I think it's so important. I come from a background of-- of really priding myself on collaboration and working in coalition, and I think that's the only real way to fix this system and to restore the public trust in what is probably the most important system here in New York City. So I want to thank you all for your testimony, and I-- and I wanted to-- I know you-- you mentioned specifically that you had a chance to meet with Doctor Katz, and I wanted to ask, in-- in terms of your conversations, have they been addressing-- has Doctor Katz and his team been addressing some of your-- your biggest priorities, giving you answers, adjusting some of the staffing needs? One thing that's come up are the work titles and the corresponding duties, and I know I think DC 37 is here to also testify, but I wanted to know how the conversations are going in terms of communication and what you see as hopefully increased transparency.

ANNE BULVE: Part of the problem lends itself to it's a labor issue, and that's the decertification of titles. The role that I just retired from in-- in Bellevue was in nursing staff development. And in that title of clinical

instructor, there's actually four payroll titles that are doing the same job. Subsequently-- subsequently, they've basically done away with, as like when I retired, I'm not-- my position is not going to be replaced by another labor line.

CHAIRPERSON RIVERA: Hm.

ANNE BULVE: And subsequently it'll go into a management line, decertifying that role. But then it-- it-- then you lose-- it becomes very blurred in terms of what the actual function is of that individual. So the efficacy, the productivity, is not outlined. And it's very-- it's very blurred, and subsequently, in a time where you need structure for further development, you're losing that in terms of management. And then you know I-- I said this to Doctor Katz. Nepotism and cronyism has got to stop. And the idea of qualified individuals need to be placed in that role where you have consistency in terms of credentialing for these roles.

KEVIN COLLINS: And in terms of Doctor Katz reaching out, in his short time here we've met with him a couple of times, and he met with almost a hundred of our members for a couple of hours and stayed there and answered every question, and he gave

out-- as he has to all the employees in H + H, but he gave out his email address, and speaking with Doctor Katz after the meeting we had last week, I know many of our members have already been in contact with him, and he's had dialogue back and forth with them, and a number of our doctors have shared ideas about how to impro-- try to improve wait time, getting patients from the E.D. up to the floors, so I've-- I've found so far in the short time here to be very open and collaborative.

ANTHONY FELICIANO: Just within the district, since workforce development's highly important as well, besides with community-based engagement, the idea of new titles that are going to merge from transforming the health system, the trainings that-- or re-training of-- of workers is highly critical, but knowing how those-- those funds are being used, what facilities they're going to, all that helps as part of the transparency that needs to happen as well.

JUDITH CUTCHIN: New York State Nurses Association, we also had the opportunity to meet with Doctor Katz. I feel that he's-- he's very open, he's very fair, he's-- the-- the nurses had a lot of

questions, and he didn't brush off anyone even though some of the questions may have sound the same. He answered each and every person. So I'm confident-- I'm feeling very confident that his transparency, his openness and willingness and-- and his goal along with the collaborative team, we could actually turn around (INAUDIBLE)

CHAIRPERSON RIVERA: Okay. Thank you so much. Thank you.

JUDITCH CUTCHIN: Uh-hm. Thank you.

CHAIRPERSON RIVERA: We have one more panel. Thank you, everyone. Leon Bell, who's also from NYSNA, Moira Dolan from DC 37, Louise Cohen from the Primary Care Development Corporation, and Chad Scherer (SP?) from the United Hospital Fund. Thank you for your patience in waiting. (BACKGROUND VOICES) Yeah, red is-- red is good in this case.

MOIRA DOLAN: Red is good? Red is good. Good afternoon, Council Member Rivera and members of the committee. My name is Moira Dolan, and I'm the Senior Assistant Director in Research and Negotiations for District Council 37. I am testifying on behalf of Henry Garrido, our Executive Director. We are pleased that the council has

created a committee to examine and oversee New York City hospitals, both public and private. Healthcare is a major economic sector in New York City. Improving the successful provision of healthcare is an important goal for the health and wellbeing of all New Yorkers. In this hearing, we're focusing on the New York City Health + Hospitals system where 18,000 of our DC 37 union members work every day and night. In order to stabilize the financial health of New York City Health + Hospitals, the mayor invested nearly a billion dollars in tax levy money to support the ongoing provision of care since 2016. In exchange, the city wanted to see reform and transformation in the system. As a union, we have seen progress and as-- and difficulties in-- in this process. On the positive side, no unionized workers have been laid off, true to the mayor's commitment. He and the-- the city council recognize the critical value of the over 35,000 workers, our sisters and brothers who care for fellow New Yorkers every day in the labor and delivery room, the emergency room, or the mental health clinics. Without these workers that care for low income, medically needy, and uninsured would not take place nearly the rate that

it is now, and we would not have the good outcomes that we provide. Another positive is that the use of temporary workers is down across the system. Permanent workers provide stable care with knowledgeable, dedicated staff who have good wages and benefits. We want to see this continue. I'm going to ad lib a little bit since I heard some good things from Doctor Katz this afternoon. There has been limited movement or redeployment of staff so far, mainly only consolidation of small programs or centralization of finance and central supply staff. Sometimes staff have a change in physical location but often only a change in a cost center and a reporting structure. Eventually, that will effect the layoff unit and seniority status of some of our members, so we watch this very closely, and-- and we listen very closely when he talks about movement of administrative staff back to facilities because that affects people's transportation, and it may affect their seniority status. But we are in favor of-- of reducing administrative costs and-- and rental costs, although it's a beautiful view at 55 Water Street. Our main criticisms i-- is that up-- up until recently there has been heavy reliance on consultants

instead of directly engaging workers and managers on areas to improve. The consultants develop plans which are poorly communicated to the facility level. An example of this is the revenue cycle plan, which is an ambitious plan to improve billing practices as he described. The consultants developed it without talking to the workers, without getting worker input. There was a lot of talking to managers. There was a lot of fear of a consultant sitting by my elbow watching everything that I'm doing but not explaining to me what I was doing or what they were doing, and there have been role changes within title, but there is anxiety about what this means for people, and so the communication we hope will improve as it rolls out to the next several facilities. If we can achieve the additional 20 million dollars per month in revenue, that will benefit all of us. There's heavy reliance on overtime or on not staffing areas at all, and so all of this overtime is stressing out workers and-- and causing people to be getting sick. Areas that are direct patient care areas have not been subject to a hiring freeze, but there are very lengthy delays in hiring, which leads to more problems with wait time and stress for the remaining

workers. The areas that are not direct patient care usually do not get any replacement of lines when there's a retirement or a separation. Many staff do complain of stress due to overwork, of not being approved for vacation time, and of managers that are disrespectful. Certainly, we can understand that managers are probably more scared, or at least up until a few months ago there was-- there was several 400 managers who were laid off who were not represented, and so the remaining managers I'm sure are scared. Hopefully with Doctor Katz and-- and this different outlook that he's bringing, there will be more respect up and down the line. In the meantime, we did lose a number of staff with long institutional knowledge, and that has been hard to replace. For civil service titles that we represent, including clericals, there are a high number of people who are provisionally appointed. They are not appointed as a result of a civil service list, and so they have no security, even though there are outstanding existing exam lists and some of those same people who sit on the list are sitting at a desk, and they could be appointed. So that's-- that's an issue that we work with the facilities.

Another challenge we see is the flu crisis is testing the limits of many of our facilities, but it also shows the critical need for the public health system that serves everyone regardless of their ability to pay. We are encouraged to see the rate of staff immunization is much improved over the previous year. This year we're at 92 percent overall versus 75 percent last year. I think our members have realized that in these short staffing times they can't afford to be sick or-- or put extra burden on their coworkers by being sick. I won't go into the state and federal budget. That's been done and done. We do urge you to support the state legislative efforts on the safety net funds and to press for equitable distribution of any conversion or windfall funds that may be out there. We don't want to find out on March 30th, March 31st, some deal's been made and that we lose out again. As income inequality in New York City rises, we must find ways to fund and provide healthcare, including primary and preventive care, and it must be provided by the workers who themselves have steady, reliable jobs with good wages and benefits. And I'll just close with this brief story. Last November, on a cold and snowy day, Woodhull

service aide William Vega saw a woman in heavy labor getting off the bus in front of the hospital, across the street from the hospital. He ran inside and got a wheelchair and brought her directly to the labor and delivery floor where she delivered in front of the nurses' station. His quick action saved her from delivering in the freezing cold parking area. He's just one example of the dedication of all of our members in the Health + Hospitals system. We must protect these workers and patients for the good of us all. Thank you very much. I have to go to the Bronx. I have to go to the Bronx.

LEON BELL: Is this on? Yes.

CHAIRPERSON RIVERA: Thank you. Thank you, Moira.

LEON BELL: Thank you to the committee for hosting us today. My name is Leon Bell. I'm Director of Public Policy at the New York State Nurses Association. I'll be very brief. I just wanted to emphasize two points I think that were touched upon by various speakers today but which I think going forward bear you know-- are really important in terms of addressing the issues of the public health system. First, I think the issue that

needs to be emphasized and-- and looked at going forward is the interaction between the public hel-- hospitals and the private hospital systems. In many ways, this is a symbiotic relationship. The private hospitals are raking in roughly about 800 million dollars a year, the five big systems, 800 million dollars a year in profits. Even though they're nonprofits, I will use the term profits. Which is about the same amount that the Health + Hospitals system is losing currently, and in many ways they are able to make those large surpluses because of the role played by H + H, and in some-- in many ways they take advantage of H + H, and I think one thing to look at going forward, for example, Doctor Katz spent some time today talking about the need to improve billing. What billing is in the hospital setting is really coding based on the diagnosis of the patients that come in, and if you look at the report, which we've distributed, and I-- some of you may have already seen, you know the-- there is clear evidence that H + H under codes for conditions, and-- and partly it's because of a culture, and that the private hospital systems are very adept at I won't say over coding because that's illegal, but coding to

the fullest extent permitted by the rules and regulations. And one-- one area where that symbiotic relationship could work to the benefit of the Health + Hospitals system, and something that the committee might want to consider, is to pressure or force the public-- I mean the private systems to provide technical and technological assistance to H + H in order to get its billing up to the levels that the private hospitals employ, which could bring hundreds of millions of dollars into the Health + Hospitals system. It would be s-- sort of creating a-- some sort of sister hospital program or something. Something to explore. The second thing I think I just want to mention is on the enhanced safety net legislation. Doctor Katz mentioned that he-- he didn't really have a solid figure on how much that might mean for Health + Hospitals, and I think he threw out a nu-- number four million. I think the importance of that legislation is to at least start to change the political dynamic in terms of how the state of New York distributes not only (INAUDIBLE) funds but also how they distribute DISH funding and a whole bunch of other funding streams in a way that-- that channels the money to the hospitals that most

need it. The safety net definition that was used under the DSRIPP program, for example, qualified I-- I don't remember the exact number, but pro-- approximately 140 out of 180 hospitals in the state of New York met the criteria under DSRIPP for safety net providers. And we think it's kind of ridiculous that-- that any money that's intended for safety net hospitals are providing uncompensated care to uninsured persons or to large numbers of Medicaid patients should be going to a hospital like NYU in any amount, you know which-- which registered a profit I think of 325 million last year. And why they're getting a cut of those-- those funding streams that are intended to help hospitals that are financially strapped because of the large numbers of uninsured or underinsured patients that they are providing services to is really beyond-- beyond comprehension. So I think the importance of that legislation is not that it provides a specific number but that it changes that political dynamic and puts on the map the concept that the money should flow to the hospitals that provide the services. And with that, I guess I will pass the baton. Thank you.

LOUISE COHEN: Thank you. Good afternoon. My name is Louise Cohen. I'm the CEO of the Primary Care Development Corporation. Congratulations on your appointment to this committee. We think this committee is a really needed one, and we're glad to have it. I would also just like to say that my family and I have also used-- spent a lot of time in the Health + Hospitals system, and the-- the Bellevue palliative care team, I'm here to tell you, is second to none. So we think that this is a critical component both sort of from the point of view of the organization and also from the point of view of my family. The Primary Care Development Corporation was founded in 1993 by then Mayor David Dinkins and a visionary group of health and civic leaders where (SIC) a not for profit community development financial institutional, a CDFI, that has partnered with the city of New York for 25 years to catalyze excellence in primary care for millions of New Yorkers in neighborhoods all across five bor-- the five boroughs. You have my testimony, I'm not going to read the whole thing, but I want to focus a little bit on the issue of the primary care infrastructure which we think is

critically important. Our mission is to create healthier and more equitable communities by building, expanding, and strengthening primary care through strategic capital investment, practice transformation, and (INAUDIBLE) advocacy. We believe that every New Yorker in every neighborhood should have access to high quality primary care. Just alone in New York City we have helped finance more than half of the community-- the federally qualified health centers in the city in terms of building out new space, and nationally we've invested almost 875 million dollars in 130 primary care health center projects, and importantly leveraging five dollars of private investment for every one dollar of public investment. These projects have provided primary care access for millions of patients, created thousands of jobs, and brought new community primary care access to communities all across the country in underserved neighborhoods. 25 years ago when PCDC was founded, New York City's primary care landscape was bleak. There was a front page New York Times article that talked about the doctor deficit, and there was a study that showed that there were only 28 properly qualified doctors to serve a population of

1.7 million in nine low income neighborhoods in Harlem, North Central Brooklyn, and the South Bronx. Sounds a little bit familiar, right? That story also highlighted PCDC's founding to bring facilities to those very neighborhoods through a 17 million dollar investment from the city, and at the same time, you may not know, but then Mayor Dinkins also provided the Health + Hospitals Corporation with 48 million dollars in capital and operating funds to build 20 family health centers in 13 of New York City's most medically underserved communities in what was then called Communicare, which is now known as Gotham Health. While the New York Ci-- while New York City's primary care infrastructure has improved dramatically over the last 25 years, looming federal actions are creating a bleak outlook for the city's healthcare safety net, directly undermining healthcare access coverage and service delivery for millions of New Yorkers. This service is a critical time, and we thank you for having this hearing to talk about access and to accelerate the work to make sure that all neighborhoods have access to high quality primary care. We are very excited and applaud the vision of the-- of H + H's new president,

Doctor Mitchell Katz, to focus on primary care. His commitment to quote turn the nation's largest public healthcare network into an agency that focuses less on hospital care and more on primary care is right in keeping with PCDC's historic vision, not only in terms of the safety net but to improve the health of all of New York City's communities. We believe that primary care should be and is the heart of the healthcare system. High quality, affordable, accessible, and I really want to point out well resourced primary care is the key to healthier people and communities and to achieving health equity. Studies show that primary care costs-- primary care, excuse me, can bend the cost curve, but the costs for primary care will go up before the total cost of care goes down, and we think that-- that that's a really critically important point because as Health + Hospitals faces and deals with the financial deficit that it has, it must spend more on primary care, both in terms of facilities and in terms of service delivery, if it is actually to achieve the mission goals that it has, and we believe that this primary care does contribute significantly to important jobs in the community and to good career paths. HHC has

actually been a leader in healthcare reform, what many people call transformation of the healthcare system, which really fundamentally means transformation from a reimbursement system that's based on a per visit reimbursement to something that is more global that focuses on rewards for access, quality, and patient provider satisfaction, and we have been glad to work with H + H over the years to help them do-- do this work better. The entire premise of the healthcare system though, this healthcare reform rests on a robust primary care system, and without this primary care we know that families risk not only physical ill health but also financial distress as well. And therefore, we actually consider primary care to be a social determinant of health right along there with-- with housing and food-- food security and-- and reducing economic inequities. And just today, to point out, primary care in our healthcare system gets seven cents on the healthcare dollar. Reporting quality metrics alone costs 50,000 dollars per provider per year. Achieving a patient-centered medical home recognition costs about 14,000 dollars per physician or provider F.T.E., and to maintain it another 8,000

dollars per provider monthly. So the costs of maintaining a really high quality primary care system are substantial. And while today there are some resources from the DSRIPP program, as you-- you know, that program will end soon, and those dollars will not be sufficient into the future to maintain the system. So as the health reform discussion has evolved, primary care has been expecting to enter into the payment arrangements aligned with the outcomes we all want to see, and the One New York report talks about this. But we do want to caution that this idea that the primary care system in itself will have what is called downside risk. In other words, they will be responsible for the-- for the rising total cost of care, is actually kind of a dangerous path to go down for primary care, so we definitely urge looking at the need to fully resource-- particularly fully resource H + H, and we really appreciate both the administration but also the city council's commitment to-- to funding H + H, and-- and not withstanding the enormity of the task in front of Doctor Katz and his staff and the seven point plan that he has developed, which I think makes a lot of sense. I think that we should expect that

there needs to be continued city funding for H + H into the future, and we would su-- support that. So finally, I-- I want to say that-- that a-- a number of things in the One City report talked about the-- the physical infrastructure of the-- of the primary care system, and we support the investments that have been made by the city council, by the administration, to expand and build new community health centers and to connect more New Yorkers to accessible and quality primary care. The city's commitment to build five new primary care centers in Manhattan, Queens, Brooklyn, and Staten Island for H + H, as well as expanding services at existing sites in the Bronx, Brooklyn, and Queens, we believe this is critically important, and this along with the caring neighborhood support for non H + H facilities in which PCDC has been a financing partner with the city has already-- already brought significant new primary care capacity to communities, and this is a long-lasting legacy which we believe will im-- improve the health of these poor communities in New York City, and we stand ready to support Doctor Katz's education into the healthcare financing environment in New York City. PCDC has been a strong and willing partner to

the city across administrations. In addition to our technical assistance capacity, we have a var-- variety of financing mechanisms, and which can support new or renovation-- new facilities or renovating primary care facilities, which we have used to support new primary care facilities in East New York, the Rockwaways, the Bronx, East Harlem, Harlem Chelsea, just to name a few. We are most successful when we leverage our resources to partner with the city and with other entities to jointly finance projects for community primary care providers that do not have recourse to bank capital. In particular, we believe that leveraging grant capital through city, state, or federal government programs, providing a percentage of debt to finance more projects will ensure that scarce public resources really are matched with private dollars to finance more and larger projects. Therefore, we strongly support the One New York recommendations to invest in new community care in underserved neighborhoods and to build primary care sites on vacant and underutilized parcels, both on H + H campuses and in the community, and we stand ready to partner with you

to make this reality-- this str-- strategy a reality. So thank you for the opportunity to testify.

CHAD SCHERER: Chair Rivera, my name is Chad Scherer. I'm Vice President for Policy at-- and Director of the Medicaid Institute at the United Hospital Fund. Thank you so much for the opportunity to testify today. UHF is a 139-year-old nonprofit dedicated to building a more effective healthcare system for all New Yorkers. Obviously, inherent in that mission is an interest in the sustainability of the safety net, and that's why we're here today to talk about H + H. As has already been noted a number of times today, H + H faces massive challenges on all sides, but from our vantage point, which is really an independent entity focused on the healthcare system as a whole but not in or of that system, we are truly independent, we think there's really reason for optimism. My written testimony goes into more detail, but I want to touch briefly on four points. One, increase in coverage is a very important goal, and we're all for it. That said, it doesn't necessarily mean through enhanced coverage that you're fully going to get to financial stability for H + H. Two, quality of healthcare services will be

what drives future financial performance. And at least on the in-patient side, and actually on the health plan side H + H is performing well on that front. Outpatient and primary care, I can't do justice to what Louise just did, but that's where expenditure growth is heading, and H + H is really working hard to transform that, as we heard from Doctor Katz, and we think that's important for meeting this new emerging reality in how the health system is working. And finally, H + H is really uniquely positioned to improve the health of communities in New York City. And as Doctor Katz talked about, you know the internal strategies and external collaborations that are already in place really make us feel that H + H is moving in the right direction on that front. So briefly on coverage, I-- I direct you to figure one on page three of my written testimony. We've talked about you know just how bad the payer mix is for H + H, but it really is stark when you look at it on a table and compare it to non H + H facilities. What-- you know as Doctor Katz said, Medicaid makes-- makes up a much larger portion of the in-patient amount of dollars at H + H facilities, and we did have a big uninsured decrease

already as a result of the Affordable Care Act, but when you look at these same numbers in 2013 and compare them to the 2016 numbers that I've provided, yeah, we do see additional people insured, there's less other in that category from the state hospital discharge data, but there's a lot more Medicaid even now than in 2013, and we know that Medicaid on the in-patient side doesn't fully pay the bills. So just getting more Medicaid people in the door might not be sufficient to-- to support H + H financial stability going forward. That said, I agree with Doctor Katz that a central plan, exchange, we need to get people in all types of coverage, but it-- it may not be the Panacea. In terms of quality, quality of care is always important to health systems and to their patients, but it becomes especially more important in this current context where we're in the shift to-- towards value-based payment. On the in-patient side, Health + Hospitals is very similar to its New York City peers across the-- the sta-- across the city in terms of a core composite measure of mortality outcomes for common in-patient procedures performed at H + H facilities. I think that's a good sign and something that H + H should think about promoting in

terms of the high quality provided, at least at the in-patient level, in its facilities. And we also have had a long relationship with H + H and their participation in UHF's quality in-- initiatives, especially our clinical quality fellowship program, which trains mid-career clinicians to become quality improvement champions in their own organizations, and we're fortunate to say that we have a number of those people that have been through our program and are true quality improvement champions in H + H facilities today. Primary care has been covered. We are also extremely excited about that. As we think about the broader market trend that's driving the change to primary cov-- to care, spending on outpatient physician and clinical services is now growing faster than in-patient spending nationwide. 5.3 percent growth in 2017 com-- on the outpatient side compared to 3 percent growth nationwide on the in-patient side, so I think we've hit that (INAUDIBLE) mark where we're going to see more and more spending outside of the four walls of the hospital. Doctor Katz and other folks have really messaged the need to focus on primary care, and we've done a lot of work in this space, especially with the

Department of Health and Mental Hygiene, and we truly believe it's the right thing to do. That said, it's not easy. Transforming primary care is hard. But it's really required to keep people out of the hospital long term, and keeping people out of the hospital is what's going to lead to financial stability in terms of value-based payment systems in the future. Primary care also has the potential to really transform health in neighborhoods, and that's a nice segue into my last point, which is we need to focus on health of communities, and there's a new buzz phrase that we've all been throwing around, social determinants of health (INAUDIBLE) what that means is the 80 percent of healthcare costs that can't be dealt with through clinical care. They are the behavioral, environmental, and social conditions that impact healthcare serv-- service utilization. To address social determinants effectively requires strong partnerships. Most of those partnerships will happen between clinicians at H + H and community-based organizations that can address those social needs out in the community. We've been fortunate to work with the pediatric clinics at Gouverneur and at Coney Island over the past year to identify and then

work with community-based organizations to do a social determinant screen and then connect families to services in hopes of promoting healthier early childhood development. We think that in general this partnership model holds promise for Health + Hospitals and the entire healthcare system as a whole, and we're really excited about the steps that we've seen Health + Hospitals put in place. One, working with other DSRIPP performing provider systems around a technology solution that can really enhance the connectivity between clinicians and community organizations around social determinants of health, and then there-- H + H's own couple of social determinant screen pilots that they're doing in three of their clinics, we think that is a very positive sign. As the council thinks about community health, I think we'd encourage them to think about how action on the social determinants can really benefit from cross-agency collaboration and how the council can help to break down some of the historical silos between H + H and other city agencies. They're all really working towards a goal of improved community health. Again, thanks for the opportunity to testify today. We really look forward to being a source of

unbiased information for this important new committee going forward, so thank you.

CHAIRPERSON RIVERA: Thank you. I also wanted to add Carrie Tracy from the Community Service Society. Thank you for your patience today.

CARRIE TRACY: Thank you for giving me the opportunity to speak. As you said, I'm Carrie Tracy from the Community Service Society of New York, and CSS is a 173-year-old organization dedicated to fighting poverty and strengthening New York, and I'm going to focus on talking about the important role that disproportionate share funding has for New York City's hospitals. As we've heard, DISH funding is intended to help hospitals that provide uncompensated care to low income patients, and we-- we know that Health + Hospitals is the largest provider in New York of care to uninsured folks and people with Medicaid. We also know that hos-- people of racial and ethnic minority communities are more likely to be insured through Medicaid or public programs or to be uninsured, and so hospitals that serve these communities have a really important role to play in eliminating racial and ethnic health disparities. So we recently published a report last month, which

you've got a copy of, called Unintended Consequences, and so we looked at how New York is distributing one part of the DISH funding. So New York distributes 3.6 billion dollars in DISH funding every year, and 1.13 billion dollars of that is through the Indigent Care Pool. And so nearly all policymakers agree that DISH funds should go to safety net hospitals, but then that-- you have to ask well, what's a safety net hospital? So we looked at some national organizations' estimates of what's-- you know how do you define a safety net hospital, and we looked at 2015 data, and we found that nine of the top 10 safety net hospitals in New York State were H + H hospitals, and 22 of the top 25 were located in New York City. So the question of how you distribute this funding has a really big impact on our study. And in 2012, New York reformed the Indigent Care Pool distribution formula to u-- so that now roughly 85 percent of it is distributed under an accountable formula. But at that time, the law included a three-year transition collar to give the hospitals time to adjust. And so it limits how much they can gain or lose under the new formula, and then in 2015 that transition collar was just extended for another three

months. So that would expire in 2018 if no action is taken to extend it again. So we wanted to look at how that collar affected the distribution of funding, and we found a lot of things that I'm not going to make you listen to, but we did find that in 2015 it took three-- 138 million dollars from 54 losing hospitals and distributed it to 93 winning hospitals, and the losing hospitals on average provided half as much care to uninsured patients who qualified for financial assistance as the winning hospitals, and-- and we think that's really important to consider that. So while public hospitals in New York right now, the way that the DISH funding is distributed, they're receiving as much as they can under federal law. When the DISH cuts go through, it's New York City Health + Hospitals that's going to get hit first because of the way that the funding is distributed. And so as we heard, the DISH cuts got pushed back for two years, and they'll be even bigger when they do take effect, so we think that it's really important to take the time that we have to figure out how to best spend this funding. And so we recommended in our report that the transition collar not be extended again, that the new more accountable formula take

effect immediately, and that New York examined ways to make sure that, as we've heard so many times, the funding follows the patient. That there's a more accountable system like Massachusetts has, other places have, where hospitals that provide care at a discount or for free to patients who need it actually are the hospitals that receive this DISH funding. So Governor Cuomo's executive budget does extend the transition collar for one year, and his-- his staff said that they're doing that so they can have time to consult with stakeholders and hospitals and figure out a-- a new distribution formula, and the-- his State of the State Address also said that they'll be looking at having just one-- one more uniform for-- application for hospitals to use to eliminate some of the barriers that hospitals are kind of setting up for patients who would qualify for financial assistance. So we just wanted to make-- to make you aware of these findings and hope that you'll be mindful of that in-- in the coming time. And there's a couple of maps in my testimony as well that show how the hospitals that received windfalls over three years through these-- the transition collar and some

of our safety net hospitals that took big losses under the transition formula. So thank you.

CHAIRPERSON RIVERA: Thank you. Thank you so much for-- I know you all covered a lot. I know Moira's not here, but the use of temporary workers, sharing her story about William Vega, the consultants and the work that Doctor Katz has done thus far to eliminate the excess of funds that we feel go into consultants' pockets, and of course utilizing the-- the-- I guess improving really the public and-- and private relationship, and perhaps even looking at what they're doing to improve our own H + H internal systems. Of course, the capital funding and our commitment to H + H, I will do everything I can to try to really encourage the financial stability going forward and looking at what DISH cuts are going to look like in the future, and then of course looking at other places and-- and what they're doing and seeing how we can implement that as well. I want to thank you all again for-- for staying with us this long, and of course to Doctor Katz, I see you still in the back listening. Copious notes, I'm sure. Really reinforcing everything that you've been discussing with a lot of the people that

are here in this room and-- and citywide. I know that we have to increase and accelerate quality access to healthcare service and of course primary care. I think that's how we have not just transformation into what I think are going to be better patient outcomes but healthier communities. So I want to thank everyone for being here. I don't know if there's any other members of the public that wish to testify. You know you can always contact my office if you have any questions or any recommendations. I want to make sure that you know my door is wide open and that to keep communicating. I'm looking forward to a term filled with exciting hearings based on very nuance issues and then broader issues, and of course keeping the financial health of Health + Hospitals on its way to really just taking care of us all. So thank you, everyone, and with that, this meeting is adjourned. (Gavel) (BACKGROUND CONVERSATION)

# C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.


Date March 29, 2018