CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

OF THE

COMMITTEE ON HOSPITALS JOINTLY WITH
THE COMMITTEE ON HEALTH AND THE
COMMITTEE ON CIVIL SERVICE AND LABOR

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Friday, January 10, 2025
Start: 1:10 P.M.
Recess: 5:21 P.M.

HELD AT: Council Chambers - City Hall

B E F O R E: Hon. Mercedes Narcisse, Chair,
Hon. Lynn Schulman, Chair
Hon. Carmen De La Rosa, Chair

COUNCIL MEMBERS:
Committee on Hospitals:

Selvena N. Brooks-Powers
Jennifer Gutiérrez
Kristy Marmorato
Francisco P. Moya
Vickie Paladino
Carlina Rivera

Committee on Health:

Joann Ariola
Oswald Feliz
James F. Gennaro
Kristy Marmorato
Julie Menin
Susan Zhuang

COMMITTEE ON HOSPITALS JOINTLY WITH THE COMMITTEE ON HEALTH AND THE COMMITTEE ON CIVIL SERVICE AND LABOR

COUNCIL MEMBERS (CONTINUED)

Committee on Civil and Labor:

Tiffany Cabán
Erik D. Bottcher
Eric Dinowitz
Oswald Feliz
Kamillah Hanks
Julie Menin
Francisco P. Moya
Yusef Salaam

Other Council Members Attending: Brewer

A P P E A R A N C E S

Dr. Mitchell Katz,
President and CEO at NYC Health + Hospitals

Dr. Frances Quee
President, Doctors Council SEIU

Dr. Adedayo Adedeji,
NYC Health + Hospitals, King's County Hospital

Dr. Andrew Goldstein,
Health + Hospitals, Bellevue Hospital

Sonia Lawrence RN, BSN
Nurse at Lincoln Hospital; President of New York State Nurses Health Director, President of New York State Nurses Health, NYC Health+Hospitals/ Mayor’s Executive Council

Jennyfer Almanzar,
CIR SEIU

Dr. Roona Ray,
Vice Chair of the New York Metro Chapter of Physicians for a National Health Program (PNHP)

Dr. Sindhu Vangeti,
Postdoctoral Fellow at Icahn School of Medicine at Mount Sinai; Steward for the United Auto Workers Local 4100 UAW; Doctors Council

Dr. Deborah Shapiro,
Chief of Rheumatology at Lincoln Medical Center

Dr. Richard Sinert,
Director of Research, Emergency Department at Kings County Hospital

Dr. Joaquin Morante
Critical Care Physician at Jacobi Medical Center; Member of Doctors Council

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

Arthur Schwartz,
General Counsel of the Center for the Independence of the Disabled in New York;
Democratic District Leader for Greenwich Village;
Counsel for Community Coalitions to Save Beth Israel Hospital

Earl Kimmick,
Community Activist Advocate for the New York Health Coalition for the New York Health Act

Dr. Elizabeth R. Jenny-Avital,
Infectious Disease Doctor at Jacobi Medical Center

Dr. Lori Lemberg,
Primary Care Physician at Jacobi Hospital

Roberta Pikser,
Support for NYC Health + Hospitals' Doctors

Osendy Garcia,
Community Organizer -RE: Health + Hospitals and Vulnerable Communities

Anne Bove,
Commission on the Public Health System (CPHS)

Dr. Adam Hill,
Emergency Medicine Physician at Elmhurst Hospital; Elmhurst Bargaining Committee

Nicole DeNuccio, MSN, CNM, LM
Midwife at NYC Health + Hospitals/Woodhull

Dr. Jasmeet Sandhu,
Hospitalist at Elmhurst Hospital

Sean Petty,
Pediatric Emergency Room Nurse at Jacobi Medical Center

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

Dr. Gray Ballinger,
Primary Care Physician at Queens Hospital Center

Dr. Yogangi Malhotra,
Neonatologist at Jacobi Medical Center

Debra Bergen,
Former member - Labor Organizer,
Educator And Negotiator, Testifying in Support of Doctors Council

Osvaldo Garcia,
Member of the Public in support of Doctors Council

Dr. Cheryl Smith,
Primary Care Physician and HIV Expert at Gotham Health Center, Sydenham

Katherine McFadden,
Midwife; Former NICU Nurse at SUNY Downstate

Max Fisher,
Testifying in support of Health + Hospitals Doctors

Dr. Mamta Mamik,
OBGYN Department at Jacobi Hospital

Dr. Oluwakemi Adegoke,
OBGYN Provider at Jacobi Medical Center

Dr. Ahmed Amer,
Emergency Room Physician at Kings County Hospital

Pranayjit Adsule,
Psychiatrist at Jacobi Medical Center

Dr. Anna Liveris,
Trauma Surgeon at Jacobi Medical Center

SERGEANT AT ARMS: This is a microphone check for the hearing on Committee with Hospitals, joint with Health, and Civil Service and Labor. Today's date is January 10, 2025 – located in the Chambers.

(PAUSE)

SERGEANT AT ARMS: Quiet down, please, find seats.

Good afternoon, and welcome to today's New York City Council Hearing for the Committee on Hospitals, joint with the Committee on Health, and the Committee on Civil Service and Labor.

At this time, we ask that you silence all electronic devices, and at no time should you approach the dais.

If you would like to sign up for in person testimony or have any other questions throughout the hearing, please see one of the Sergeant at Arms.

Chair Narcisse, we are ready to begin.

CHAIRPERSON NARCISSE: (GAVEL SOUND) (GAVELING IN) Good afternoon, I am Council Member Mercedes Narcisse, chair of the Committee on hospitals. I'm joined by my colleagues, Council Member Lynn Schulman, chair of the Committee on Health, and Council Member Carmen De La Rosa, chair of the Committee on Civil Service and Labor.

Welcome to today's hearing where we will be discussing the ongoing challenges faced by the physicians at NYC Health + Hospitals, including concerns about competitive wages, working conditions, staffing shortages, and the impact on patient care.

As a registered nurse with experience working at NYC Health + Hospitals, I deeply understand the critical importance of having a well supported health care force. I know firsthand the dedication of our patients and health care staff, especially during the times of extreme pressure. The challenges we face in our public hospital system are significant, but we can address them if we work together.

I want to begin by acknowledging the tremendous work that New York City Health+Hospitals does every day. And to start, I have to say thank you to my friend, Doctor Katz, for making time to testify at this hearing. We appreciate your continued leadership and your commitment to serving our city's patients.

Despite the challenges we face, H+H remains a symbol for all New Yorkers, especially our most vulnerable populations. I commend H+H for its ongoing commitment to ensure that no one is turned away from receiving the care they need.

However, we must recognize that there are ongoing challenges, particularly for the physicians who play a vital role in delivering care at H+H. While H+H has made efforts to address staffing and compensation issues, there's still work to be done to ensure that our physicians are adequately supported in their work.

Today, we will be discussing some of the ongoing challenges that our frontline physicians are facing, including salaries, working conditions, and staffing shortages in our public hospitals.

These issues are amplified by the nationwide physician shortage with projections showing a shortage of up to 54,000 physicians by 2033, particularly affecting underserved urban and rural communities.

At H+H, these issues are particularly acute. Our physicians are stretched thin with vacancy in critical departments, which result in longer wait times, delayed care, and lower (UNINTELLIGIBLE) among staff.

We know that when doctors are overworked and undervalued, it doesn't just affect them, it ultimately affects patient care. It is clear that

addressing these concerns is crucial, not only to retain skilled physicians, but also to ensure that we continue to provide the highest level of care to our patients. After all, this is New York City, the capital of the world.

We are here today to have a constructive discussion on how we can further support our physicians through competitive compensation, better working conditions, and a more sustainable model for retaining our medical professionals.

I look forward to hearing from our witnesses and exploring solutions that will help us continue to improve the health of our health care system and support those who are in the front line of patient care.

Before I begin, I would like to thank committee staff, Legislative Counsel, Rie Ogasawara, and Policy Analysist, Mahnoor Butt, for their hard work, and, of course, in preparing for this hearing. I would also like to thank my staff Saye Joseph, Frank Shea, and Stephanie Laine for their work as we strive to serve this City Council and our constituents.

I would like to recognize that we have been joined by Council Member Zhuang, Council Member

Marmorato, Council Member Ariola, Council Member Moya on Zoom, Council Member Dinowitz, and Council Member Cabán on Zoom.

I know turn it over to my colleague, Chair Lynn Schulman.

CHAIRPERSON SCHULMAN: Tank you, Chair Narcisse, and thank all of you for joining us for today's very important hearing.

As many of you know, primary care is the cornerstone of a healthy community. It is the first line of defense against preventable diseases, the key to managing chronic conditions, and the essential element in ensuring that every person has the opportunity to lead a long, healthy life. Yet despite its importance, too many people, especially in underserved areas, continue to face barriers in accessing the care they need. At the same time, our nation is grappling with a significant shortage of primary care physicians.

According to recent reports, we face an alarming deficit of tens of thousands of primary care providers nationwide. This shortage is expected to worsen over the next decade, putting even greater strain on our already overburdened health care

system. The implications of this crisis are far reaching, longer wait times, increased emergency room visits, and a growing number of individuals without a consistent, trusted health care provider.

Here in New York City, we are not immune to these challenges. In fact, the need for accessible, high quality primary care is even more pronounced given our city's diversity, the health disparities that persist across different communities, and the unique challenges presented by our urban environment.

That is why the city of New York has launched the HealthyNYC campaign, an initiative that aims to tackle these issues head on.

HealthyNYC is not just about approving healthcare access, it's about creating a sustainable, equitable health care system that provides every New Yorker with the care they deserve, when they need it, and where they need it.

Through this campaign, we are focusing on strengthening and extending life expectancy of all New Yorkers by strengthening our primary care infrastructure, expanding the availability of healthcare professionals, and fostering partnerships

that bridge the gap between healthcare providers and underserved communities.

We know that quality primary care leads to better health outcomes. It improves early detection, encourages preventive care, and ultimately reduces the need for costly crisis driven interventions. But to make this a reality, we must address the underlying issues, chief among them the shortage of primary care physicians within our public hospital systems.

As we move forward with the HealthyNYC campaign, we are committed to working collaboratively with healthcare providers, policy makers, and community organizations to create a system that works for everyone.

By increasing the pipeline for primary care providers, investing in training programs, ensuring that physicians are adequately compensated, addressing physician burnout, and expanding access to care, we can build a healthier, more equitable future for all New Yorkers.

Thank all of you for your continued commitment to the health and well-being of the city and its residents. I look forward to a productive discussion

on how we can collectively address these pressing issues and ensure and ensure that every New Yorker has access to the care they need.

I want to conclude by thanking Chair Narcisse, Chair De La Rosa, members of the Administration, the committee staff, and my own staff for their work on this hearing.

Before I pass the mic on to Chair De La Rosa, I want to acknowledge that we've been joined by Council Member Bottcher.

I will now pass the mic to Chair De La Rosa for her opening statement.

CHAIRPERSON DE LA ROSA: Thank you, Chair.

Good afternoon, I am Council Member Carmen De La Rosa, chair of the Committee on Civil Service and Labor.

I'd like to start by thanking Chair Narcisse and Chair Schulman for convening this hearing and for their commitment to ensuring that all New Yorkers have access to high quality health care for all of their medical needs.

Today, we will be discussing the potential upcoming work stoppage across four New York City Health + Hospitals locations.

The Doctors Council, the nation's oldest and largest union of physicians, recently voted to authorize a work stoppage to shed light on the challenges caused by the current under staffing crisis.

In in a recent press release by the Doctors Council, the union pointed to reductions in sick leave, cuts to benefits, high rates of burnout and stress, and contract negotiations that have eluded an agreement since September of 2023.

Understaffing is not an issue that is unique to New York City's public hospital system. Unfortunately, low recruitment and retention rates have been reported across the country while coinciding with the aging population that requires consistent medical services.

Understaffed hospital systems lead to overworked hospital staff, which then threaten the quality of care that each patient is able to receive.

Physicians in New York City shoulder an incredible amount of responsibility and do so with grace and selflessness. We are extremely grateful to them for their service to our city of over eight million patients. In a city where the cost of living

is a 130% higher than the national average, these doctors deserve a competitive salary that addresses increased cost of living, robust benefits, mental health, and mental health supports. This will give them the peace of mind knowing that New York City's health care system can deliver high quality care even when a physician takes a sick day.

We understand that negotiations are ongoing, and we respect the limitations on what can be discussed today. However, we would like to take this opportunity to better understand the concerns that doctors have with their working conditions, learn about the mechanisms in place for physicians to request and receive help when they encounter physical, mental, or emotional challenges, and try to determine what impact a potential worker strike would have on our city's health care system.

I'd like to thank our committee staff, senior policy analyst, Elizabeth Arzt, and our legislative counsel, Rie Ogasawara, for their hard work in preparing for today's hearing, and I'd also like to thank my staff, James Burke, Kiana Diaz, and Fray Familia.

I now turn back to Chair Narcisse, thank you.

CHAIRPERSON NARCISSE: Thank you, Chair. I would like to acknowledge that we have been joined Council Member Gennaro.

We will now be hearing testimony from representatives from the Administration. I now turn to committee counsel to administer the oath for the panel of our administration officials.

COMMITTEE COUNSEL: Thank you, Chair. We will now hear testimony from the Administration. Before we begin, I will administer the affirmation.

Panelist, please raise your right hand, and I will read the affirmation once, then call on you, Dr. Katz, to respond.

Do you affirm to tell the truth, the whole truth, and nothing but the truth, before this committee, and to respond honestly to council member questions?

DR. KATZ: I do.

COMMITTEE COUNSEL: Thank you.

CHAIRPERSON NARCISSE: Thank you, Dr. Katz, now you may begin, thank you.

DR. KATZ: Thank you, Chairwoman Narcisse, Chairwoman Schulman, Chairwoman De La Rosa, and members of the committees on Hospitals, Health, and Civil Service and Labor. I'm doctor Mitch Katz, I am

the president and CEO of New York City Health + Hospitals, and I'm also a practicing primary care doctor. Thank you for holding this important hearing.

Health + Hospitals has an amazing group of physicians. Our physicians are well trained and deeply committed to taking care of vulnerable populations. Many of them have told me about their own experiences as children growing up in immigrant families where they, uh, took their own parents and other relatives to New York City Health + Hospitals facilities and made the decisions as children that they were going to work at Health + Hospitals as their way of giving back to the city. We are absolutely committed to them, and we are committed to paying a fair wage.

As, Chair De La Rosa said, the negotiations have been going on for quite a long time. All of the people involved on all sides, I think, have the same goal, which is a happy physician workforce, which, Chairwoman Narcisse referred to. We like to say happy doctors make happy patients and a vibrant health and hospital system.

I don't sense in spending much, uh, many hours, with our doctors, any difference in the goal. I think we all share that is the goal that we're aiming for.

I am very hopeful we began a mediation this week under the aegis of the mayor, and I think progress has already been made, and that I hope, although the number of issues, as you've referred to, is complicated, and I'll mention a few of the reasons why it is as complicated as it is, but I remain hopeful that with mediation, we will be able to resolve this.

So, in terms of understanding the complications so that we're all have a level understanding, the majority of doctors who work at Health + Hospitals are not employed by the City. There is a group that is employed by the City, but that is the minority.

The majority of our physicians are employed by four different affiliate groups. The largest affiliate group is PAGNY, the Physicians Affiliate Group of New York, which is a nonprofit that was created explicitly and solely for Health + Hospitals. It occurred... it was created at the time it was about 25 years ago when the City and some of the medical schools decided that they did not want to

work together any longer, and so PAGNY was created. And when PAGNY was created, all of the existing agreements that existed between physicians and, say, Columbia for Harlem, Jacobi, and Einstein, the New York Medical College and Metropolitan, Lincoln and Cornell, all of those agreements were then mirrored in PAGNY, which has had the complicated effect that PAGNY, which is just one of our affiliates, has multiple different agreements with each of the doctors' groups.

So part of what you hear, and Chair De La Rosa you had mentioned, you know, the sick leave and the... part of the issue is that each of the different groups have different numbers of sick days, different numbers of CME days, different numbers of vacation days, even different number of hours, which has caused quite a bit of both jealousy, because people say, well, but over there, they get three days, and we only get two days, or we get seven days five days. And so while I know it has not been easy for anyone, the goal has been to try to come up with a common work set of rules, which will make everything more efficient for PAGNY, which has to

maintain all of these separate agreements and to try to make it fairer to everyone.

And I recognize and, you know, I wanna be honest that everybody's face... everyone is not experiencing that, and I understand that, and I think that's important, and that's part of the goal of today's hearing is to allow an airing of that.

But that's the goal. The goal was to try to have the different hospitals have similar rules so that there was a sense of fairness and that it was easier, frankly, to administer. We also, have academic affiliations, NYU, Mount Sinai, and SUNY Downstate. So those are the four different affiliations.

So now going beyond the differences within PAGNY, we all want again, I feel both myself and the doctors who are going to speak for themselves, we all want to fair and equitable contracts. That's all of our goals. We all wanna be able to have salaries that enable us to recruit and retain.

All four of the affiliates have different arrangements, different salaries, different work hours, different pension plans, different numbers of days, different longevity bonuses. And so, it becomes extremely difficult to get to what we all agree is

what we want, which is fair and equitable contracts, and very easy to feel, well, this is unfair because the doctor over there is earning $20,000 more than me. And we don't want that, but it also isn't easy to then say, okay, but we have to look at what is their pension plan versus what you have, what is their hours.

And so, again, I just say this to provide some color on understanding that part of why this has been so difficult, even though we all share the same goal, is that we're starting in a very complicated place, and that I'm hoping that where we're going to end is both with more common rules, more common practices, there's less sense of jealousy, but in a way that everybody feels good about, which we haven't... which I acknowledge we haven't yet received.

Regardless of who our doctors work for, we are committed to them. We are committed both to their economic well-being, and to their, uh, well-being from a mental health point of view, from a physical health point of view, it's hard to be a doctor. It's hard to practice, a lot... I mean, everybody within the health care role has difficult aspects of their job, but a lot is expected of physicians in terms of

the ones to decide what the ultimate orders are, and especially in a safety net system where things can often feel more chaotic, where there may be less support staff, people do experience secondary trauma. Secondary trauma is when you're hurt because somebody else was hurt, because you couldn't get what you wanted for them. We've done our best both before COVID and even more intensely after COVID, to try to put in place the various supports that would enable our physicians to feel good and to be able to do their best work.

I think this is an area where there is more that can be done. I do wanna note, as one practicing physician through COVID, there was, and I think it's one of the things that's led us to where we are, you'll remember that there was a lot of talk about combat pay and rewarding the heroes. Well, my doctors, we went into the rooms, we put our faces right against the faces of people who had COVID at times when no one even knew yet whether or not the masks were effective. And at the end, there wasn't any economic reward for the physicians. I mean, I think there's... that our physicians should take a great deal of pride for what they did. There was a

state program that you'll remember that that did reward people, but it capped at a $110K, so no physician benefited from that program.

And I think that that sense of how people put themselves on the line, how people did so much during what was, you know, apocalyptic moments is part of why we are where we are today.

I know that besides the better mental health services and better professional opportunities, I know our physicians are seeking better compensation. I'm certain that there is not a single physician nor a single person at health and hospitals who came to us because we were the highest paying hospital.

We are a safety net system. We have never been the highest paying hospital. With the with the support of the mayor and the city council, and I wanna give a special shout out, to our nurse, Chair Narcisse, we were able to get equity for our nurses, but it was equity to the safety net. It was not the market that's available for nurses. It was a huge step, and I was told today that since then, and you'll be particularly happy, Chair, I asked just today, we have hired 3,659 nurses since that time, and we are almost at the end of any registry staff.

Today, Metropolitan Hospital, we met with them, is using zero registry staff. But that was to get to safety net, which is where most people within Health + Hospitals where their benefits are.

We have, over the last five years, invested through the affiliates in our physician compensation. The current average compensation of a physician at Health + Hospitals is $269,000.00, recognizing that there's a broad range with the top end very specialized surgeons. The $269,000.00 does not include most of our physicians; although, not all, but I'd say 80%, benefit from faculty practice income, which is an additional $20,000 to $80,000 depending upon the hospital.

But there is no question that salaries have grown for physicians across the city. Many physicians after COVID left practice or, you know, felt that they were going to at least cut down on their number of hours because of the traumas that people had during COVID.

We do work hard to try to find other ways of compensating people, and one of the things that I'm proudest of is that through generous private donations, we've been able to put together a loan

repayment plan for behavioral health, which is one of the hardest areas for us to recruit.

I love loan repayment, because it enables us to recruit effectively from the communities that our patients serve. The people who typically have the largest loans, so people who grew up in lower income settings, and so being able to provide them that additional loan repayment.

So, I wanna close and say that, I've been involved in much, 30 years, uh, with a lot of union negotiations. This has been particularly painful for all sides. We among the physicians, we are a kind of family, and sometimes families have issues that require mediation. That's not unusual. But I am very hopeful that with the mediation, with today's hearing, I think it's always good for things to have an airing and for people to have an opportunity to talk about the issues. We all learn from that, and I'm hopeful that we will soon be able to reach agreement with our physicians.

Thank you for your time and consideration and support of our physicians. Thank you.

CHAIRPERSON NARCISSE: Thank you so much, Dr. Katz.

I think we spoke about that many times, like saying the contract the different contracts, because we're human beings. So when we work together, we're doing the same work, and knowing that your partner is getting more money than you, and sometimes you probably do more than the other partner and the partner is getting more. So we know that in New York City you know how expensive that is to live in New York City. We can... I recall vividly there's a guy that was out there talking, you know, wannabe, uh, mayor of New York City and he used to say, "The rent is too damn high!" Even it's damn high for them too.

So, now since we get to that point, we cannot go backward. We have to reimagine. I understand most of the contract was drawn many years decades ago, but I think sometimes we come to a point where we have to think, and we have to be wiser in making decisions.

I'm not saying the other people... folks when they started was not wise, but we have a chance to make it better. So, I hope with that process I know you're not gonna answer, uhm, question about contracts where we are, but I'm saying like I'm hoping in the conversation that we've been having that is gonna be pushed forward to make sure our

doctors get contract that mid... in the middle. They cannot be too far. What I'm hearing the numbers are too far apart and it's wrong.

To get to some of the questions so we can get to, sorry... How will... how will the reduced appointment times - because we will hear a lot about the time from 20 minutes, 40 minutes to 20 minutes if I'm correct, right? - Impact the quality... how is that gonna impact the quality of care, particularly for patients with complex medical needs?

DR. KATZ: Right. Well, thank you.

So, again, nothing sometimes it seems in health care, nothing is exactly straightforward. So I wanna just make sure we're all talking about the same thing.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: A follow-up appointment has always been 20 minutes, and the vast majority of our appointments are follow-up appointments.

CHAIRPERSON NARCISSE: Okay.

DR. KATZ: New patient appointments have typically been 40 minutes.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: The change that we asked was that if people were taking new appointments, and not everybody is taking new appointments, because some people have already filled up their panel, but if you have not yet filled up your panel, we have reduced the 40 minute appointments to a 20 minute appointment.

But that does not mean... and, you know, I saw patients as recently as Wednesday under the same rules as everybody else. That doesn't mean that you have to spend 20 minutes with the new patient, because we're asking people to do eight visits in a session. A session is three and a half hours, eight 20 minutes is two hours and 20 minutes.

So you have three and a half hours to do two hours and 20 minutes of appointments.

That's important because you have to chart. Right? You have to fill out forms. Right?

So we would never... we would never use up the whole three and a half hours. Right? You have to give people time to catch up.

But asking people to see eight in an afternoon, is certainly well within the community standard. Many people in other federally qualified health centers

are seeing 10 to 12. When I looked up the overall US data, it's 11 in a session.

Asking people to see eight, is not unreasonable for the standard. But, again, I wanna go a level deeper and say, we didn't do this for money. We didn't do this to make people's lives harder. We did this because there were 20,000 people waiting for a new primary care appointment, because as Chair Schulman talked about, primary care is probably the most effective and least expensive way to provide health care to people.

So we have a long list of people waiting for appointments, and we recognize that people, if you once were going to spend 40 and now people have less time, we realize you're not gonna be able to do everything in that visit, and that's okay. We want people to address whatever is most pressing to that person and have that person come back again, and that's certainly what I do if I don't have enough time.

I would also tell you, and I think every primary care doctor would agree with this, I don't always know in my session who is going to need more time.

In my Wednesday session, it was a follow-up person with a very complicated social situation who needed the 40 minutes, and my new patient was very straightforward.

The point is it's really not, in my view, about a 40 minute or a 20 minute. It's about eight patients in a session -that's 20 minutes, eight hour... eight, it's two hours and 20 minutes; it's a three and a half hour session.

We ask that people do their best, recognizing that nobody can address every issue. That's... this has been studied, that if you total up all the recommendations that we primary care doctors are supposed to do for every patient, we would never sleep. Right? We would... because it's just not possible. So you do those things that are most important to your patient.

Final point about this is, and we think it's... this is a good airing and good for people to understand, and I... and I believe support, there are not enough primary care doctors to hire. Right? I... if any of you know primary care doctors, our salaries for primary care doctors are absolutely competitive with the market, we will hire them.

There is an absolute shortage in New York City and most of the country of primary care doctors. So the solution has to be to identify things that are currently being done by primary care doctors that could be done as well by somebody else in the team so that the primary care doctor can function.

So what we have done, and it's been a little bit uneven because any new thing takes a little bit of time, we have asked for other staff to do prior authorizations for medications, something I know I personally detest doing. I have spent 25 minutes on the phone with an insurance company in order to get them to agree to pay for a medication. And there's nothing in the rules that says it needs to be a doctor. Interestingly, nothing in the rules that says it has to be a nurse. It absolutely can be somebody, so long as the doctor or the nurse has explained what is the medication and what is the indication -the problem is you spend 25 minutes on the phone, because for one thing they don't answer for the first 15, and then you go through three different voice mail systems until you get to the person, and then their question is, what's your name? What's your address? What's your license number? What's the patient's

name? What's their insurance number? What's their date of birth? What's the medication, and what's the indication?

So our vision is, let's not have our primary care doctors do that. Let's have an administrator or a physician assistant do that.

Another example is same with MRIs and CT scans. Right? The physician can determine the order. The prior authorizations are about communicating the information. And, frankly, the real reason they created, the prior authorizations, is to discourage doctors from ordering the tests and ordering the medicines, because, generally, we know what indications they'll approve and what indications they won't.

If I had a patient who at this moment needed, uh, who I wanted to treat for obesity, I would know that the medicines used for diabetes won't be approved. I won't do the prior authorization. It won't be approved. On the other hand, if the person has diabetes, I know it will be approved, but it's still 25 minutes of my time.

So another example that we're working on, and many of you may have had the same experience, in the

private world, if you go to a primary care doctor for the first time, you'll be asked to fill out your information likely online, what medicines you're taking, what your prior diagnosis are. Right? That's something that we haven't yet achieved. So we, as primary care doctors, I'm asking you, please tell me what your medicines are, and I'm typing them in as you're talking. Right? It would be much easier for us to do a first visit if all of that information were already populated. Ideally, in my view, by the patient, that might mean that we would assign somebody to help someone who is not as high-tech in the waiting room to do it while they're waiting for their appointment. It could also be done by a nurse with the patient, things like allergies, smoking history, alcohol use. There is a large number of things where we are currently expecting doctors to do it. As long as there are enough doctors, that can be okay. But if there are not enough primary care doctors, rather than leave people on the waiting list, we would like to try to get them in for a visit.

CHAIRPERSON NARCISSE: Thank you, Dr. Katz. One thing, uhm, for the primary doctors, what are you

doing in your space where you are... where you are right now to help in that process? Because we know there's a shortage. And what are we doing? Are we creating a pipeline to H+H to make sure that we have in the future, more primary doctors? That's one.

DR. KATZ: Yeah...

CHAIRPERSON NARCISSE: Oh, you can answer that before.

DR. KATZ: We are. It is a national challenge. And, again, I think, you know, my heart, you know, I practice primary care, my heart goes out to, you know, the bravest people in my Health + Hospitals, I believe, are my primary care doctors who are doing nine sessions a week of it, because we are the ones who are expected to reconcile the medicines that every other doctor prescribes. We are the ones who fill out all of the forms.

CHAIRPERSON NARCISSE: I know.

DR. KATZ: One person, uh, this week brought me an SDI form, an SSI form, and a Housing Authority form in a 20 minute visit.

CHAIRPERSON NARCISSE: I know.

DR. KATZ: Because it was a follow-up.

CHAIRPERSON NARCISSE: Yeah.

DR. KATZ: Right? So, I mean, right, I'm going to need to fill that out at a different time than, but only the primary care doctors... We are the ones, we do all the cancer screening, mammography, cervical cancer screening, colon cancer screening. Right? Liver... I mean, that's what the prime... so we... we've created a world where the expectation is that the primary care doctors are doing everything, and that then when you have someone difficult, you send them to a specialist. That's good. But what we haven't done enough of, and this, again, is a national problem that people write about, is making the job of a primary care doctor more sustainable.

CHAIRPERSON NARCISSE: Thank you for that.

And you know for the follow-up, I'm still gonna hear from the physicians...

DR. KATZ: Of course...

CHAIRPERSON NARCISSE: that are going through the process, because (UNINTELLIGIBLE) to 20 minutes, and if you're working in the Caribbean community, you know by the time you ask the name, you take back to the Caribbean, to the ocean, to the all the things before they come back to tell you the actual thing that you asked. So it can be quite difficult when

you're doing assessment. We all know that because I have to do it myself. And even in a home care, I can tell you it was very difficult for me sometimes. Because I hear... I know the names of the cats and the whole family and the whole things before I can get to actual question.

So that can be quite difficult... who... it depends on the doctor and what's the setting.

In term of the medication, how far in proximity that doctor will be when they're doing the authorization? Because sometimes, let's say if you have a complex medication, somebody have no knowledge of medicine cannot answer the accurate question, and then that can put you to where you're gonna get a deny. Am I correct?

DR. KATZ: Well, if the doctor... again, there is the... you have to remember that the major reason the insurance companies create prior authorization...

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: is to create an obstacle.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: Because they know that most doctors won't wanna spend 20 minutes.

CHAIRPERSON NARCISSE: Correct.

DR. KATZ: My doctors will, but most doctors won't.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: And that's what the whole system is based on.

So, we wouldn't be asking someone else to... to decide what the indication is...

CHAIRPERSON NARCISSE: No, what I'm saying.

(CROSS-TALK)

DR. KATZ: Doctor would say, uh, say, we... what I do - so here's how it, uh, it works a little differently. In my... where I'm working right now, it's a physician assistant, and I say to him, I send a text, and I say, can you do the prior authorization for this medicine?

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: The indication is x.

And one of the reasons that this works well is that he batches them...

CHAIRPERSON NARCISSE: Okay.

DR. KATZ: because you will spend 15 minutes on the telephone until you get to the person... (CROSS-TALK)

CHAIRPERSON NARCISSE: You might as well... Mm-hmm?

DR. KATZ: So he holds them till the end of the day, and then he does them altogether.

If I do mine, I'm gonna have to deal with that 15 or 20 minute thing, as long as I'm clear to him what the indication is...

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: And, again, if you just remember, it's mostly about creating an obstacle because they could just as easily create a box that I would just check "diabetes".

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: I know in the case of the medicines that we're... the GLP one, uh, inhibitors, I know that if the person has diabetes, they're going to approve it. So why do I have to do... why can't I just check the box? Because that doesn't create an obstacle, and the insurance companies are trying to create an obstacle to expensive medications or expensive procedures, hoping that a certain number of doctors will say, you know, I'm sorry, your insurance won't pay for it.

CHAIRPERSON NARCISSE: Let me have a clear understanding. For you, you have PA. You can kind of, like, delegate that. But in the setting of the hospital where the doctor's working, do they have a PA or nurse practitioner or nurse helping them out to get those prior authorization?

DR. KATZ: So, yes, we've allocated money, and we've hired. What you'll hear and, you know, again, in a system of our size, which you know well, we have 34,000 employees, 10 hospitals, five skilled nursing facilities, 35 outpatients. Everything doesn't roll out smoothly.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: So you could, for example, have a case where we allocated money for a physician assistant to be hired, but just as we were hiring that physician assistant, a different physician assistant left. And so the new one we hired went to do that one, so right now, no. But in general, yes. And we are committed and, again, I think this has to be the right direction because, otherwise, we're gonna fall... we're have a longer and longer list of people waiting for primary care if we can't take things off the... (CROSS-TALK)

CHAIRPERSON NARCISSE: the doctors hands...

DR. KATZ: the table.

There are the things that that physicians, PAs, nurse practitioners who do primary care are great at is listening, examining, diagnosing, counseling. We don't have to do all the forms. We could create other ways of dealing with the forms.

Another example that we're, uh, looking at is, there is something called ambient charting. Ambient charting means that, uh, the, application, the computer application listens to the visit with the permission of the patient and the doctor and essentially writes the notes based on the conversation.

So it can hear it's like a transcript, like the transcripts that the city council has, so that you can actually have... and you can say, "I would like to order hydrochlorothiazide for my patient in a diagnosis... in a... in a quantity of 25 milligrams, send to the pharmacy, CVS, send 90 pills with three refills, and it will put it into the chart. The doctor will still have to read it all.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: Right? Because we know that AI is not a perfect thing, but neither are humans. Right?

So you get AI to write the notes, write the orders, then the doctor will read it.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: If the doctor finds it correct, the doctor sends it. If the doctor finds an error, doctor fixes the error.

CHAIRPERSON NARCISSE: We have to go through a lot of questions, but I can ask you many questions because I have been in the setting.

But one of the things that I... I'm trying to get clarification on is just who's assisting the doctor?

Because sometimes a person that assisting the doctor can cause more problem for the doctor if they don't have the full understanding. That's what I'm trying to get to that point.

Because, if you get someone that has no knowledge coming to help the doctor, they can get a form, but actually certain question they ask, they would not be able to answer unless they are in close proximity with the doctor to do the process.

DR. KATZ: So (INAUDIBLE)... (CROSS-TALK)

CHAIRPERSON NARCISSE: But I'm gonna get to the (INAUDIBLE) because I know it's a lot.

DR. KATZ: It’s alright, they’re always in prox... proximity. But you are wise, you understand that people’s talents vary. Right?

CHAIRPERSON NARCISSE: Yeah...

DR. KATZ: In the time... in the seven years that I have been at Gouverneur, I've had, I'd say, five permanent PCAs, and I, uh, person... patient care assistants, and I've probably, you know, had floated another five. They varied. Some could do everything.

CHAIRPERSON NARCISSE: We know.

DR. KATZ: Some had challenges. Most of us are average. Right? That's how average goes.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: But, in all these areas, we can... we can make it better if we... if this is our commitment. If our... if we continue to say doctors have to do everything, then we will not have enough doctors. And, again, this is not about money. This is purely about access.

CHAIRPERSON NARCISSE: I understand that.

Can you please share your understanding of how an understaffed workforce could affect the quality of care of the patients, for the patients?

DR. KATZ: Sure. Well, I mean, what... think about what we want for ourselves, for our family members when we go to see a health care provider. We want somebody who will listen. We want somebody who will listen with intention.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: We want somebody who cares.

I think there are many ways to show that you care. I don't... I don't think that I mean, again, people greatly vary, not everybody I mean, I take care of also at Gouverneur, working people who I can tell would like to get in and out of my office as quickly as possible, who I have, you know, no trouble seeing in five minutes because they have a job. They wanna know were their labs okay, blood pressure good, do you need any refills? Got it. And they... that's what they want.

I have other people who would like to talk for 30 or 40 minutes, because they have very complicated social situations, and they trust me.

And what you try to do as best you can, as a primary care doctor, is you try to see everybody in your three and a half hours, you try to allocate the correct time. But if it goes wrong, right, if people come in late, right, and so they... if someone, for example, comes in 40 minutes late, do you see them? Do you not see them? It's not an easy question.

On one hand, they made it to the clinic, you wanna see them. On the other hand, if they're now 40 minutes, it’s somebody else's slot, do you make everybody else late? Do you stay late?

Good primary care doctors do this. A typical thing I'll do is to say, yes, I'll see them, but tell them they're going to have to be seen last. And when I see them, I might say, we don't have a full appointment, tell me the most important thing today, and then come back and see me. Right?

That... we have an incredibly, and you'll hear from them, loving, committed group of people who recognize the challenges of our patients, and it is natural to want to do everything for your patients. That's actually even a good thing.

But as a system person, my job is to try to deal with the 20,000 people on the waiting list. And that

means talking to my doctors and others about, okay, well, maybe we can't today deal with everything that's important to the person. Can we deal with the things that are most important? I ask my patients, what's most important to you to deal with today? I think that may not be everything...

CHAIRPERSON NARCISSE: I know you're a good doctor; I can tell.

Uhm, we have been joined by Council Member Brewer and Council Member Menin.

It is our understanding that the Doctors' Council announced that their work stoppage will take effect on January 21st if an agreement is not reached.

How will H+H ensure uninterrupted patient care in the event of a strike, particularly in emergency department and critical care units?

DR. KATZ: Right. So I think at the moment there's no strike notice because of the arbitration. So... but the Doctors Council and our doctors do, and we respect their right to strike, have the right to strike with a 10 day notice. So, we recognize that. The... it gets missed. The strongest reason in my view for there not to be a strike is that, at the end of the strike, whether the strike is an hour, a day,

a week, you still have to have all the same issues, still have to resolve all the same issues. All the issues that are before us have to get resolved.

I don't see how a strike will change any of the issues. So that's why I'm hoping that through this arbitration, we are able to reach agreement and get everybody to see that, yes, it's... this is hard work, reaching an agreement, but that at the end of the day, if you think a strike is going to... again, I respect the right to do it, I just don't see how it will change anything. We'll have a strike. Okay, we'll have a strike a day, a week, a month. Then what happens? We still have the same hard work that we had before the strike.

In terms of the... how we would plan, we, when Woodhull had a water main leak, and we had to remove all of the patients, 223 patients in one day. We did that.

CHAIRPERSON NARCISSE: You did.

DR. KATZ: We are triage people.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: We, if there was going to be a strike, we would obviously cancel elective surgeries. We would cancel outpatient visits. We would still...

city workers cannot strike, as you know. So our nurses, our nurse practitioners, our physician assistants, all of our residents, and I'd say about, you know, I don't... I will say about 25% of our doctors who are, you know, in supervisory roles are not unionized. So that would be your workforce.

It is not known by anyone on either side of this how many doctors would still choose to come to work. As best as we understand it, there is not a strike fund. So a doctor who didn't work would not get paid on that day.

There is nothing wrong with the doctor authorizing their union to strike and themselves decide that they're going to work. How that would numerically work out, I don't know. I don't know whether that would mean that 5% of doctors would come to work if there were a strike 80% of doctors. I don’t know that anybody knows, it would probably depend on how everybody was at that at that moment in time.

We would obviously transfer sick patients in the ICU to other facilities. But, again, if we're not doing, uh, outpatient practice and we're not doing elective surgeries, you then have a group of senior

physicians who are the supervisors, the residents, the PAs, the NPs to serve as a additional workforce in the ED.

So, you know, I'm hoping not to do that, you know, but, you know, we will certainly make sure that everybody is safe. If we can't... if we don't run... we can't run safely, then we will transfer out. New York City is a place that is full of great hospitals and great hospital systems.

We're not anticipating that there would be a strike notice at all of our facilities. Some of them, you know, have not been, you know, involved. As we said, as you know, when we mentioned, right, the City did reach agreement with Doctors Council for City employed doctors. So all the City employed doctors, that are primarily at Kings County where you worked, right, they will all be at work and able to accept patients.

So we would get through it. I think the biggest, hard part would be the emotional part, frankly.

CHAIRPERSON NARCISSE: On the record, I worked for H, uh, Elmhurst. I did res... I mean, kind of did internship at in Kings County.

DR. KATZ: We're a family, and my doctors care deeply about our patients.

CHAIRPERSON NARCISSE: Yeah.

DR. KATZ: And a strike will be...

CHAIRPERSON NARCISSE: I know...

DR. KATZ: very painful to everybody.

CHAIRPERSON NARCISSE: It’s a calling, that’s what I said, being a doctor or nurse, so...

DR. KATZ: Absolutely.

CHAIRPERSON NARCISSE: So, I thank you. So you have a plan in motion if that happened?

DR. KATZ: Yes.

CHAIRPERSON NARCISSE: Okay.

I pray and I hope that does not happen because we don't need that. So we're going to make sure the doctors are happy.

How will H+H maintain care quality and safety for patients, especially those underserved communities during a potential work stoppage? I think you kind of geared to it. So, uhm, so you're going to do your best. You're going to make the plan in motion.

So now in regards to the face, to the physician who would participate in the work stoppage, what are the titles of the medical staff who assist? You said

PAs, nurse practitioner I think you said. And what credentials they have. For instance, are they registered nurses, physician assistant? I asked because I know it's a different level. I think you pretty much answered those.

DR. KATZ: Right.

CHAIRPERSON NARCISSE: Uhm, at this time, are you able to tell us which units at specific hospital or Gotham Health Centers will be most heavily affected by the work stoppage?

DR. KATZ: Well, at the moment, there's no strike notice. When... the strike notice that we appreciate, Doctors Council withdrew, included, Jacoby, NCB, Queens Hospital, uhm, as the facilities, and South Brooklyn Health. So those were the four facilities that were affected.

Doctors Council would have the right to put in a strike notice about any of the facilities that it has, assuming it has the appropriate votes. So it doesn't... they are not limited in a future to those facilities, but those were the ones that they put in the strike notice previously.

CHAIRPERSON NARCISSE: You know, I don't have any hospital. My closest, you know, is (UNINTELLIGIBLE)

And of course, King's County. So, therefore; it's become a personal, too. So I have to make sure that we can work something out. The doctors belong in the hospital, not outside the hospital. Right?

What training or support has been provided to other healthcare workers to prepare for potential disruption in physician availability?

DR. KATZ: Yeah, I don’t... I mean, we will... we can't... we're not going to have non physicians do physicians' work for... in clinical. I mean, I'm a big fan of non physicians doing administrative work for physicians, but not clinical work.

So we would instead be relying on the residents who are still, you know, coming to work, and the supervising doctors. And then as you know from your own work, nurse practitioners and PAs commonly work in emergency rooms. So it's not a... it's not a new scope of work. It might be a different site of where they're working, but everyone has to work within their scope. We're not gonna... we can't change the scope because of a strike. If we have to transfer patients out, we'll transfer patients out. If I mean, we... we'll... we will not operate unsafely.

CHAIRPERSON NARCISSE: Okay. That would be my last before I turn it over.

For the resident, you just mentioned the resident will come to work. The resident, like, when they work after certain hours, do they get extra pay? They can (UNINTELLIGIBLE)...

DR. KATZ: You legally cannot ask them to work extra hours...

CHAIRPERSON NARCISSE: Oh...

DR. KATZ: It's... They... There's a law on...

CHAIRPERSON NARCISSE: Yeah.

DR. KATZ: that limits 80 hours is the work week, so, uh, we would not, uh, ask them to work additional hours.

CHAIRPERSON NARCISSE: Because in some states, I think, like, if after certain hours, like, even your fourth year or third year or something, you can make some extra money?

DR. KATZ: Yes, it's complicated. I don't want to say... I'm not expert on... You are correct... in certain years... (CROSS-TALK)

CHAIRPERSON NARCISSE: I'm beat because I have kids...

CHAIRPERSON KRISHNAN: years, in certain in certain fields, you're allowed to moonlight...

CHAIRPERSON NARCISSE: Yeah.

DR. KATZ: I think you're allowed in New York to moonlight, but not at the same facility. It's a complicated issue.

CHAIRPERSON NARCISSE: Yeah.

DR. KATZ: But that... I... that is not a major part of our plan at (INAUDIBLE)...

CHAIRPERSON NARCISSE: Moonlighting...

DR. KATZ: Yeah.

CHAIRPERSON NARCISSE: It’s what we used to call it...

DR. KATZ: Yes...

CHAIRPERSON NARCISSE: back in the days...

DR. KATZ: Yes.

CHAIRPERSON NARCISSE: Alright, I am not going to pass it on to my colleague, Chair Schulman.

CHAIRPERSON SCHULMAN: Thank you very much. Hi, Dr. Katz.

DR. KATZ: Hi.

CHAIRPERSON SCHULMAN: Welcome.

DR. KATZ: Thank you.

CHAIRPERSON SCHULMAN: So, I want to talk about some other aspects of this. One is, can I... If we can go back to the panel for a second...

DR. KATZ: Sure.

CHAIRPERSON SCHULMAN: Uhm, who sets the timeframe for that panel? Is it H+H or is it OMB?

DR. HAYES: H+H.

CHAIRPERSON SCHULMAN: Does OMB have any say?

DR. KATZ: We haven't asked them.

CHAIRPERSON SCHULMAN: Okay.

Uhm, I just... Because I know they talk about productivity for other agencies and everything else, so that's why I wanted to figure out if there's any...

DR. HAYES: I mean... I... We would not be considered a high, productive system on...

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: primary care. We are not that even with the eight... we currently average seven.

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: Uh, is where we currently are. But I also agree, and you'll hear from our physicians more articulately, but I do it myself, so I know – our patients often have problems that go beyond their

hypertension or diabetes. And as you know well, sometimes that's the easy part. The easy part is my prescribing the hypertension and diabetes medicines. And it's meeting the other needs, and I think in a lot of other systems, nobody would care. They'd say, "I'm a doctor ,you know, I... I ,you know, ask someone else." My ,you know, very committed doctors came to Health + Hospitals to do this work, that's why they came. So, I think ,you know, anything that feels like I'm going to have less time for my patients who are homeless, my patients who are domestic violence survivors, my patients who in difficult family situations, feels bad, and I understand. I just would say, it also feels bad that there's people waiting for visits for whom we're doing nothing. So, let's... Let's do something for them, let's figure out what their number one problem is.

CHAIRPERSON SCHULMAN: Thank you.

So if... If a provider doesn't hit eight patients per session, what happens? Anything?

DR. KATZ: Okay. So first, I should say eight is scheduled.

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: That doesn't mean that you're gonna see eight.

CHAIRPERSON SCHULMAN: Okay.

DR. HAYES: Right? You're gonna see who's scheduled. We don't, discipline people...

CHAIRPERSON SCHULMAN: Mm-hmm...

DR. HAYES: on productivity.

1:00:06

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: What we try to do is to have a reasonable expectation, so we book you, so, I mean, a primary care doctor will be booked for eight appointments. They may or may not get it depending upon the number left without being seen. Since we've changed how we've done it, we've actually had lower left without being, uh, fewer people not coming, because we're scheduling those new appointments closer to the actual appointment.

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: And that seems to be resulting in smaller, you know, losses of people not coming. But, you know, we try to set expectations. We try to say this is what's a reasonable... for a gastroenterologist to do. This is what is reasonable

for a pulmonologist. But we, you know, we... and we try to counsel people who are outliers.

CHAIRPERSON SCHULMAN: Mm-hmm.

DR. KATZ: But we are we are not people who go around firing doctors because they they're at six, not eight.

CHAIRPERSON SCHULMAN: Okay, do the affiliation agreements are convoluted, as we know.

DR. KATZ: That would be the nicest possible word for it.

(LAUGHTER)

CHAIRPERSON SCHULMAN: We can talk all day, I mean, I as you know, I worked at Woodhull for a number of years in in the leadership, and I actually helped to draft the NYU affiliation agreement when I first joined Woodhull. So I'm aware... so and what I wanted to ask you was, so you talked about the different salaries, you talked about the different pensions - if a physician is burnt out or has some issues or whatever, is there... is the process the same across the board or it's dependent on what the affiliation is?

DR. HAYES: If somebody is in an FMLA kind of spot, then I'd say it's a legal issue. So it has to

be the same... (CROSS-TALK)

CHAIRPERSON SCHULMAN: Right, but, uh, but if they're... they have issues or concerns about their... their work hours, their, you know, that kind of stuff...

DR. KATZ: I'd say it's more even more individual than even the hospital.

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: Right? I think some people have better bosses who understand that all of us have good and bad days, and some people have more rigid bosses who say, “Well, I did it, so you need to do it too.”

We're trying to work against that old, you know, medical, you know, “I worked a 110 hours, so why are you grumbling about 45?” That's unhelpful to everybody.

CHAIRPERSON SCHULMAN: So how do you hold the bosses accountable since you brought that up? Because you've... we... you and I have had separate conversations about that, and you've been very good about trying to change the system in that way. So I'm just curious, do you go to the different... you or other leadership staff go to the different facilities, see what's going on? Do you hold focus

groups with some of the docs? I mean, I'm just curious.

DR. KATZ: All of the above. I mean, you may know from the years, one... in one of the famous times, you know, someone actually got fired during a board quality improvement meeting, which is, like, totally wrong. Right?

The whole the whole point is to not be punitive, right, to help figure out because we all make errors. None of us are robots. Right? I mean, I think that we have gotten to a, you know, less, you know, rigid, you know, more, you know, thoughtful... Are we are we perfect?

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: No.

CHAIRPERSON SCHULMAN: But, uhm, and there... and there's a... there's a process where people can go through to get to folks?

DR. KATZ: Correct, including anonymously

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: Which is one of the things we added because worried about retribution.

CHAIRPERSON SCHULMAN: Mm-hmm.

DR. KATZ: So now somebody can call a hotline and say, you know, this... this is what how I'm being treated, I'm being yelled at, I'm being belittled, and they don't have to reveal who they are.

CHAIRPERSON SCHULMAN: So I... my understanding is that if places that have a faculty practice or practice that is better for the physician, it's, uhm, so do all... how many of the facilities have faculty practices?

DR. KATZ: Now, with King's coming on, it will be all.

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: But Woodhull was late. That that was the next to last, and Kings is the last where we're setting it up. And, yes, I mean, it's a... the range, as I told you right now, it's between $20K and $80K. So and it can also vary based on your surg... whether you're a surgeon. Each... we... each group determines, uh, what the allotment is per doctor. And it is one, again, it's one of the complications because in any negotiation, we are looking at base pay. But then we also know people are getting the faculty practice dollars, which are real dollars, but people are getting different amounts of dollars. So

then how do you set... what is a fair base pay if people are getting anywhere between $20,000 and $80,000 in a faculty practice depending upon where they're seeing their patients? It's very complicated.

CHAIRPERSON SCHULMAN: Do the... so the chairs of the practices, are they selected by the affiliate or by H+H or it's a joint decision?

DR. KATZ: The medical group at the... so in your example, the Woodhull Medical Group determines it.

CHAIRPERSON SCHULMAN: Okay. So and what... what about the other facilities?

DR. KATZ: At every facility... (CROSS-TALK)

CHAIRPERSON SCHULMAN: (INAUDIBLE) facility...

DR. KATZ: the medical group within it's not PAGNY.

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: It's not NYU.

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: It's not... it's the medical group within the hospital that determines it.

CHAIRPERSON SCHULMAN: Do you put an emphasis... I know, having worked with a number of chairs, some of them have hands on, I know you're a hands on physician, uhm, do you try to push that, uhm...

DR. KATZ: We do.

CHAIRPERSON SCHULMAN: And encourage it?

DR. KATZ: We do. We do. But then sometimes they have the same issues of, you know, mental stress, feeling overwhelmed as everybody else has.

But, yes, we encourage... I did a big push when I came that I wanted all administrators to see patients because I believe in it. I think... that's what we are, and I don't accept the idea that anyone is too busy to see patients if you're a doctor. Right? That's what you train for. You should see patients.

So we ask all of the administrative doctors to see patients.

CHAIRPERSON SCHULMAN: Okay. Because it helps them to see through the eyes of the actual line physicians...

DR. KATZ: Yes...

CHAIRPERSON SCHULMAN: what’s going on in a particular area. So that's important because if you don't do it at all and you don't...

DR. KATZ: Correct.

CHAIRPERSON SCHULMAN: You don't sit with them, I mean, you don't... you don't really know hands on what's going on in... with them.

So, I want to ask you just a few questions about the 20 minute rule.

What metrics are being used to assess the success of the appointment, the 20 minute appointment policy?

DR. KATZ: So we've been doing ability to see new patients.

CHAIRPERSON SCHULMAN: Mm-hmm.

DR. KATZ: The continuity with existing patients, which is higher now, because it's helped us because it... the... what used to take two slots, by putting it one slot now, you know, gives us another slot for follow-up patients, and we have lower no show rates.

So, you know, the... that's what we do... what we're doing.

I think another metric that we're not yet up to is being able to say, and it has to do with the question that Chair Narcisse asked, being able to say in every single facility who is doing some of the admin work, and what are they doing, and quantitating that so that people can feel like, yes, you’re right, by doing x number of things, you've made my life easier, and that makes it more possible for me to see the additional person.

CHAIRPERSON SCHULMAN: Has the 20 minute appointment policy affected physician morale within H+H?

DR. KATZ: Well, I think from the doctors, you hear that you will hear yes.

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: I mean, they, uh, and, again, I have some insight. It can be overwhelming to be a primary care doctor. You feel like you're responsible for all the aspects of this person's care, and they're coming to you with all of these issues, and it can feel overwhelming.

And when you say, and now I want you to do one more thing, or now I want you to see someone you've never seen before, and I want you just to deal with just their, you know, most important issue, it feels wrong to people.

And I understand. And I... but I still think that the answer can't be 20,000 people on the waiting list. The answer has to be that we have to learn to practice differently by focusing on the thing that people need the most that day, recognizing that even if you haven't done everything, if we didn't do this, you wouldn't have done anything.

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: They would have just been on the list.

So, yes, you didn't do everything, but you did something, and you did the thing they cared most about. See them back. And by the way, we're gonna help you with these other tasks. But I understand, and I feel it.

CHAIRPERSON SCHULMAN: What kind of, uhm, so the docs, like, what, do they have a ton of paperwork to do? Do they, I mean, is there ways to alleviate that or, you know, I know, I mean, I was there a long... a while back, but in terms of AI, in terms of digital, in terms of anything that could be helpful to their experience?

DR. KATZ: Well, I think there's a lot that we can do. You know, 30 years ago as a primary care doctor, a common note on a follow-up patient would be "no triangle". Sign my name, and the triangle being no change. Right? That's not an acceptable model anymore. And now I open a record, and I have, like everyone who's seen the person in the last three months, I have to reconcile their medicines. I have to reconcile their diagnoses. I mean, it's a completely... and it's on me. The specialists feel,

well, I saw them for their heart, I wrote the nice heart note. Right? Whether that heart note then conflicts with everybody else's note, that's my job to fix. Or the patients, you know, who I see on... they come to me for their three-month follow-up, and they're on multiple nonsteroidal anti-inflammatories, because people keep adding them and no one tells them it's all the same. So all you're doing is poisoning your kidney if you're taking Ibuprofen, and you're taking Naproxen, and you're taking, you know, a third one. But how's the patient supposed to know? They're different medicines. That falls... that falls to us.

So, I mean, I think trying... you're on the right track, or at least this is how I feel - The answer can't be primary care doctors seeing fewer people; the answer has to be making it easier for primary care pay people to see patients without burning out.

And I think it's changing expectations. I think it's AI. I think it's making it more a team sport. It's making the patients... we've had some, you know, we use MyChart, and the happiest moment, and this often happens, I'm reconciling my medicines, and I see the patient, he or herself, has put in “not taking”. I love that. Right? That's the person who

should be putting in "not taking" it. Right? Because they... right, we want to reach a point where patients look at their own records, you know, and object... I love it also when patients object to their diagnosis. You know? And as soon as they object, I take it off. Right? Oh, yes, people will object to their diagnoses. And on MyChart, you can. You can write, no, I don't think I have this. You can write; I'm not on this medicine. But that's where this needs to evolve.

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: And people say, well, you know, our patients, you know, are not tech savvy, that's not true. Our patients all have a smartphone. There are language challenges, you know, Epic has not been as great as I would like them to be about other languages.

CHAIRPERSON SCHULMAN: Mm-hmm

DR. KATZ: Like, we have full translation on the computer version...

CHAIRPERSON SCHULMAN: Mm-hmm.

DR. KATZ: of Epic. So everything in Spanish on the computer version, not on the phone version yet.

So...

CHAIRPERSON SCHULMAN: Okay.

DR. KATZ: You know, there's work to do. You know, it's not... it's not... Epic has to do that. It's not us. Right? But they're, you know, again, 30 years ago, there would have been no computer, 10 years ago, nothing would have been in Spanish.

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: Right, I mean, it’s... the world is moving, but these are the directions we have to make it possible for people to meet the moment.

CHAIRPERSON SCHULMAN: No, absolutely.

And I, you know, I want to thank you for making sure that you can get the insurance companies to approve the medications because, I happen to have a physician that really pushed, like, way beyond what he needed to get... (CROSS-TALK)

DR. KATZ: And it worked, didn’t it?

CHAIRPERSON SCHULMAN: Yes, it did, yes...

DR. KATZ: Yes. See, that's what I mean, it's mostly an obstacle. It's assuming that you won't be able to find a physician who's willing to do that, even though it's the right thing. Because, of course, there's no reimbursement for that. Your doctor did

that because your doctor, he or she, is a good doctor, not because they got paid for that.

CHAIRPERSON SCHULMAN: And in fact, I actually I went somewhere, and the doctor didn't follow-up with the insurance company; I went to another physician who did, and I got the medication.

DR. KATZ: Yes...

CHAIRPERSON SCHULMAN: So...

DR. KATZ: The insurance companies also blame the doctors. What they write is, you... If you ask for a medication, and they deny it, they write, "Your doctor did not submit appropriate documentation."

CHAIRPERSON SCHULMAN: Yeah, I've gotten that back...

DR. KATZ: All that means is they decided that what the doctor wanted to use was not appropriate. Your doctor did submit appropriate documentation. They just decided that they didn't like the reason.

So but how, again, how the patient comes to you, and I've had that, "My insurance company says that you didn't put down the right thing." It's like, well, I put down what was honestly true. Right? I mean, I can't make up diagnoses. Right? I can't say you have diabetes if you don't have diabetes. Right?

I mean, I can't do that. But I can push, and I do, and I know our doctors do. And that is one of the ways that our doctors are different and why time causes more of a crunch than in a make money, fee the service, you know, churn people through, just get the dollars. That's not my doctors.

CHAIRPERSON SCHULMAN: You know, speaking of which, when you brought that up, what is, uhm, H+H doing in terms of the new federal government that's gonna take over in a couple... in another week or so, in terms of the federal dollars that H+H gets, and how is that gonna affect the doctors and patient care?

DR. KATZ: Right, well, I think it could be, you know, very difficult. I mean, on one hand, whether you're a Democrat or Republican, conservative or liberal, everybody cares about health care for themselves and their family.

CHAIRPERSON SCHULMAN: Mm-hmm

DR. KATZ: And, frankly, hospitals and drug companies and tech companies are big business. Right? And they are... right, they are interested in selling their drugs. They are interested in selling their stents.

So on one hand, I feel like there will be, you know, a push to keep that going. On the other hand, the interest in low income people and the various ways that, I mean, New York is unique because New York City, due to people like you, provide, uh, the same standard of health care, I can prescribe anything for an uninsured person that I can prescribe for an insured person. I mean, I can't prescribe anything. It has to be the right indication.

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: But as long as it's the correct indication...

CHAIRPERSON SCHULMAN: Mm-hmm

DR. KATZ: I can prescribe anything. I mean, that doesn't that doesn't exist in other places. I mean, there are, you know, San Francisco, Los Angeles, New York, you know, that's probably about it, where there is one standard of care in other places - People who are poor are just expected to get by with less. And I don't know if we're going to be able to get the same federal contribution that enables us, with your contribution as New York City leaders, to do.

CHAIRPERSON SCHULMAN: Okay. So the last question I'm gonna ask is what, you know, considering that

there's some difficulties and, you know, and the doctors are, you know, they just have a lot of... a lot on their plate and everything else. What do you do to recruit and retain high quality doctors?

DR. KATZ: Mission. I mean, the... at the end of the day, I think most people in jobs most reverberate with their mission, both what you're doing and mission... by mission, I also include, do you like the people you work with? You like the people you work with; you stick it out. But, several of you mentioned New York City is an expensive place to work, very hard for me to recruit anybody from out of New York, right, if I... to my system. You tell people, you tell them about the job, and then they look up what the rents are. Right? If you're not you know, if you're... if you've, like many of us, been here for a long time, it sort of works out. But if you have no family connection, New York City, very expensive place to live.

So, you know, I mean, the good thing is we have a great mission. A lot of people, you know, like the idea that they can provide care with one standard, and very few places would allow you to do that.

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: Uhm, to not have to make decisions based on somebody's insurance status. But we have to have also competitive wages. And, again, I think everybody agrees on that. I think the whole, you know, what we're trying to figure out is, in this context with these multiple affiliations and these multiple plans, what is fair compensation for... and I didn't even mention, right, we're not talking doctor, we're talking pediatrician, internal medicine, hospitalist, general surgeon, vascular surgeon, orthopedic surgeon, neurosurgeon, psych... I mean, so obstetrician, gyn... I mean, so we... in some areas, for example, the doctors may not agree, but I think there are some areas where we're at market. I think there are some areas where we're not at market.

CHAIRPERSON SCHULMAN: Mm-hmm

DR. KATZ: It turns out we don't all agree on which those are.

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: Right? And, again... and, again, it has to do with how you define the market. Do you mean what NYU and Presby are paying? You know, is that...

is that what the market is? Do you... is the market what you can hire someone today for?

What exactly is... there are various measures that you might hear about, but the measures are all self report measures of hospitals, and they lag in time. And there's no New York City one, there's Northeast doctors, there's a Northeast academic doctors, there's a Northeast non academic doctors.

Is that the standard? Is it what you can hire for? We all want the same thing.

CHAIRPERSON SCHULMAN: Right.

DR. KATZ: We just have to get to something that everybody can feel good about.

CHAIRPERSON SCHULMAN: Okay, well, none of us wants to see a strike, so I'm hoping that there's some kind of settlement that's done, fairly soon. And, I appreciate...

DR. KATZ: Me too.

CHAIRPERSON SCHULMAN: your responses. And I'll hand it back over to Chair Narcisse, thank you.

DR. KATZ: Thank you.

CHAIRPERSON NARCISSE: Thank you, Chair. And before I get to the next chair, I have one of the

nurses in the house that wants to ask a question, Council Member Susan Zhuang.

COUNCIL MEMBER ZHUANG: I do have some questions, I really appreciate the work you guys are doing, and also as a wife of a doctor, also primary care doctor, I understand how much they put in their work. I have to say during COVID time, I asked my husband, "Take off your clothes in your car before you get in the house," that I did to ask him, he did that during COVID time. He never complained because we have two little ones at home. I said, "I understand that you see a lot of patients, we love you, but still I want my kids safe."

So in that period of time, he's scared to come home because he want to protect his children.

DR. KATZ: I'm sorry, it was a horrible time. I'm sorry that you were subjected and your children, and I'm sure it was very hard on him.

COUNCIL MEMBER ZHUANG: Yeah. But in New York City (CRYING) sorry...

DR. KATZ: That's okay, many of us shed a lot of tears over those days. They were... they were horrible days.

COUNCIL MEMBER ZHUANG: In New York City, a lot of time, people feel like doctors make a lot of money. I can tell you from my personal experience, we even cannot pay for buying a house in our neighborhood. It is very expensive to live in New York City, and a lot of doctors love to work in hospital, but the salary just cannot work. Is there anything H+H is doing to help those doctors? And, also, do you think the doctor is trying their best to do their job? Then why 40 minutes should be changed to 20 minutes?

DR. KATZ: Right. Well, just on the last... I mean, we changed it because we had all these patients waiting, and we wanted... we felt that, isn't it better to do what you can do in 20 minutes than to leave people on a waiting list where we're doing nothing for them?

So we recognize that if people have to see more patients, they won't be able to do all the things. Your husband won't be able to do all of the things if he sees more patients.

On the other hand, is it possible that we can both help physicians like your husband with their admin work and is it helpful to, uhm, to focus on what does that new patient most need?

Because otherwise, if we say, well, but in 20 minutes we can't do anything, then they're just on a waiting list. So they're getting zero. Maybe they'll come in and they'll say, the thing I most need is - and you'll address that, and then have them come back when you next have a follow-up.

I... it's imperfect. It... I can't... but there... there is a world where people are... are seeing 10 and 12, and we're not asking that, we're asking for eight. Could it be six, and then we could spend more time? Yes. But you have to decide, where is your balance between access and how much you offer to that individual person?

COUNCIL MEMBER ZHUANG: Is this access... is it the doctor’s fault?

DR. KATZ: I’m sorry, say again?

COUNCIL MEMBER ZHUANG: Is this... the limited... because we don't have enough access to the doctor, is this doctor's fault? Who is responsible for that? Is that the doctor?

DR. KATZ: I would say that there's a national shortage of primary care doctors, uhm...

COUNCIL MEMBER ZHUANG: Then we need to fix the shortage part, not push the doctor doing more. Is that correct?

SERGEANT KOTOWSKI: I think that's fair. I don't... I don't have an immediate answer to how to do that. I mean, it's not a New York City specific problem; although, what you refer to, the cost of living here, and I'm sure many of my doctors will talk about that, is absolutely part of the issue, is that it's very expensive to live in New York City and raise your children. It makes it very challenging. I agree.

COUNCIL MEMBER ZHUANG: And is that... the doctor in New York City is underpaid...

DR. KATZ: I understand...

COUNCIL MEMBER ZHUANG: Uh, compared to other states.

DR. KATZ: Well, certainly, underpaid in the sense that it's so much more expensive to live here. Absolutely. Right, I mean, people could obviously, in a different place, afford a different life. New York City is a hard place for anybody to own a house.

COUNCIL MEMBER ZHUANG: What's the average salary for a hospitalist, primary care hospitalist, in New York City?

DR. KATZ: In New York City, it's in the, uh, somewhere between $225 and $250.

COUNCIL MEMBER ZHUANG: It's... compared to other state, it's much lower or much less... much higher or much less?

DR. KATZ: I think the major thing is that New York City doctor salaries are similar to everywhere else, but the cost of living here is outrageously higher. (TIMER CHIMES) And so the salary seems okay until you have to pay your rent.

COUNCIL MEMBER ZHUANG: So...

CHAIRPERSON NARCISSE: Uh, colleague, I have to say...

COUNCIL MEMBER ZHUANG: Okay...

CHAIRPERSON NARCISSE: sorry, because, the, uhm, Chair De La Rosa has been waiting, and that was her turn. So, I apologize, but we have to move on to Chair De La Rosa, thank you.

Chair De La Rosa?

CHAIRPERSON DE LA ROSA: Thank you, and I also want to thank Council Member Zhuang for sharing her

personal experiences, and I appreciate her comments and how hard and difficult it is for families contenting, uhm, across our city with, uhm, the conditions. And I want to thank you, Dr. Katz, for being here as well.

We have talked about the understaffing issues, uhm, we have heard some of the real challenges that you have with understaffing and retention, have you heard of any successful initiatives taken in other systems to improve recruitment and retention, for their staff?

DR. KATZ: Well, I mentioned loan repayment, we think, is a real one, that it's a real winner for all of us because it recruits exactly the people we most want to recruit.

And we have heard that one of the reasons people don't go into primary care is because they are coming out of medical school with hundreds of thousands of dollars of debt...

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. KATZ: and therefore need to, you know, pay off that debt. And so loan repayment is... and we, uh, we already have one, especially in behavioral health, and we wanna roll out another one, uhm, but,

uh, obviously, that doesn't deal with the doctor's salary who's 10 years in already. Right?

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. KATZ: That's more the... the recruitment tool for... especially for people with large loans.

CHAIRPERSON DE LA ROSA: So what would we need in New York City to make something like that happen?

DR. KATZ: We... we're working pretty closely; we think that we might be able to actually do it, uhm, so I'm hoping in the next few months that that's something we're able to come forward with. It's like everything else, it has slightly complicated legal things. What can you... right, we don't have indentured servitude. Right? You can't... so you have to figure out how you... how people... what can people be asked to do in terms of the commitment, right?

CHAIRPERSON DE LA ROSA: In a dignified way, absolutely.

DR. KATZ: Right. But you ultimately, you don't really want somebody who doesn't wanna be there. Right? On the other hand, you can't be paying people's loans off if they're, you know, for five years and then they're leaving you at one year.

So we're trying to we're trying to figure out some of the legal aspects of it. But I think loan repayment is one certainly very positive thing.

You know, just to give credit to your city council, I've heard a lot about trying to make New York City more affordable for the housing crisis.

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. KATZ: And I think we all agree that having minuscule vacancy rates drives everybody's rent up. Right? Because the competition, you know, at every economic level in New York City, seems so extreme that if we could build more housing successfully, it would, in fact, drive down the cost of housing, which would make it more possible for people to live here.

We also hear a lot, and I think the Council's done good work also on quality of education. I mean, that's a lot, that's the... after the affordability, that's the second question we have. You know, do... you know, is my kid going to be well educated? Right?

I'm a product of the New York City public schools. I got a great education. You know, we need to be able to deliver that.

CHAIRPERSON DE LA ROSA: Great. I'll come back to some of the comments you just made, but I did want to

ask a clarifying question: You've mentioned several times, as you respond to questions, and in your testimony, about a waiting list, can you shed some light on what that waiting list looks like?

DR. KATZ: We have a waiting list, uh, well, we... I don't know what it... where it is today, but prior, at the start of this, we had 20,000 patients waiting for a new patient appointment for a primary care doctor.

CHAIRPERSON DE LA ROSA: Okay.

DR. KATZ: And, again, just to distinguish, on one hand, you know, we're a triage system, if you need something, we'll give you something today, but that's via the emergency room. Right? So, and anybody who's sick, I mean, we have, you know, 11 great emergency rooms for people to go to. But in terms of connecting people to, you know, what Chair Schulman talked about, you know, primary care and why we think that is so important - we have 20,000 people waiting. And, again, partially, that's because if you're uninsured, you have very few choices.

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. KATZ: There are some wonderful FQHCs (Federally Qualified Health Centers) in the city, but

they also are having trouble recruiting doctors. And all of them would require more than eight appointments in a session. They have to because they can't make their margin otherwise.

CHAIRPERSON DE LA ROSA: Okay. I wanted to go back to the, uhm, comments around housing and other, you know, cost of living and other challenges that you have.

Other than increasing salaries and obviously hiring more staff to share the workload load, are there any adjustments that hospitals can make such as providing housing, improving benefits for employees that may help decrease attrition rates? We know, like, in the private hospital system, sometimes housing accommodations are made. What is the state of that for each?

DR. KATZ: I mean, we... there was a day when there was a nurse residence and there was a doctor residence. I think most cities have decided that we're not experts at, you know, running housing, uhm, in part... there... It turned out to have been some, like, awkward moments when the doctor didn't pay the rent And, like, do you evict the doctor who you expect to come to work tomorrow because they haven't

paid the rent? And I think most cities sort of got out of, you know, that business.

CHAIRPERSON DE LA ROSA: Mm-hmm.

I think, uh, it's important for all of you as thoughtful people to keep it in mind, these are issues that face all of my workforce.

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. KATZ: And so it's hard for me to ever... all of my staff are working at safety net salaries with safety net benefits. My staff are not working at private hospital - salaries and private hospital benefits.

Whether we have reached a point where the answer is that that only if we are paying the same salaries to doctors as the private hospitals are paying, how that impacts how we view nurses, other staff, you know, it's a complicated question.

CHAIRPERSON DE LA ROSA: Mm-hmm

DR. KATZ: In general, what I would say about Health + Hospitals is that we all agree, collectively, to work at safety net wages and safety net benefits. It's not uncommon for an administrator to come to me and say, "But I've looked up the market, and by the market I should earn way more."

And I say, but we're in this collectively together. We're all on safety net wages, different levels, depending on... but that's how it is.

And I think, I mean, maybe this discussion, you know, prompts a broader questioning about whether Health + Hospitals should remain on safety net wages across the board, it's challenging for me to figure out how... what equity means in this setting. Right? Is it... am I... is equity equaling, what private hospitals are paying doctors? Is equity paying doctors and nurses different wages, but similar kinds of, you know, safety net type? These are very complicated questions.

CHAIRPERSON DE LA ROSA: Mm-hmm. I appreciate that answer.

What positions have been experiencing the most attrition?

DR. KATZ: The most attrition? Our biggest holes, I'm gonna start with that, have been very specialty oriented, especially surgical specialties, in part because it's not unusual in New York, a urologist might earn between $1 million and $3 million in the private sector. And so, figuring out, you know, how you know, what makes sense, you know, in a safety net

type of system, can be very challenging. Things like urogynecology, you know, so these are... these are the ones that I just know we have trouble hiring. They aren't... they're relatively small. We're having a lot of trouble right now with OBGYN, because modern graduates of residencies are choosing to do specialty fellowships. The desire to do what we would call floor OB, being on the floor, regular OB, it's such a high risk, you know, enterprise. We find more and more of our own residents want to go into reproductive endocrinology, other specialized fields. And good for them, but hard for us. Same with psychiatry, uh, the ability for people to do meaningful work on Zoom, you know, doing therapy for people - and it's good therapy, I have nothing you know, people benefit from it.

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. KATZ: But then very hard to get people to want to work on a hospital ward with potentially violent people. So psychiatry has been a huge issue.

We've talked a lot about primary care. The way I view primary care is so many of us, and I think you'll hear from them, love the relationships that we

develop with our patients, and it keeps us where we are.

You know, an anesthesiologist can jump around for the highest salary, right, because they do a case, you're done with the case. They're never gonna see you again. Right? You're done. For those of us, whether you're a primary pediatrician or you're a primary internist, you hate leaving because you're leaving your patients.

So but, you know, I don't think, therefore, they should get paid less just because they have less sway in the market. But I think that's one of the reasons why primary care doctors and pediatricians get paid less, because we have less sway.

The radiologists, the anesthesiologists, they can just move for a better offer. We hate to move because then we'd lose... we have to leave our patients.

CHAIRPERSON DE LA ROSA: Can you share any data, or does H+H can collect the data in some way on how many hours of overtime were logged in total by physicians or registered nurses in the last few years, 2024, 2023, 2022?

DR. KATZ: Well, we could get you certainly, I mean, the nurse stuff is known. We don’t, I don't

have the figures. Just say a little bit about physicians - Physicians are FSMLA exempt, you know that from your civil service work.

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. KATZ: They do not get overtime. What we do is we pay sessional rates.

CHAIRPERSON DE LA ROSA: Okay.

DR. KATZ: So we create, you know, a... let's say you're a doctor on Monday through Friday, 8:00 to 5:00, but then you're going to cover in the hospital from 5:00 to 11:00, we'll hire you at a separate sessional rate.

And we move the sessional rates based on the market, what's necessary in order to hire. It's generally a higher rate because it doesn't... a sessional doesn't have separate benefits if you already have benefits. But there's no... strictly speaking, there's no overtime.

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. KATZ: But there is a large amount of sessional work. And Health + Hospitals wouldn't function, especially because think of it, we run five trauma centers, and they have to be covered 24 hours a day, seven days a week. So the people you're gonna

hear from often, you know, at great, you know, commitment and expense to their families, agree to work nights, weekends because there's no... you can't close a trauma center.

CHAIRPERSON DE LA ROSA: Yeah. And is there a tracking of this?

DR. KATZ: This we know how many sessional hours there are...

CHAIRPERSON DE LA ROSA: Okay.

DR. KATZ: It's a very large number.

CHAIRPERSON DE LA ROSA: in H+H?

DR. KATZ: Yes.

CHAIRPERSON DE LA ROSA: Okay.

Let me see. Has the City conducted any analysis on paid disparity within the workforce at H+H or their affiliates? And what kind of results did those analysis yield? And I know you explained that it's very complex...

DR. KATZ: Yeah, well, again, you know, it's the market moves, is another thing we didn't talk about. Like, it's a very dynamic market for hiring physicians. I mean, if you asked me what I think is the best way to tell the market, can you hire someone?

I mean, at the end of the day, when I get ,you know, after I've listened to 14 different arguments, I often say, okay, how long have you had that ad out? And if you've put out an ad for an OBGYN, and I think we typically, we're doing it at $275, and you haven't hired anybody, then by definition, it's too low. Right? I mean, in some ways, it's become the only thing that I feel I can really count on.

What's complicated there too, though, is better managers are better able to hire for all the reasons that you probably sought out employment with a boss you liked. And I bet your staff worked for you because they like working for you.

So it turns... you're always dealing with all of the... so someone will come to me with an ad and say, we've had this ad out, and we haven't hired anyone. And I'll know that at one of my other hospitals, we have no vacancies even though the salary is lower.

Why is that? Because they're all committed to this incredibly, you know, mission driven chair.

So whatever we're gonna come up with, it's not gonna be perfect. It's... also I would say it's easier in... to do it in fields that are comparable. It's like primary care and emergency medicine are...

the work is pretty comparable wherever you are - nine sessions of primary care, 32 hours of ED, but then when you talk about a rheumatologist or gastroenterologist, the jobs themselves can be so different. This one is doing procedures all day long. Procedures pay better. They're earning huge salary. This one is doing more office visits, earning less in the private sector, you want a comparable salary, which do you choose?

CHAIRPERSON DE LA ROSA: How does H+H balance the need for financial stability with the need to invest in staff, compensation, and resources?

DR. KATZ: It's a great... it's a great question, and appreciate the city council's participation. And you tell me if I've, you know, viewed it this wrong.

You know, I've been director in three different safety net systems. Not many people can say that -San Francisco, Los Angeles, and New York, and they're the best safety net systems, not because I was there, but because of the commitment of the political leaders to adequately fund them.

CHAIRPERSON DE LA ROSA: Mm-hmm

DR. KATZ: That's what makes them, you know, good. People say, you know, what's the pot for the

settlement? You know, what... what can you put up? And the way I feel it, and this is how I've always tried, there isn't a separate pot, everything are choices. We, Health + Hospitals has a budget of $13.3 billion About a $1 billion of that comes from the City. The rest is what we generate in revenue. We can do anything, but anything more that we do here will be something less there because we spend all the money. Right? And that's... you view that in your Budget Committee. Right? There's no... there's no reserve, we don't pay astronomical consultants. We don’t... we don't do... right, we don't have the mahogany walls all over. Right? Every nickel is spent. So whatever we do for anyone or anything, it all has to balance out. And sort of my job as I view it, with partnership with the mayor and the city council, is try to spend that money in the best way possible to deliver the most good to the people we're trying to serve, whatever that is. And what I do try to pay attention to is equity among my workforce, because I feel like if one group feels that they're not getting the same thing another group is, then I'm going to lose. I need happy doctors, but I also need happy nurses, and happy social workers, and happy

administrators. And it has to be a collective thing that we all acknowledge, or at least this is how I've always viewed it, that we all acknowledge that we are a safety net system.

CHAIRPERSON DE LA ROSA: Mm-hmm

DR. KATZ: And that's what we are, and we don't typically pay private hospital salaries.

CHAIRPERSON DE LA ROSA: Okay, thank you, Dr. Katz.

DR. KATZ: Thank you.

CHAIRPERSON NARCISSE: Oh, thank you, Chair.

Doctor Katz, I really appreciate your honesty. I have a couple of more questions, but I have some of my colleagues that have some questions. Oh, before I get to my, so let me pass it on to someone in the medical field as well.

DR. KATZ: Yes.

CHAIRPERSON NARCISSE: Council Member Marmorato?

COUNCIL MEMBER MARMORATO: Thank you, Chair.

So I just wanted to ask you, when did this begin where you're not, uhm, where these doctors and PAs are actually pre authorizing treatment and medications? When did this practice begin in Health + Hospitals?

DR. KATZ: Submitting prior authorizations or allowing people other than doctors to submit?

COUNCIL MEMBER MARMORATO: Them submitting them themselves.

DR. KATZ: So they... I would say we've been doing it for several months.

COUNCIL MEMBER MARMORATO: Okay.

DR. KATZ: We always do it on behalf, I mean, they're clear... they don't... no one's impersonating anyone.

COUNCIL MEMBER MARMORATO: No. But it's... this is a new practice...

DR. KATZ: Yes.

COUNCIL MEMBER MARMORATO: that it's the physicians are actually submitting the pre authorization?

DR. KATZ: Yes.

COUNCIL MEMBER MARMORATO: Okay. Because I've never experienced that. We've always had a team of people that took care of it for the physicians...

DR. KATZ: I see, you were ahead of us...

COUNCIL MEMBER MARMORATO: So they wouldn't waste their... so they wouldn't have to waste their talent

making phone calls and they can focus more on their patients. So...

DR. KATZ: So You were ahead of us, we...

COUNCIL MEMBER MARMORATO: What?

DR. KATZ: You were ahead of us.

COUNCIL MEMBER MARMORATO: Well, no, I've always, yeah, I've always worked in a setting, whether it was a private facility or a hospital, we always had teams that would do that for the doctor. So it wouldn't tie them up, you know, that they can really focus on the patients and let them allow them to do what they needed to do.

So, I just wanna touch on Jacobi. So Jacobi and North Central Bronx have been without any full time rheumatologists since the entire division resigned in 2023. And this is an extreme example of how the system's failure to recruit and retain doctors have no negatively impact patients.

Do you agree that Health + Hospitals failed the Bronx patients who need rheumatologists? Or...

DR. KATZ: It was a complicated moment. Many people have a variety of explanations of what happens. I feel bad, I mean, it's very unusual that a whole division leaves.

COUNCIL MEMBER MARMORATO: Yeah, that's like it must have been very bad for that to happen.

DR. KATZ: It was, I would say, it was not a disagreement about money.

COUNCIL MEMBER MARMORATO: Okay, can you...

DR. KATZ: It was a disagreement. And I don't... at the end of the day, I sort of see it as a no fault divorce.

COUNCIL MEMBER MARMORATO: Okay. So you're saying it had nothing to do with the contracts and, like, like, pay and... No? Okay.

DR. KATZ: It was a fundamental difference of opinion among good people. And I happen to know the people on both sides of that, and I have good things to say about both, but there was a fundamental disagreement.

COUNCIL MEMBER MARMORATO: Okay, so moving forward, how do you plan on recruiting doctors and retaining them?

DR. KATZ: Well, again, as we mentioned, and I appreciate your question, rheumatology is one of the areas where we've had trouble. The more specialized, the more difficult it has been for us to recruit. I think salary is one aspect, but it isn't the whole

aspect. It's trying to create, you know, positive work environments. And, clearly, at Jacobi with Rheum, for whatever reason, it didn't succeed.

We did offer... and just, again, to tell you how odd situations are, I have an excellent rheumatologist at Metropolitan who is currently underused - not her fault - because she's in a full time position in a hospital that doesn't generate a full time amount of work. We said send the patients from Jacobi to her.

COUNCIL MEMBER MARMORATO: Well, that's not really...

DR. KATZ: Don't wanna do it.

COUNCIL MEMBER MARMORATO: Right

DR. KATZ: We don't... we're not a city that does that.

COUNCIL MEMBER MARMORATO: Right.

DR. KATZ: And I get it. Although I'll say rich people, they always ask you, where do I have to go, do I have to go to Mayo Clinic? Do... where should I go? You know, I always feel like we're blessed with a great subway system, but we're... as New Yorkers, we don't do that.

COUNCIL MEMBER MARMORATO: No.

DR. KATZ: We... it does not happen. I'm totally... I'm totally with you. We have to hire a good rheumatologist at Jacobi.

COUNCIL MEMBER MARMORATO: Okay...

DR. KATZ: I agree.

COUNCIL MEMBER MARMORATO: And I just wanted to say, I know you had mentioned about housing, so, uhm, you do have on the property of Jacobi building two, 78 vacant studio apartments. That would be a really nice bonus and blessing to your 525 doctors that could possibly walk out on a strike.

So that would always be a bonus or a plus to help them with the housing and the affordability problem here in New York City.

DR. KATZ: Understood.

COUNCIL MEMBER MARMORATO: Thank you.

DR. KATZ: Thank you.

CHAIRPERSON NARCISSE: Thank you. Next, we will go to Brewer who has a question.

COUNCIL MEMBER BREWER: Two questions.

One, you have several medical schools that are now free. Are you recruiting from them?

DR. KATZ: We will. I mean, I think it will really help, with, uh, Council Member Brewer, with the... things like primary care that people will leave.

But remember, this just started, so you haven't right, they still have... to they have the full four years, then they have the three year residency.

COUNCIL MEMBER BREWER: But you're focused on trying to get from them?

DR. KATZ: But...

COUNCIL MEMBER BREWER: Mm-hmm?

DR. KATZ: Absolutely. Absolutely. And I think they will simply because I think a lot of people were choosing specialty because they had $300,000 in loans.

COUNCIL MEMBER BREWER: Right. Okay. I'm just... you'll let us know that you're doing it and not just talking about it.

DR. KATZ: Yes.

COUNCIL MEMBER BREWER: Okay.

Second is, you're closing a lot of the of the migrant shelters. I just got the list today for April 4th. Will that give you some money to pay the doctors?

DR. KATZ: No.

COUNCIL MEMBER BREWER: Why not?

DR. KATZ: Because the way, uh, the City does the dollars, we're paid actual expenses for the shelter system. Right? And that was something that we arranged early on because I said I wanted to help, but I wasn't prepared to sacrifice the dollars that we were spending on health care. So OMB agreed with us that they would it's essentially, like, boarded off. They... we have actual expenses. We report to them. They keep us whole, so that no one could say that we have less because of the migrant crisis. But at least... that money is not available to me, I mean, to you as council members... (CROSS-TALK)

COUNCIL MEMBER BREWER: It just seems to me that, I mean, that was a lot of money, and it's gonna go somewhere. It's not going to be paid. It seems to me that you have the greatest health system, you have to keep the doctors, it would seem to me that we should be all advocating for whatever the amount is that would make the doctors whole, figure out what you need, retention. For God's sake, why are we not advocating for that? I don't know, but you could do the same.

DR. KATZ: But you have the power.

COUNCIL MEMBER BREWER: Well, I'm just saying, I guess what I'm asking for you to provide is what are the dollars that are being quote, unquote "saved"? Could be a one time. We're not talking necessarily sustainable.

DR. KATZ: Oh, it's millions.

COUNCIL MEMBER BREWER: Okay. Well, we could use that number. We could use that number, so that we could advocate for your staff, which does need more funding, and your hospital system, which does need more funding.

So we would appreciate for the Committee to get that information, what is being transferred, I guess, back into the into the general fund, because that's where it goes if it doesn't go to you.

DR. KATZ: Right.

COUNCIL MEMBER BREWER: And we'd like to have it stay in the system for the good that needs to be done. You'll get us that information?

DR. KATZ: Absolutely.

COUNCIL MEMBER BREWER: I know that at least seven or eight are being closed, if not more.

DR. KATZ: So it's a very large number... (CROSS-TALK)

COUNCIL MEMBER BREWER: April 4th, I'm very aware of it.

DR. KATZ: It's a large number.

COUNCIL MEMBER BREWER: Okay. We want that number to know what it is and to know, uhm, what we can do with it that would be alternative for your system.

DR. KATZ: Alright.

COUNCIL MEMBER BREWER: Thank you.

CHAIRPERSON NARCISSE: Thank you. Now you heard it. She's going to advocate, and whenever she starts, I will be right there, because whenever we can get money for the doctors, why not?

For the Epic, Epic right, you use Epic...

DR. KATZ: Correct.

CHAIRPERSON NARCISSE: to... all the system throughout the hospitals?

DR. KATZ: Everything is Epic...

CHAIRPERSON NARCISSE: Every hospital, right?

So, uhm, is it a doctor that has to enter all the process or... because when we were talking about staffing before, yes, we can get some help. It can some... like, kind of doctors or trained PAs whatever that you have in the front to start doing

the primary questionnaire? So the doctors' gonna have to do all of it?

DR. KATZ: Yes. So, historically, yes, the doctors have done all of it.

CHAIRPERSON NARCISSE: Mm-hmm

DR. KATZ: In my own place at Gouverneur, the nurses have started to do, uhm, for the primary care patients, put in the medicines, the allergies, and do some of the questionnaires.

Again, I think the ideal is actually for the patients with help on the tech because that's the primary source. And I think people should know and take responsibility to know what medicines they're on.

But, yes, that's the vision. And as I'm sure you'll hear, and I accept, it's not perfect. Nothing that we roll out across Health + Hospitals ever perfectly happens. So it might be great over here, but over here, the person who was supposed to come to work didn't come, and the doctor is still doing it. And the doctor feels like, hey, Mitch, you know, wanted us to do eight and promised us these things, and that extra person still isn't here yet. I mean, you understand.

CHAIRPERSON NARCISSE: I do.

Are there specific when if there is a stoppage, right, are there specific patient population like the elderly, chronically ill folks who will be disproportionately affected?

DR. KATZ: Well, that's certainly who we take care of. So, I mean, the low income people in New York City will be disproportionately affected, because that's that... that's who...

CHAIRPERSON NARCISSE: That’s the nature...

DR. KATZ: we take care of.

I mean, in terms of transferring, we would first transfer out the ICU patients just because if you're not fully staffed, right, that's, you know, where you worry the most about any losses as somebody... If you don't have everybody in your ICU, you know, to take care of the patients, you're gonna have to transfer them out.

But, you know, we'll, you know, we'll... we’re a triage system. Right? I mean, the for example, you'll... we'll cancel the outpatient appointments, but we'll tell anyone when we call, “If you have an urgent problem, go to the emergency department,” and all of those outpatient people who are not on psych

will be in the emergency department. Right? Some people have a visit that can wait a month, and some people have an issue that has to be dealt with today. And we'll have to triage which of those it is.

CHAIRPERSON NARCISSE: We know that language barriers are linked to increased medical errors, as well as lower patient satisfaction and health outcomes.

Giving that language access and interpretation services can be time consuming to set up, how is H+H ensuring that patients receive proper care and thorough evaluation during the brief 20 minutes appointment windows?

DR. KATZ: Sure. Well and you're an expert, and you've been a great advocate for the importance of Haitian Creole in Central Brooklyn, which we have.

We have wonderful, both phone and video translation. I mean, I use it every week, and that is great. I would say, and I do recognize one of the challenges, and I'm sure people will talk about it, I hope they do, I'm fluent in Spanish, so I can do all of my Spanish speaking patients with no additional time.

When I was in there on Wednesday, I had one French speaking patient. French speaking, I need the interpreter. No problem with the interpreter, but, of course, the visit has to take twice as long.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: There's no way around that. Right? Because I have to talk, and then the translator has to talk, then the patient has to talk, then the translator has to talk. Right?

So I mean, I think that, especially when, you know, we don't have language concurrence and it's impossible nobody can speak all languages. Right?

So to the extent, you know, I do recognize that that is one of the challenges. And again, all I can say is that there is no answer anywhere between desire for broader access and the desire to spend more time going deeply with the same person.

Everybody has to decide, you know, what is a reasonable line. Right? Some places have 15 minute visits or 10 minute visits. Some places have 30 minutes. Right? If you're in, you know, if you're wealthy, right, you're going to not pay... your doctor is not gonna take your insurance, and you're

gonna pay out of pocket, and the doctor's gonna spend 50 minutes with you. Right?

I mean, these are there is no, in my view, one answer to it. It's just trying to do something reasonable to address these people that I know my doctors care about, and I know all of you care about. It's just not a simple answer.

CHAIRPERSON NARCISSE: Last February, the Hospital Committee held a hearing on residency conditions where we learned about the Helping Healers Heal or H3 program.

Health + Hospitals representatives describe this H3 program as being a proactive approach to improve mental health challenges by offering an anonymous internal support hotline, organizing individuals and group peer support sessions, and offering training for people in managerial positions to improve the ways that emotional and psychological needs of the healthcare worker are addressed.

Is the H3 program still active and if so, do you have any access to data to see if employees are aware of these options and if they are being used? I mean, if they are being used actually, sometimes you have program and they're not being used.

Have you received any feedback from employees that have utilized the H3 program?

DR. KATZ: Yeah. So it's only grown since that hearing, and we get a lot of positive feedback. And one of the nice things about it, which I think is a good model for all helping programs, is you can be on both sides of being a helping healer.

CHAIRPERSON NARCISSE: Mm-hmm

DR. KATZ: You can need a helping healer, and you can be a helping healer.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: Right?

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: I think we make the mistake of think... of not recognizing that people benefit from helping others. So today, maybe I had something awful, and I need to talk to Chair Narcisse, and she's gonna support me. And maybe tomorrow, Chair Narcisse is gonna have a bad day, and she's gonna call me and I'm gonna support her.

I mean, that's the whole, that's... the peer part. And that's why we think it's been popular because it's not... it's not an outside person. It's doctors and other nurses, social workers throughout

our system who are agreeing to help each other in times of crisis, recognizing that crisis is not necessarily a mental health problem. Crisis is what's happened to me - I saw a lot of patients, I was moving quickly, I made a mistake. I felt bad. That happens. That's happened to me, you know, as recently as about three months ago. I prescribed something that I later decided was not a good choice. I felt terrible about it. Right? So the ability to talk... I didn't need to see a mental health professional, right? It was reasonable that I felt that, uhm, I care much about my work, I care about my patients. I prescribed the wrong thing. I felt that.

But the whole point of Helping Healers Heal is recognizing, well, periodically, all of us make a mistake, and none of us are robots, none of us are perfect, and therefore, we help each other.

So I'll get you, though, the numbers. I don't have them with me, but I'll get you the numbers of how many interactions we've had. But it's only grown.

CHAIRPERSON NARCISSE: Beside that and about feedback. Because to know if a program worked, you have to have feedback.

DR. KATZ: Sure, feedback has been uniformly positive. And one of the ways we know this because people volunteer to do it. We don't pay people to be the healers. And we have large numbers of people who agree to be healers in all of our facilities. We've never had difficulty recruiting.

CHAIRPERSON NARCISSE: Mm-hmm. Okay.

DR. KATZ: People... people like it.

CHAIRPERSON NARCISSE: That sound like a good plan, because especially now because they're not getting paid. They have issues to pay their bills, so I'm sure it should be crowded because everybody have issue now. Because the rent is too kind of damn high.

(LAUGHTER)

Chair, do you have any questions... no, that's true, New York City is tough. It's a tough city, and we want doctors inside a hospital, not on the street striking.

You have any questions here?

CHAIRPERSON SCHULMAN: Yeah. I want... I did wanna ask one follow-up. Wasn't there a time when Health + Hospitals helped physicians find apartments? When I was there, I thought it... my understand... yeah, they did.

CHAIRPERSON NARCISSE: Mm-hmm.

DR. KATZ: Seems like a good idea. I mean, again, maybe with all of these, maybe we don't, we don't necessarily want to do it ourselves. So you probably don't want...

CHAIRPERSON SCHULMAN: No...

DR. KATZ: me to be looking...

CHAIRPERSON SCHULMAN: Right...

DR. KATZ: for your apartment.

CHAIRPERSON SCHULMAN: But, you know, with the with the Mayor's State of the City yesterday and talking about having a lot... a ton more affordable apartments, maybe there should be some conversations around that.

DR. KATZ: Right. I mean, what we do, and it actually makes me sort of sad, right? We mentor people about things like maybe you can live in Jersey City or right... It's not the... as a New Yorker, it's not the answer, but that's often what we wind up doing is, okay, well, you know, what would be a reasonable commute? Where does the, you know, the new train line go? You know, allows, you know at least that's New York State still. You know, if the... if the metro north now goes to where you live in the

Hudson, right, housing prices are lower. But, I mean, it's not an ideal. Right? I mean, I grew up in Brooklyn, I feel like everybody should be able to live in New York City, if they work here.

CHAIRPERSON SCHULMAN: Dr. Katz, we're about to go into budget negotiations, and my suggestion is to make the ask, and we'll see what we can do as a group here.

DR. KATZ: Alright, thank you so much.

CHAIRPERSON SCHULMAN: Okay.

CHAIRPERSON NARCISSE: Thank you. As you usual, but before I go, I was... I have to acknowledge my colleague, Majority Whip Brooks-Powers, that's watching you, that listen to you, that's our friend, is on Zoom.

Dr. Katz, I know you're going to do the right thing, because you are a practitioner yourself and you know how difficult - We went over and over how difficult it is for our doctors to function in New York City. Like I said, I want them in the hospital and to be happy, too, because if they sad they have issues, we know we're not going to get good service, too, because they're human. So let's do the right thing with the contract, push, push. I'm going to

push my way, you know I'm making calls. So, we want the doctors to be happy, too.

So thank you so much for your time as usual...

DR. KATZ: Thank you.

CHAIRPERSON NARCISSE: Appreciate you.

DR. KATZ: Thank you.

CHAIRPERSON NARCISSE: And if you can stay, you...

DR. KATZ: I will, I will be here.

CHAIRPERSON NARCISSE: You will be? Ah, you, superb, thank you so much.

CHAIRPERSON NARCISSE: Okay, I now open the floor to public testimony. Before we begin, I remind members of the public that this is a formal government proceeding and that decorum shall be observed at all times. As such, members of the public shall remain silent at all times.

The witness table is reserved for people who wish to testify. No video recording or photography is allowed from the witness table.

Further, members of the public may not present audio or video recordings as testimony, but may submit transcripts of such recordings to the Sergeant at Arms for inclusion in the hearing record.

If you wish to speak at today's hearing, please fill out an appearance card with the Sergeant at Arms and wait to be recognized. When recognized, you will have two minutes to speak on today's hearing topic regarding Health + Hospitals Doctors Council Work Stoppage.

If you have a written statement or additional testimony you wish to submit for the record, please provide a copy of that testimony to the Sergeant at Arms. You may also email written testimony to Testimony@council.nyc.gov within 72 hours after the close of this hearing. Audio and video recordings will not be accepted.

When you hear your name, please come up to the witness panel.

For the first panel, we invite, the first panel, if I butcher your name, I'm sorry, I'm trying my very best here for the names, Frances Quee, Adedayo Adedeji, Andrew Goldstein, Jennyfer Almanzar, and Sonia Lawrence, please approach.

(PAUSE)

CHAIRPERSON NARCISSE: Mr. President? I think we have a president here, Frances Quee, thank you. Oh,

Mrs. President? Madam President! I love it even more, Madam President, sorry.

DR. FRANCES QUEE: Hi, good afternoon, City Council. We really appreciate you having us here today for this hearing.

I am Dr. Frances Quee, I am the President of Doctors Council SEIU, and I am a practicing primary care doctor at Gotham sites. I've been working with Health + Hospitals for 30 years.

As president of the Doctors Council, the largest union of attending doctors in the country, I'm here representing 2,200 members who serve New Yorkers regardless of the color of their skin, the country where they're from, and their ability to pay.

We love the work we do, and we stand by the mission of New York City Health + Hospitals Corporations. But we also demand respect and equitable treatment.

I'm also here today as a physician representing my own patients and their families because I believe in the mission of Health + Hospitals to extend quality care to all New Yorkers.

I am here today because I'm concerned that the mission that we dearly love is in danger. In order

for us to provide high highest quality of care that we want to give, and that our patients deserve, we need qualified and principled doctors. That requires an investment in attracting talented doctors, and retaining the doctors who have dedicated years like myself - even decades to serving New Yorkers who need our care the most.

Instead, Health + Hospitals are making shortsighted and rushed decisions without the input of the front line doctors. This adds to a revolving door of doctors leaving which adds to short staffing and unsafe workloads. And the cycle of crisis continues.

I would like today to point about physician compensation. I echo the sentiment of the council lady who spoke before us, Council Member Zhuang, we know that the current salaries are not enough to effectively recruit and retain doctors. We have watched our colleagues leave the system. (TIMER CHIMES) We oh, my time is up?

CHAIRPERSON NARCISSE: Try to complete it.

DR. FRANCES QUEE: Okay.

And we have seen vacancies that persist for years. I know it's gonna be shocking to let everybody

know that most of us, over 50% are working paycheck to paycheck. And, we really need Health + Hospitals to have competitive salaries for the doctors in the public health care system.

I know we are mission driven, but at the same time, but at the same time we also need to avoid the fact that a lot of our doctors are going to walk out of the job and we're going to be left with even more shortages.

CHAIRPERSON NARCISSE: Thank you. And now I just remember, we've been on Zoom, never seen anyone face to face, thank you, welcome.

Continue, yes?

DR. ADEDAYO ADEDEJI: Good afternoon, my name is Dr. Adedayo Adedeji; I work at King's County Hospital, and, I've actually been a medical doctor for about 31 years now.

I started working at King's County in August of 2020, uhm, after 20 years in private practice because it just became a case of, I just didn't want to work for money alone. And I trained at Kings County Hospital as an ID fellow and I decided to go back then, I was very impressed by the work they did.

I do two 12-hour days and two 8-hour days, and in those 12 hour days, I have 29 patient, slots. And usually, I have four double booked new patient slots for those 12 hour sessions.

Recruitment and retention at Kings County has been terrible. I mean, most of our new doctors in primary care are just newly graduated residents. And we all know, of course, the longer it's been the job, the more experience you do have.

There has been no screening colonoscopy that I've sent a patient for in my almost five years at Kings County Hospital because we just don't have any gastroenterologists to do them. We shuffle everybody out and out to South Brooklyn Hospital. G1 is not taking any appointments.

We've got very little ENT, cardio, and neuro. We have got an increased complexity of patients that we've got to see in 20 minutes. And as you all know, when you ask anybody a question, you get back 10,000 things before you actually get to what information you need.

PAGNY, our employee union, actually implemented a contract which basically cuts vacation time, CME

time, sick days for providers, and they're very unhappy about it.

I am in negotiations now with the union and the mediator. I can tell you now we're all going to be unhappy with our contract. And the soonest chance that people get to get out, they will.

I do my own prior authorization; there's nobody to help me to do them. (TIMER CHIMES)

CHAIRPERSON SCHULMAN: You can summarize it and then you... (CROSS-TALK)

CHAIRPERSON NARCISSE: Finish, finish...

CHAIRPERSON SCHULMAN: By the way, just want to also...

DR. ADEDAYO ADEDEJI: In summary, I feel that when not being respected as providers - gratitude is great. You know? I do (INAUDIBLE) thing, I know what a good job I'm doing (INAUDIBLE) might thank me for that. But actually, you know what? If you don't want to thank me, it's like Cuba Gooding Jr. said it in whatever movie, Jerry Maguire? Show me the goddamn money.

CHAIRPERSON NARCISSE: Thank you.

DR. ANDREW GOLDSTEIN: Hi, my name is Andrew Goldstein, I'm a primary care doctor at Bellevue Hospital, I've been working there since 2015.

I went to medical school at Mount Sinai and rotated through Elmhurst, and then I went to residency at Columbia.

My time at Elmhurst in the Health + Hospitals system motivated me to take offers that were less paying, uh, to refuse offers that were higher paying and take a offer that was less paying at Bellevue right out of residency.

I, after a few years reflecting on my time, I realized I love my patients, I love my coworkers. I was, you know, for many years saying my bosses all the way up to our CEO, I was just so happy to be in the health system that I was in, and I wanted to work in it my entire career.

I've been a bit heartbroken over the past two years, frankly. I think there's been so many good policy changes by our H+H leadership, in the Mitch Katz era, and I think most of my peers feel the same way.

I think the recent round of contract negotiations have been really, really disappointing. I'm in the

public sector unit, many people in my unit reluctantly, uh, authorized, our agreement because we didn't have a right to strike. But we are very disappointed in it and feel like it is sub inflation, substandard, and many people, unfortunately, in my unit are planning on leaving.

So like Dr. Katz said, uh, we see based on whether people take jobs or leave jobs, and I'm scared for the amount of exodus we're gonna see based on my sector, uh, public sector unit having people leave.

I'm worried that if the City doesn't offer enough to my colleagues in the affiliates, that there's also gonna be an exodus because of unfair, uncompetitive contracts.

But I'm here mainly today as a primary care doctor to talk about how it's not just 20 minute new patient visits, it's a massive increase in the size of our panel sizes, the effective size of our panels.

Many people who thought they were full, whose patients struggled to get follow-up appointments and thought that their doctor's panel was full, are now being told they need to absorb another 30% of patients.

(TIMER CHIMES) These increases are going to drive a mass exodus. We have a survey that we sent out to all the primary care doctors in our health system, which said that about a third are planning on leaving because of this policy, and about another third are considering leaving.

We need to prevent that mass exodus before it happens. Now is the moment, and I hope that you'll help the City cover fair competitive contracts for our workers and also make sure that patients get the care time that they need and the adequate follow-up that they deserve.

CHAIRPERSON NARCISSE: Thank you, I appreciate it.

NURSE SONIA LAWRENCE: Thank you.

Good afternoon, my name is Sonia Lawrence, and I am a nurse at Lincoln Hospital in the Bronx. And I'm the president of new the New York State Nurses Health + Hospitals Mayoral Executive Committee representing nearly 10,000 nurses in New York Health + Hospitals

Today, I stand in solidarity with the Doctors Council as they continue to fight for a fair contract.

We are witnessing a crisis in recruitment and retention that is impacting not just our doctors, but

also the entire health care system, including nurses like myself.

Over the past several months, I have seen firsthand the strains that the staffing crisis has placed on our Health + Hospitals facilities. It also feels like we are just barely keeping our heads above water, and the crisis has real consequences on our patient.

When we cannot recruit and retain qualified health care professionals, it becomes increasingly difficult to provide the high quality care that our community deserves.

The unilateral cuts to new patients' appointment time implemented by H+H has further exacerbated this crisis. As a nurse, I witnessed the frustration and anxiety on our patients' faces when they cannot access timely care.

This decision has forced doctors to see more patient in less time, reducing the opportunity for meaningful interactions and proper assessment.

Comprehensive patient evaluation are critical to accurate diagnosis and development of effective treatment plans. Rushing through assessment due to insufficient staffing and unrealistic time

constraints increases the likelihood of misdiagnosis, improper treatment, and ultimately worse health outcomes, jeopardizing our well being and the well-being of the community we serve.

The Doctors Council decision to plan a work stoppage is not just about physicians. It's about all of us who are dedicated to the mission of providing health care (TIMER CHIMES) for all who need it. Doctors are taking the stand for their patients.

As we have seen with nurses, residents, and other frontline workers, collective actions to demand safe staffing and better working condition results in greater working retention and better patient outcomes.

NYSNA's victory for nurse parity pay and real staffing improvements has shown that investments in our public health system are both possible and the path to stronger patient outcomes. The employers and H+H should follow that model to get the Doctors Council a fair deal.

NYSNA supports the Doctors Councils demands for fair pay and better working conditions. I urge the City Council and the members of this committee to recognize the critical nature of these negotiations

and to advocate for fair treatment and adequate resources for all H+H healthcare workers.

Our patients deserve a robust H+H healthcare system that prioritizes their needs and ensures that those who serve them can do so without fear of burnout or inadequate support.

Together, we can create a healthier New York City for everyone. Thank you for your time.

CHAIRPERSON NARCISSE: Thank you.

MS. JENNYFER ALMANZAR: Good afternoon, my name is Jennyfer Almanzar, and I am here to testify on behalf of CIR/SEIU, representing over 6,000 residents in New York City and as someone who has directly benefited from New York City Health + Hospitals.

As someone who grew up in New York City and received care at the public hospitals, I've seen firsthand how vital H+H is to our communities.

These facilities were a lifeline for my family and for so many others who rely on them just not for health care, but for hope and dignity.

As someone who has benefited from the attention and expertise in New York City's public hospital doctors, I know the importance of a thorough patient

doctor relationship. But today, many families don't get that.

Shorter appointment times and critical staffing shortages mean that doctors struggle to properly address their patients' needs. This disproportionately affects vulnerable populations, especially working class patients of color, immigrants, incarcerated folks, and refugees - those who have no other options.

What we need now is for PAGNY, Mount Sinai, and H+H to come to the table in good faith. Our public hospitals doctors don't want to strike. They're being forced to buy an attainable system of medicine in New York City and across the country, a system that prioritizes budgets over lives and cuts corners at the expense of care.

H+H is meant to be a beacon of something different, and that is what it was for my family. As they demand a fair contract, the physicians' members of Doctor Councils are fighting to ensure our public hospitals fulfill the promise to the people of New York.

This is the same fight that members of Committee of Interns and Residents took on last year. After

months of sustained actions, they secured a contract that will support H+H residents and patients for years to come.

Now the time has come to do the same for the attending coworkers. The solutions are clear. The solutions are as clear as they've ever been. Respect the work the doctors do. Invest in them and let them do their jobs without fear of burnout and neglecting their patients. Thank you.

CHAIRPERSON NARCISSE: I say thank you to all of you, and one of the great things that I appreciate is Dr. Katz stayed in the house to listen – the People's House – to listen. Most of the Admin, when they come, they just walk away. And for him to be here so that he's hearing you, and I am hearing you, and I truly believe that we are going to do ,you know, very well. And I know (INAUDIBLE) involved, so the fight continues.

Oh, you have questions? Okay, my colleagues have questions. Before I get to my questions, let me let my colleagues go.

CHAIRPERSON DE LA ROSA: Thank you, Chair Narcisse.

I have a have a few clarifying questions. So you mentioned the double bookings. Can you explain, give us, uhm, a little bit of insight into what that looks like and what the double bookings mean and how they show up in the system for you? Like, what happens when you're double booked?

DR. ADEDAYO ADEDEJI: So when I first started working at King's County, I noticed, you know, on the, like, eight 20 slots, there'll be two patients in there. So I'd go to the front desk and say, there's a mistake. You know? What's going on here?

They're like, oh, well, they kind of figure that there's a 20% chance that one patient's gonna show up, so they double book in one slot. And invariably, it turns out that it's not the revisits that they double book, but the new visits.

And as you well know, whoever's been on Epic, you have to put in an inordinate amount of information. Their allergies, and patients always say they're allergic to stuff - I'm allergic to iodine because when I touched it as a kid, you know, it made me vomit. That's not an allergy, you know.

So, we have... I have four patient new patient slots and they're all double booked. And invariably,

what will happen is all those people will show up. This one needs an interpreter, this one needs social services, this one's depressed, this one has no food. And, of course, you're know being in a safety net hospital, you're responsible for everything. Patients come and just tell you everything. You know? And you...

CHAIRPERSON DE LA ROSA: So in that... sorry to interrupt, but so in that situation...

DR. ADEDAYO ADEDEJI: Yes?

CHAIRPERSON DE LA ROSA: If you're quadruple booked and all four patients show up, those four patients are added to your eight patient portfolio for the day?

DR. ADEDAYO ADEDEJI: Well, they're... (CROSS-TALK)

CHAIRPERSON DE LA ROSA: Or you see those four and then...

DR. ADEDAYO ADEDEJI: it's not four slots; instead of four new patient slots, there are actually eight patients in those four slots. So that's two patients per slot.

CHAIRPERSON DE LA ROSA: Mm-hmm

DR. ADEDAYO ADEDEJI: So instead of just seeing one patient for 40 minutes, you are basically seeing one patient for 20 minutes, that's one new patient for 20 minutes.

CHAIRPERSON DE LA ROSA: And if you spend 30 minutes with each of those four patients that are quadruple booked, that, for new patients, then you'd have the time limit, the new policy for the time limit, correct?

DR. ADEDAYO ADEDEJI: This was before the new 20-minute policy.

CHAIRPERSON DE LA ROSA: Okay.

DR. ADEDAYO ADEDEJI: So what would happen would be I would rush through everybody, just try and get them out as quickly as possible, and then spend the next x amount of hours, after work...

CHAIRPERSON DE LA ROSA: Mm-hmm...

DR. ADEDAYO ADEDEJI: after 8:00 p.m., stay in there, finishing my notes.

CHAIRPERSON DE LA ROSA: And how do they reconcile your panel with then now these four patients that are added?

DR. ADEDAYO ADEDEJI: Well, it just seems to be a shifting thing where you are told you need 1,200

patients, and suddenly your panel is 1,400 patients. And frankly, I have no idea what the new panel is like now.

CHAIRPERSON DE LA ROSA: Okay.

DR. ADEDAYO ADEDEJI: It just keeps growing.

CHAIRPERSON DE LA ROSA: Okay, and, then, I... My followup question was about the panels. So, uhm, what are the numbers that you... What are those numbers for the panels? What do the panels look like?

And, then, someone testified about a 30% absorption rate on the panels. Can you shed some more light into that?

DR. ADEDAYO ADEDEJI: I'll say one quick thing about panel size. It just seems like it's... it almost seems to be almost like an arbitrary number that somebody in Central office comes up with. Nobody ever comes down to us and sits us down and says this is how we came up with this number. Never. They are decisions that just seem to fall from the sky, and now we're just meant to, like, figure it out somehow.

CHAIRPERSON DE LA ROSA: Okay.

DR. ANDREW GOLDSTEIN: Yeah, I can provide a little bit more context on it.

So historically, H+H had a panel size for us of 1,500 patients, and I believe in 2021, it increased to 1,750.

CHAIRPERSON DE LA ROSA: Mm-hmm

DR. ANDREW GOLDSTEIN: But those panel sizes didn't matter if there was no system to make them actually felt.

So, currently, it's not just 20-minute new visits that's this policy that people call the 20-minute new visit policy. It's actually, also a panel progression. And so the number of new patient visits that you have per week or per month is set by how full you are on the benchmark of 1,750.

So if you're 50% full, you're gonna see a lot of new patients. If you're 95% full, you're not gonna be seeing many new patients.

And so now we actually have a system to get everyone to 1,750. So we've all been living, who knows, maybe at 1,400 on average. People have been practicing for decades, and they felt full based on how sick their patients are, how often they need to be seen how hard it is for them to get revisit access.

But now they're being told, you're actually losing revisit access. You're gonna see more new patients in shorter visits, and you now have more patients who have less revisit access for you. They're gonna write MyChart messages. They're gonna show up at the front desk. They're gonna call the clinic. And then you, outside of those visits, have to provide care for them over the phone.

And so this is the struggle that a lot of us are facing that is driving a lot of the worsened burnout.

I'll just say one other thing...

CHAIRPERSON DE LA ROSA: Mm-hmm?

DR. ANDREW GOLDSTEIN: There are industry norms that our leadership has told us about this. We are well aware.

These industry norms are part of what have driven primary care workforce shortages nationwide. This is corporate health care. This is productivity cult.

You know, this is what's causing people to feel so burnt out and fried that they leave medicine earlier than they wanted to. So many primary care doctors 40 years older than me have told me they left because it's awful now. They remember when it was good.

CHAIRPERSON DE LA ROSA: Mm-hmm.

DR. ANDREW GOLDSTEIN: We really don't need to do this. We could be better, and I hope we could be.

But this one size fits all panel size is a really terrible metric. Complexity scoring is one thing, but if the average still pushes us up 10, 20, 30%, it would be a really bad thing.

But our patients, we know from peers who have left the system that they've gone to work elsewhere that have 17,050 - 2,000 patients on their panels, they're like, it's doable because those patients are so much less sick than they were at H+H and so much less complex socially.

So whatever the number is for us, we can't just reference some, you know, number in a vacuum. It needs to be appropriate for our patients. And we are reaching a breaking point. So that should tell you that, you know, this is not the right number for our system.

CHAIRPERSON DE LA ROSA: Thank you for shedding some light.

And then I have a question from Madam President, uhm, my question to you is, uhm, Dr. Katz testified regarding contingency plans if a strike does happen.

And, obviously, I think all of us across the board are hoping that a strike can be averted.

DR. FRANCES QUEE: Mm-hmm

CHAIRPERSON DE LA ROSA: But one question that I do have is, uh, Dr. Katz mentioned uncertainty about a strike fund. Does one exist? Is there plans for that? And, what is your take on adequacy of contingency plans should a strike occur?

DR. FRANCES QUEE: so we are physicians, and I don't think "strike" has ever been in our dictionary or in our minds. We're just trained to take care of patients. But it got to a breaking point that people could not take it anymore.

Other unions that are always going on strike, of course, have a strike fund. This is something we have discussed among ourselves. I agree with Dr. Katz; we had agreed to suspend the strike since negotiations are going on at this time.

But at this point, people are still organizing. That's how pissed people are. We just feel undervalued. The doctors who have stayed in this system for many years are not getting compensated.

I, myself, had two children. I had to do a second job to take care of my family. So, we are not here to

be rich, but we just want those of us who have been in the system for a longer period of time that are aging out, once we leave, we want other people to replace us, but nobody's coming.

I understand, Dr. Katz, they've been putting ads, but nobody's showing up. So, after a couple of ads, they just remove that line. So, if you are six in a department and you are now three, after so many ads and those lines go away. So it seems like you are not understaffed because there's no vacancy, but you're still three.

So, he said there are eight patients or six patients in a half-a-day. No, there are 10 to 12 patients that are scheduled even with the 20 minutes now.

So, it is kind of a little difficult. I understand, uh, so, Health + Hospitals, without even discussing with the doctors, unilaterally just went ahead with their 20 - 40 minutes to 20 minutes, change of time.

I know we're working for them, but at the same time we are the ones who are in the front line. It would have been nice to explain things so that we can all come to a decision.

Dr. Katz said they are hiring PAs and nurse practitioners. It's been three months, and we had a town hall meeting with him in December where I told him I have not seen any NPs or PAs hired yet. And, they told us where we are putting ads.

So, we are still doing the same work and even more. Prior authorization, I just did two of them on Wednesday myself, because I don't know who to ask. I mean I know they said there's somebody to ask, I can't put work on the nurses. The nurses are also burnt out.

I mean I am not just being... thinking of the doctors. I'm thinking of the nurses. I'm thinking of the clerical staff, the PCAs. Everybody's burnt out.

So I'm not gonna give somebody else the work that I'm supposed to do. So I don't know, I know the administrators who made the decision, of course, most of them see patients but they see half a day patients. And when they come in, they have a whole nurse, they have a whole PCA.

So you can really not understand what the rest of the doctors go through. So the amount of patients on the on the schedule is not eight or six as Dr. Katz said. It's more than that. And then if you don't if

you have a no show they add more. So, like Dr. Adedeji said, you have like four new patients and you're rushing through them. We have language barriers. There are some of us who can go through a little bit of Spanish, thank God, but there are other languages as well.

So, if you have a lot of patience, and if... with the Epic there's so much more work to do, administrative work, all of that has been done by us.

The patients just sit in their, you know, sit on their bed and they send you a message and they expect you to respond in a couple of hours which we're supposed to do and we're doing. But that just brings more work onto us and more burnout.

So if you open the Epic on your schedule, you already see all the patients that you have. So whenever somebody checks in or somebody's registered, you know. So now you're feeling pressure. You're only on number two because there are two new patients. And you have like six people waiting for you. We don't want people to make mistakes. This is not why we're here. We're here to see patients, uh, give them the dignity they want and deserve. And also, we also wanna be safe in practicing.

So we're kind of rushing, and we don't even finish our administrative work. We take it home. We go home and we're still writing notes.

This is not good for life quality with your with your family. You go home, you don't even have time to talk to your kids or your husband. You're busy typing notes because you have to finish. We have a deadline. You have to write your notes - 48 to 72 hours.

So there's just so much burnouts like Dr. Goldstein said. We did a survey with the primary care doctors before we had the second town hall meeting with Dr. Katz. We've had two with him. And a lot of the doctors are just saying this is not just for me. I understand there's primary care shortage; I told Dr. Katz and he's aware of it.

Let us not let the people who have invested all this time in our system leave. They're looking for people everywhere. I know people say, so why don't you just go look for another job? This is where we want to be. We want to take care of the people who nobody wants to take care of. So that's the mission we're here for.

CHAIRPERSON DE LA ROSA: Thank you, for your insights. Chair?

DR. ANDREW GOLDSTEIN: Could I add one thing?

(CROSS-TALK)

CHAIRPERSON NARCISSE: I'm glad you asked the questions because I'm going to get to another part because I was going to ask a question and go around.

But this is what I'm asking right now. I heard it.

So I'm going to start with you. Were you involved in the process at all of recommendation when it comes to turn the 20 minutes, 40 minutes?

DR. FRANCES QUEE: No, ma'am.

CHAIRPERSON NARCISSE: No? So now I heard the problem, I hear it, I mean, I heard it all.

Now, I'm asking you, yourself right now sitting here to tell me exactly what is your recommendation? What will... I know the list can be long, but I wanted you to kind of putting a couple of... three priorities that the doctors, since you've been dealing with all the doctors that they need in moving forward before that stoppage?

Because no one, I don't want it, you don't want it.

DR. FRANCES QUEE: We don't...

CHAIRPERSON NARCISSE: So what are the three top things you think that should be part of things that can satisfy you to move foreword?

DR. FRANCES QUEE: So to move us forward, we need Health + Hospitals to roll back their 40 minutes, 20 minutes.

We have nurse practitioners who also can see patients. They can then empanel them. I don't need a nurse practitioner to review my inbox. That is waste of their time and waste of Health + Hospitals dollars. So, that is the first thing.

And secondly, once that is done, we can sit together and bring all these, uh, 20,000 people in.

In the beginning we heard it was 50,000, so I don't even know how many people are still waiting to be seen.

We don't want anybody... primary care, first of all, when you come in for the first time, people need to be comfortable to share their stories with you. So if you're rushing, I'm busy looking at who's waiting to be seen next, you don't build that connection. So people just come in and they don't feel that they have been served. That is wrong.

So once they come in, we need them to feel comfortable, tell you all their stories, whatever is in... whatever they're here for, and you can take care of that.

I know Dr. Katz said you can do one, you know, what are you here for? Is it your knee or your ankle? And I'll take care of something in the next, uh, two weeks. But most of us here don't have two week appointments. We don't. So you're gonna be liable for anything that happens to this patient if you do not take care of the patient in totality.

And the other thing you said about, what is the other priority? I want, Health + Hospitals - we want Health + Hospitals to offer a decent wage.

We are not asking for anything Colombia is paying. We came into a mission driven system, and we understand that. But at least something that people can be able to pay their bills and something that will be able to attract more patients, more doctors.

We have residents. We train residents all the time. They're coming out of the system. And they just say goodbye and they leave. And I understand them, because they have so much student loan debt that they need to pay. They're not coming here. I mean, we are

here, we're not going anywhere. Dr. Katz knows that. There are some of us who are lifers, we're not going anywhere. There are people in the system 40, 50 years. We're still here. We're not going anywhere.

But we cannot attract the new people. So we need something that is comparable, something that people will be able to pay their bills. So, that's the...

(CROSS-TALK)

CHAIRPERSON NARCISSE: Correct.

Uhm, the 20 to 40 minutes, you don't want nurse practitioner to do over reviewing your charts, right, your... your work?

DR. FRANCES QUEE: They can see our patients...

CHAIRPERSON NARCISSE: The patients?

And, three, the decent wages.

DR. FRANCES QUEE: Yes.

CHAIRPERSON NARCISSE: Okay, fair enough.

You?

DR. ADEDAYO ADEDEJI: I think it's exactly what Dr. Quee said. It's basically about recruiting new doctors or new providers. And it just seems that H+H will respond only when there's a crisis.

CHAIRPERSON NARCISSE: (UNINTELLIGIBLE)

DR. ADEDAYO ADEDEJI: We recently had a bump in the primary doctors pay scale, and that was because we basically weren't recruiting anybody.

And basically, what Health + Hospitals needs to go back to do is go back to the Mayor or City Council or whoever it is that's funding them and shake them for more money. Because without more money, you're never able to recruit people and this is just going to be one crisis to the other.

We also need to be able to retain other doctors we have. There is no significant longevity, uhm, reimbursements for doctors that have been there for 20, 30, 40 years, and these doctors are not going anywhere.

CHAIRPERSON NARCISSE: Okay.

DR. ADEDAYO ADEDEJI: And the hospital system knows it, which is why they are playing this game with them. It's like, where are you going to go? You've been here 40 years, you're not going anywhere.

CHAIRPERSON NARCISSE: So, your three top priorities are the same as the Dr Quee...

DR. ADEDAYO ADEDEJI: Recruit, retain, 40 to 20 minutes. And sit down with the providers and actually speak to them and treat them with respect.

CHAIRPERSON NARCISSE: Mm-hmm. Okay, Dr. Andrew Goldstein?

DR. ANDREW GOLDSTEIN: Yeah, I'm gonna answer it a little bit similarly but differently.

I think we're not in the moment where we can reenvision what should've happened six months ago when we were involved in designing this. But we should hit pause right now and reverse it back to the prior, whether that's permanent or during a period to prevent a mass exodus of primary care doctors. So right now, we do need to stop it and reverse it.

But from there, we do need to have, uh, physician, but all health worker input on this policy, because this affects our front desk staff, our service coordinators, and our nurses.

It also affects our patients. I do not believe patients or community organizations had adequate stakeholder input on this policy. I don't think they're aware of it. I think they would like to be aware of it.

So I want a pause. I want stakeholder input across the board, and I want a fair contract for all the units, especially the ones that are considering a strike right now.

But the last, if you forgive me, a fourth one, that I would add is we do need to hire more. And I don't think we should accept the, oh, there's a primary care workforce, and, oh, hiring is hard, as, like, that's just the reality.

It's hard because we are making care not as high quality as we want it to be. People feel that when they come and interview when they see stressed out doctors. They want to go to a place that feels energetic and mission driven. We need to restore that, and we need to pay more to be able to hire.

But if we do that, we actually can overcome the workforce shortage.

CHAIRPERSON NARCISSE: So what do you think of the free school for the doctors, for the new doctors coming so they can work for the H+H? Would they come?

DR. ANDREW GOLDSTEIN: I wanna hire people who are gonna be lifers. I don't wanna hire people who it helps in the beginning of their career when they're struggling with student debt. I worked so many extra shifts...

CHAIRPERSON NARCISSE: Mm-hmm.

DR. ANDREW GOLDSTEIN: to pay off my student debt, but that doesn't help me anymore once that's... once I'm out from under that.

So having an unfair, uncompetitive subinflation contract at this point still is not enough. It's helpful, but I don't think that's adequate as the solution.

CHAIRPERSON NARCISSE: Mm-hmm. Alright. Any idea before we close on? Any recommendations?

NURSE SONIA LAWRENCE: Every patient should be treated as a VIP and healthcare is a human right. And H+H needs to be fair to those who give care to our - especially our most vulnerable patients.

CHAIRPERSON NARCISSE: And being in the emergency room I used to say that word too. Every patient is a VIP for me. Everybody is a VIP once you walk in.

So I want to say thank you, thank you so much for your time. And we appreciate it. Before I close, I have to ask my colleagues.

CHAIRPERSON SCHULMAN: I want to thank everybody here for testifying. It's really important, and I want to tell you that Dr. Katz is taking notes as you guys have been testifying.

CHAIRPERSON NARCISSE: Mm-hmm!

CHAIRPERSON SCHULMAN: So, so... which is really good, so thank you.

CHAIRPERSON NARCISSE: Yes, and thank you for staying with us. Now we're done if you don't have any questions. Thank you so much for your time. Thank you.

PANEL: Thank you.

CHAIRPERSON NARCISSE: The next panel is Roona Ray, Sindhu Vangeti, Deborah Shapiro, Joaquin Morante, and Richard Sinert.

(PAUSE)

CHAIRPERSON NARCISSE: Thank you for coming, and you may begin.

DR. ROONA RAY: Hi, thank you. My name is Roona Ray, and I’m here to support the public hospital doctors who are planning to strike for a fair contract.

I would have been one of those doctors voting to strike. I was a doctor employed by Mount Sinai at Elmhurst Hospital in Queens for five years between 2019 and 2024, just a few months ago.

I moved to Jackson Heights in order to be a doctor for the community I live in and feel a connection to, because of our shared experiences of

immigration and language - I speak Spanish and Bengali.

But recently, during the contract negotiations that I was involved in, I was given notice of layoff when I was 37 weeks pregnant. Doctors are rarely laid off. Sinai HR, told me they hadn't done it in 25 years. After I gave birth, they spent months harassing me during my maternity leave, trying to take my maternity leave time, my state paid family leave, and my unemployment benefits.

So the first reason I'm here supporting the doctors need to strike is because doctors deserve parental leave in their contract and job security after parental leave.

Sinai has ignored our request for this at the bargaining table. I learned that directly employed city hospital employees are insured up to four years of unpaid leave after the birth of a child. Yet, because I worked for Sinai, I didn't have this protection. And a few months after I gave birth, my job was advertised, though it had been degraded to a per diem job with no benefits. I applied for the job twice. Elmhurst recommended me for the position, and I never heard back.

My job should have simply been transferred to the virtual express care service at PAGNY from the express care clinic at Elmhurst Sinai when it was closed.

So the second reason I'm here supporting doctors need to strike is because doctors at H+H deserve a single master contract across all 11 hospitals with parity in positions between hospitals. It would make transfers, for example, in a public health crisis like COVID easier and decrease reliance on expensive temporary physician labor.

The third reason I'm here supporting the doctors need to strike is to ask what benefit these subcontractors, Sinai and PAGNY, bring patients and health care workers.

In my case, (TIMER CHIMES) they just created a confusing bureaucracy and a cover to get rid of a worker taking a maternity leave that was considered a bothersome expense, and they allowed H+H to turn a blind eye to Sinai's unsavory and infamously racist and sexist employment practices.

When I spoke with Dr. Katz last July, he told me that I didn't work for him. It was ironic because he had just published an article in the Journal of the

American Medical Association a week prior titled *Administrative Harms—Common and Sometimes Preventable*.

So the fourth reason I'm here supporting doctors need to strike is because we need to take substantive steps toward ending healthcare segregation. The New York City Commissioner of Health, Mary Bassett, in 2021, declared racism a public health crisis. And DOH research has shown that structural racism tragically affected health out health outcomes in the COVID pandemic.

We can create better public sector physician jobs which will set the tone for better jobs and patient care for the immigrants and people of color who make us make up a significant portion of the H+H workforce and patient population.

The fifth and final reason I'm supporting the doctors need to strike is as the vice chair of Physicians for a National Health Program here in New York City, I recognize that doctors' collective action represents the most powerful challenge to the corporate race to the bottom in health care. The callous way I was treated individually was no different from how my colleagues and I were

treated... sorry, were ignored and disrespected at the bargaining table by Sinai.

As we saw last month in the outpouring of emotion from the public so far after last month's tragic murder of an insurance executive, millions of people want to eliminate corporate greed from the practice of health care. Here in one of the last remaining public hospital systems in the US, which has a rare unionized physician workforce, we can begin to do that.

Public hospital doctors need a fair and excellent contract, and we also need to pass the New York Health Act at the state level to eliminate the inequality and racist (TIMER CHIMES) two-tier healthcare system that the private insurance industry creates.

CHAIRPERSON NARCISSE: Thank you.

DR. ROONA RAY: Thank you for your time.

CHAIRPERSON NARCISSE: We try to keep to the time, because there are a lot of folks here that we have to give the opportunity to testify. So if you can kind of try to summarize and sum it up, thanks

DR. SINDHU VANGETI: Good afternoon, Council Members, my name is Sindhu Vangeti, and I'm a

postdoctoral fellow at the Icahn School of Medicine at Mount Sinai and an organizer and a steward for my union, the United Auto Workers Local 4100, which represents 2,000 postdoctoral workers at Mount Sinai as well as Columbia University.

I have a PhD in immunology from the Karolinska Institutet in Sweden, and I was recruited to Mount Sinai in 2020 to study immune responses to respiratory viruses and vaccines.

Today, I have the pleasure of speaking in support of my physician colleagues, at Doctors Council, and fellow workers in the academic and healthcare sector.

At Mount Sinai, my postdoc colleagues and I formed a union in June 2021. And after 18 months of bargaining, and a historic 12 day unfair labor practice strike, we won our first contract in December 2023.

Over 80% of postdoctoral fellows at Mount Sinai are international and come to the US to carry out cutting edge research, often bringing in up to $1.5 billion in research funding.

As international workers, we rely on our employer, Mount Sinai, for employment, visa sponsorship, career advancement through the research

we publish. And for the first three years of our fellowship, Sinai is often our landlord too.

This places us in an extremely vulnerable position for our careers as well as our livelihood.

Following the COVID-19 pandemic, our salaries, which have not seen an increase in years, remain unchanged. We have a housing and affordability crisis in the city. Our members work hard and sacrifice a lot to develop the latest advancements in medicine and in basic science. During the pandemic, my colleagues and I worked around the clock to make groundbreaking discoveries. And in parallel, our physician colleagues fought incredibly hard to save lives at the risk of their own.

Our contributions are always acknowledged, but we saw no measurable changes to our compensation or working conditions while our employers continued to make record profits.

We won a strong contract, but we had to fight Sinai very hard at the bargaining table for every single thing that we won.

With our strike, we won a record setting contract. And in the past few years, post doc unions, have raised standards and improved working conditions

across New York City, even at institutions without unionized workers.

Our physician colleagues and members of Doctors Council deserve the same sense of security and a strong contract so that they can continue to protect health and save lives.

For New York City to thrive, we need policies that support its essential workers. We need our doctors to have safe working conditions even if they need to go on strike to win.

Local 4100 stands with our colleagues at Doctor Council, and I thank you.

CHAIRPERSON NARCISSE: Thank you. Shapiro?

DR. DEBORAH SHAPIRO: I’m Dr. Deborah Shapiro; I'm the Chief of Rheumatology at Lincoln Medical Center in the Bronx, and I've come today to testify about the crisis in rheumatology care in the Bronx since the closure of the rheumatology clinics at Jacoby at the end of 2023. We're now into our second year of this crisis.

My service at Lincoln has been directly impacted by the departure of four rheumatologists, who all left Jacobi over a three month period because of

arbitrary and disrespectful treatment by their hospital administration.

The division at Jacobi was an active thriving division with two to 3,000 patients receiving excellent medical care from four highly trained, capable, and dedicated physicians.

The rheumatologists knew that their salaries were uncompetitive, but that's not the reason why the clinics closed. In about September of 2023, one of these doctors, gave notice - I believe that was for personal reasons relating to her husband getting a job offer somewhere else - and of the remaining three rheumatologists, two had school age children and one had a new baby.

Two of these rheumatologists requested flexible work schedules so that they could care for their children. The administration refused to allow them to change their schedules in any way and told them that they would have to resign unless they worked the normal eight hours a day, five days a week schedule.

One asked if she could work 10 hours a day, four days a week to total 40 hours, and that request was refused also.

Both of those two doctors then submitted their resignations. This left one doctor, the chief of rheumatology, Dr. Beverly Johnson (TIMER CHIMES), who also has three young children, and she told the administration that the situation was untenable and requested a meeting with the CEO. The CEO refused to meet with her, and Human Resources told her that it was insubordinate for her to request a meeting with the CEO.

I will have to, elide some of the chaos that ensued, but I knew that I would be... I would have more capacity at Lincoln to take some of their patients because we were in the process of hiring a new rheumatologist, Dr. Sharika Menin (phonetic).

However, the administration at Jacobi made no plan whatsoever for the continuing care of the two to 3,000 patients, and it was left to me, Dr. Johnson, and the chiefs of medicine and ambulatory care at Jacobi to scramble to find a place for these patients to go.

The lack of concern for patient care shown by the administration at Jacobi, to me, is incomprehensible and disgraceful.

I was, well aware of everything that was happening there. I had multiple discussions with everyone. I've spent - I cannot begin to describe the number of hours I spend every evening working on this. I applied for admitting privileges at Jacobi, so that I could do electronic consults, which we call E-consults, to communicate with the primary care and other doctors at Jacobi. I spent probably two hours every weekday evening, after my normal work day, doing these E-consults...

CHAIRPERSON NARCISSE: Dr. Shapiro, can you summarize?

DR. DEBORAH SHAPIRO: Okay. In a word, there are no more rheumatologists at Jacobi, because anyone who applies there who has half a brain is going to, ask why did your clinics close? And then ask the rheumatologist who left why they left.

And so no one who has young children is ever going to apply to work there. And, the proof is, you know, the fact that they've never been able to hire anybody in all this time. So it's really not a salary issue, it is an unreasonable administration at Jacobi.

CHAIRPERSON NARCISSE: Since the hearing is for the doctors, we try to keep it for the doctors to listen to see what's going on. But if you can summarize, that would be nice because we have a lot of folks that come in to testify. So thank you, Dr. Shapiro. And we can get all the writing you can share with us.

DR. DEBORAH SHAPIRO: I will definitely do the written testimony with you.

CHAIRPERSON NARCISSE: Thank you.

DR. RICHARD SINERT: Richard Sinert, this is my 40th year at Kings County. I've been in the emergency department for over 30 years. And when I look at my legacy, I look, who's gonna replace me? There's no one. There's no one 10 - 20 years my... in my sight seniority.

We have a department because in decades - and this is not just Mitch Katz's time - we have decades of underfunding and paying doctors below the fair market rate.

So and so what happens? So occasionally, we can recruit because everyone wants to work in Kings County. So we can recruit medicals residents, uh, emergency medicine residents who spend a year or two

with us to get a reputation, to get clinical experience, and then they burn out because the salary is so low, they have to work these procession shifts.

And they work a tremendous number, thank God, because if we didn't have those procession people, we couldn't cover the staff because we're so short.

And then if you're lucky enough to keep them a few years, there's no longevity differential.

So I told you, I'm 30 years in the emergency department, 30 years clinical experience; I'm an NIH principal investigator, I've worked for pharmaceutical companies, I've taught statistics, and if a new graduate out of the residency, so three or four years out of medical school, gets hired, it's the same salary that I get. Well, who's gonna stay for that? It doesn't make sense. Who's gonna stay for that? And no one stays for that.

Why did I stay? I'm a lifer. I'm like Dr. Quee, I'm a lifer. That's it. But you're not gonna find many people like that.

The other thing I want to talk about is the strike. So 40 years health care industry, a strike is an anathema to doctors. To mention a strike was shocking - 16 months ago when we started bargaining,

we talked about a strike. I was totally against it, totally against it. How could doctors strike? (TIMER CHIMES) I never heard of that. But think what they had to do to us to get thousands of doctors, like, 2,500 doctors to agree to strike. This is a big deal, and I think people don't understand that. And I understand it's complicated. Dr. Katz is right. It is complicated, but I've sat for 16 months every week at the bargaining committee.

And you know what? It's complicated, but we're pretty smart. And we figured out many, many proposals and counterproposals that were all rejected, rejected by PAGNY. That's the affiliate that's... the main affiliate. And they rejected them so often that after a while, they just implemented a contract against our wishes. And even more galling, they implemented a contract that didn't address retention and recruitment. They took away CME - I mean, it's just it's just a little thing - CME, vacation time, sick leave, people get sick. I work with COVID patients, flu season, doctors get sick - they took away days of each of those - and then the most galling, if you work, because if you work a procession shift, we just

call it overtime, but a procession shift, the first hour is unpaid. That's crazy. Who gets unpaid?

So these are just some of the reasons. What we need, from you, is when we were at the bargaining table, they said no to everything just because there wasn't enough money. They said the pot was just this big. It wasn't complexity. The pot was just too big. We need you to make the pot bigger. And that's what we're asking for. Thank you.

DR. JOAQUIN MORANTE: Good afternoon...

CHAIRPERSON NARCISSE: Thank you.

DR. JOAQUIN MORANTE: My name is... Good afternoon to all the council members.

My name is Joaquin Morante, and I'm a pulmonary critical care physician at Jacobi Medical Center and a member of Doctors Council. I completed my internal medicine residency at Woodhull Medical Center in 2016... Hello again... And began my career as an attending physician at Jacobi Medical Center in 2019.

As a child growing up in East Harlem, my hospital was Metropolitan. I have family members and lifelong friends who currently obtain their care at Woodhull, Lincoln, North Central Bronx, and Jacobi.

I believe that one of the key characteristics of a humane society is its dedication to ensuring that all members of that society have access to quality health care. The public hospital system of New York has always cared for some of the most marginalized in our communities. On a daily basis, its health professionals execute its mission to provide care regardless of one's ability to pay and to treat people with respect no matter their race, gender, country of origin, or immigration status. (SPEAKING FOREIGN LANGUAGE)

As a witness to the care that we provided, Jacobi, I can attest that since the pandemic, our public hospital system has continued to be in crisis.

It is in crisis because one of its most important resources, physicians, are now stretched so thin that our patients are suffering.

We are in a crisis that prevents us from recruiting and retaining the necessary physicians to deal effectively with the swell of community members living with chronic disease that was only exacerbated by the COVID pandemic.

This has led to a greater demand for appointments for primary care and specialty services. The solution

has been to cut visit times to accommodate the growing need for people to see doctors.

Unfortunately, the answer has not been to address the physician shortage by improving recruitment and retention throughout the system and improving staffing ratios. This is evidenced by the lack of a negotiated physician contract by the affiliates over the last 15 months.

As a result of insufficient physician staffing, especially in the subspecialties - I'll concentrate on that right now - we have been forced to start to transfer care of our patients to other facilities.

As a personal example, I treat people (TIMER CHIMES) with complicated lung disease - allow me to finish, please -that often require that doctors of different specialties collaborate on the care of one patient. At Jacobi, as a consequence of the lack of competitive salaries release, we have been without a rheumatology division for over a year. This has led us to have to send our patients to Lincoln and Metropolitan, further straining their own patient panels.

This is not a proactive solution. This is a crisis management solution.

As a pulmonologist, I'm often asked to perform procedures to aid in the diagnosis of various lung diseases, one of those being lung cancer. The biopsies that I obtain, and my colleagues obtain, are then examined by pathologists whose expertise is to discern whether a person may have a malignancy or something that is benign. Currently at Jacobi, because of the lack of pathologists, it takes approximately two weeks, 10 business days, but then you include the weekends, to have a biopsy specimen examined.

Our pathologists are responsible for examining not only specimens obtained at Jacobi and NCB, but also several other H+H facilities.

In order to ensure that the specimens are examined in a timely manner, the solution has been to outsource the work to a private company.

And why is it that it takes so long to be able to provide someone with a diagnosis of cancer? It's because the Department of Pathology and H+H and its affiliates have proposed non competitor salaries and they've been unable to hire new pathologists.

But to make matters worse, the department of oncology is also woefully understaffed. - I'll finish. I'll finish.

After a diagnosis of lung cancer has been made, because these are real world examples, patients may have to wait anywhere between three to six weeks before seeing an oncologist at Jacobi.

To make this concrete, I do a biopsy today on January 10, 2025, and that person, that Bronx resident, will have to wait two weeks to find out if they have cancer and another four weeks to then get a treatment plan from an oncologist. They're talking about now being seen at the end of February into March, all the while living with the uncertainty or living with a disease that can end your life.

The inequity is a direct result of the lack of recruitment and retention of physicians to address this massive need.

Instead of providing proactive a plan, we have decided to address this crisis with short term crisis management solutions, paying high hourly wage private contract doctors to fill the gaps instead, also known as locum physicians.

Salaried and per diem physicians, a group of physicians that make up 20% of Doctors Council membership, see themselves as part of the solution to helping our communities get healthier.

We are not the problem.

I'm compelled to speak out when I see a system that is letting down those who it is supposed to care for.

It is up to all of us to make sure that we do not accept less than the very best for our patients, and they should be able to have access to physicians who have enough bandwidth to treat them with dignity and the respect that they deserve.

Therefore, in summary, I am asking that we come together to focus on recruitment and retention of physicians at H+H facilities by increasing their salaries so that they are at least competitive and not allowing for the erosion of benefits as proposed by the current affiliate contract.

Our communities very much need the services that our public hospitals provide, and our public hospitals very much need the physicians to provide those services.

We're in this together. Thank you for your time.

CHAIRPERSON NARCISSE: Thank you.

And my colleagues have any, uh, questions? No? You do? Okay.

CHAIRPERSON SCHULMAN: Dr. it is so good to see you. I haven't seen you in...

DR. JOAQUIN MORANTE: It's good to see you.

CHAIRPERSON SCHULMAN: I know! I am so glad you stayed with the system. We were sad when you left Woodhull.

DR. JOAQUIN MORANTE: I was never gonna leave.

(LAUGHTER)

CHAIRPERSON SCHULMAN: I have a question for the panel in general.

So when I was at Woodhull, because I know every hospital has a community advisory board, and a lot of times we would get anybody that had some issues, whether it was the doctors or nurses or staff or whatever, would come and make a presentation at the community advisory boards.

Have any of you reached out to your community advisory boards? I'm just curious.

DR. JOAQUIN MORANTE: That's a better question for Doctors Council.

CHAIRPERSON SCHULMAN: Okay.

DR. JOAQUIN MORANTE: You know, I think...

CHAIRPERSON SCHULMAN: Okay.

DR. JOAQUIN MORANTE: in terms of the outreach and community outreach, my outreach is directly with (INAUDIBLE)... (CROSS-TALK)

CHAIRPERSON SCHULMAN: Because they meet... yeah, they meet once a month, and it's a it's another avenue to...

DR. RICHARD SINERT: It's a good idea, but, you know, the problem is system wide. It's not...

CHAIRPERSON SCHULMAN: Right, no, no, no, understood, understood....

DR. RICHARD SINERT: just a (INAUDIBLE) hospital.

CHAIRPERSON SCHULMAN: Understood...

DR. RICHARD SINERT: It's a system wide... this needs a system wide

CHAIRPERSON SCHULMAN: Right...

DR. RICHARD SINERT: solution.

CHAIRPERSON SCHULMAN: No. Understood.

But I'm just... but there was some folks that did testify that had specific to their particular facility. So...

DR. RICHARD SINERT: Problem with recruitment and retention is how...

CHAIRPERSON SCHULMAN: Yes, no, absolutely, is I...

DR. RICHARD SINERT: And that's the main problem...

CHAIRPERSON SCHULMAN: Is, I agree with you a 1,000%, 1,000%.

Okay. Thank you.

CHAIRPERSON NARCISSE: I want to say thank you so much for being here, because hearing from you means a lot to us. So, thank you for your time.

(PAUSE)

CHAIRPERSON NARCISSE: Alright, the next panel is Arthur Schwartz, Erlend Kimmich, Dr. Maxine Orris, Elizabeth Jenny-Avital, Lori Lemberg.

Okay, now, in the interest of ensuring that all witnesses have an opportunity to, we are going to have to stick to that two minutes, please try. Any additional testimony can be sent to testimony@council.nyc.gov. And we will review all testimony in full. Thank you.

Dr. Scwartz? Yes, you may begin.

MR. ARTHUR SCHWARTZ: Good afternoon. I am the general counsel of the Center for the Independence of the Disabled in New York, the Democratic district

leader for Greenwich Village First Avenue to the West, and I am counsel for a coalition of groups and community leaders who've been suing to keep Beth Israel Hospital open, uhm, for the last year. And we've had an injunction in place since last February.

In 2023, Beth Israel Hospital had 535,572 ambulatory care visits. It had 139,582 inpatient days, and at the time, it had 697 certified beds. It had over 65,000 visits to its emergency room.

Mount Sinai bought Beth Israel Hospital in 2014, which was a profitable hospital, and they started stripping it down, taking out maternity, neonatal, heart surgery, pediatric surgery, and many other departments.

In 2017, they proposed that they it could be replaced by a smaller hospital with 70 beds. A lawsuit slowed that down, which I'm glad to say I brought, and then COVID hit.

During COVID, the income at Beth Israel increased from $725 million a year to $858 million a year.

In 2021, Mount Sinai said that it realized the vital role that Beth Israel Hospital played in the community health of the Lower East Side, and that

they were gonna be investing $1 billion in rebuilding the hospital.

But in 2023, they announced a closure, and they said we're losing a $150 million a year. Of course, they were sitting on real estate worth $1.2 billion a year, (TIMER CHIMES) and they started shutting it down.

My and I'm gonna... my complaint here, the reason I'm bringing this up in this hearing is that we've gone through a whole process with Beth Israel opposing it, challenging it with the Department of Health, and the Department of Health approved the closure in August - the judge hasn't lifted the injunction.

But one of the key elements that they had to show (TIMER CHIMES) to justify the closure was that there was an alternative place for the patients to go. Those 65,000... there's still 55,000 people in the ED this year in this pared down hospital. And they said they'll go to Bellevue, HHC.

They said that Mr. Katz had agreed to take a $20 million grant from Mount Sinai to expand the Bellevue emergency room, which is already overloaded with patients waiting up to 24 hours just to get treated

or to get admitted to the... in a hospital which has a lack of beds.

Should... HHC doesn't have to do that. HHC's approval of the closure of Beth Israel, their CEO's approval of a $20 million (TIMER CHIMES) gift to Bellevue Hospital...

CHAIRPERSON NARCISSE: Wrap it up, please...

MR. ARTHUR SCHWARTZ: was a key piece of that. And if it happens, and if that $20 million is all that HHC wants, the doctors you've been hearing from, the extent to which they're overworked, they will not be able to exist, nor will the community. Thank you.

CHAIRPERSON NARCISSE: Thank you. Next, mm-hmm?

MR. EARL KIMMICK: Hi, thank you, my name is Earl Kimmick; I'm a community activist advocate that works with the Campaign for New York Health Coalition for the New York Health Act.

We heard over and over again, how there's, uh, visits with patients are limited to 20 minutes, and yet you have 25 minutes to talk to an insurance agent, profiteering, you know, insurance that is denying care, that is denying medication, that is, and this is life giving care -life giving medication where people suffer, families suffer.

And, so I'm here to say, of course, I support the doctors who are short staffed, the nurses who recently won some victories and agreements to no longer be short staffed, we'll see what happens with that. Congratulations on those fights both in the Health + Hospitals and the private sector nurses.

But then there's also the nurses and the doctors tell me that there's a shortage with transport workers, phlebotomists, porters, social workers, and the whole infrastructure in the hospitals. And everybody, like a team, is picking up to make it happen. But everybody's overworked, and there's zero reason why doctors should be on the phone for 25 minutes with an insurance agent denying care, denying medication when they could be treating patients.

And so whatever we can do as far as New Yorkers to push for the statewide bill, the New York Health Act, whether we're city council, union members, or just citizens, we need to make that happen for us in this time. Thank you.

CHAIRPERSON NARCISSE: Thank you.

DR. ELIZABETH JENNY-AVITAL: Hi, My name is Liz Jenny, I'm an infectious disease doctor at Jacobi

Medical Center since 1990. Dr. Katz is absolutely right, none of us came to H+H to make money.

I finished my training at Bellevue, and I was offered a job at Jacobi for $66,000 and I think the salary someplace else was $87,000, but it was a great job. I have no regrets.

I wanted to be free from the constraints of working for corporate medicine, I didn't want to have to think about profit as an incentive. I truly believed in safety net hospitals as bastions of quality where we could deploy magic bullets that would transform lives.

Just like penicillin and tuberculosis medications were magic bullets earlier in the last century, the job that I took in the HIV clinic was totally transformative. I didn't go to work there because I had any basic sympathy for the poor and the bedraggled and the disenfranchised and all the other afflictions that lead people to wind up with HIV, but I have to tell you, I learned so much, I became a much better person because of my patients.

So... and I'm still living in the same junior four that I lived in when I was a fellow. So I didn't even know that I was underpaid.

Fast forward to the corporatization of health care in America. Health care is expensive. It's too expensive. It's probably egregiously expensive, and maybe most doctors get paid too much, but that doesn't solve our retention problem. I cannot get the world to lower the salaries of other doctors in America to fix our retention problem, even though for me, salary is not the issue.

The demands of the public, the expectations of the public, the promise that's made to people of health care is limitless. And frankly, I think the value of health care is probably a lot less than the cost. That's my personal opinion.

So I ask, why is New York City in the business (TIMER CHIMES) of providing health care? It's really expensive. Can we afford it? Or maybe the better question is, what is really the mission of a safety net hospital? Who are the intended beneficiaries? Because people with insurance, even people with not so great insurance, have other places to go.

A lot of the people we take care of have no place to go, and they still can (TIMER CHIMES) benefit from the magic bullets that we have to offer. And there are many magic bullets, not just HIV drugs, the

rheumatology drugs transform lives. People who can't walk or show their face in public or get through a day without having diarrhea have their lives transformed by these drugs.

So what is our mission? Is it to provide basic healthcare or increasingly, is it to provide the kind of health care that reaps a profit? Because that's where health care is going. The things that are available are the things that make money. They're not necessarily (TIMER CHIMES) the things that our patient needs.

I know what my patients need. They need time, attention, love. I have a whole list of things, and our patients are vulnerable, and...

CHAIRPERSON NARCISSE: You can share with us, but the time, because we have a lot of...

DR. ELIZABETH JENNY-AVITAL: anyway, I can... Maybe I have gone over my two minutes.

Our patients have, you know, many disabilities, the patients that are seen preferentially in the public hospital system, cognitive, functional, language, literacy, psychiatric, insurance, et cetera.

It takes a lot of time to take care of these patients. It's not necessarily profitable, but it does a lot of good. And I hope somehow, we can solve this problem so that we can maintain a safety net and a mission, and we can still provide the services that our patients need.

Our system is gridlocked. I cannot make a referral anywhere in my system. And, I don't have a watch, so I won't go on (TIMER CHIMES) anymore.

CHAIRPERSON NARCISSE: No, it’s been over, but I was just listening...

DR. ELIZABETH JENNY-AVITAL: Thank you.

CHAIRPERSON NARCISSE: Thank you so much for your time.

DR. LORI LEMBERG: Hi, I am Dr. Lori Lemberg, I am also at Jacobi, I've been there for 31 years. I'm a primary care physician. I also do inpatient medical consultation.

And I just first wanted to correct at least that at Jacobi and my clinic director actually verified with Metropolitan, we have 10 patients scheduled for our morning, and we have nine in the afternoon. And the only reason it was changed from nine, from 10 to nine, was because we are only paid by PAGNY for eight

hour days. So if you work nine hours, you are not paid for that additional hour. On our Paycom (phonetic), it comes off as unpaid hours. So they drop the 4:40, uhm, slot for those patients so that we can end at 4:30. Although, obviously, our day is never done within eight hours.

Besides the additional - with the new patients, the 40 minute to 20 minutes comes a whole, much more in the back end between EPIC and all the documentation that you need to make for every patient that you're seeing, going over their behavioral health issues, their, uhm, if they're using drugs, the PaCO, helping them, with smoking cessation, all of the other issues that come in. It's all of the, uhm, documentation that needs to go in, and then following up on your in-basket, and then making sure that your own patients can be seen in a reasonable period of time, which obviously a lot of are booked out six months. So we don't have the ability to have them come back in a week or two or say, what's your one problem?

Because most of those patients, the new patients are coming... I've had patients moving here from other countries with medications that are not in our

system. They don't know their medications. They have uncontrolled diabetes, uncontrolled hypertension. And then, you know, on the back of that is your in-basket, so you have to do your prior authorizations. You have to renew medications and (TIMER CHIMES) check labs, and that just becomes a bigger and bigger issue.

Besides that, I'm just... I'm here as a... one of the doctors that signed the strike authorization because we need parity across the system. We have a lot of the subspecialists, especially in medicine, that are very much underpaid and not getting marketplace adjustments. Primary care did get a marketplace adjustment.

And, our benefits were then cut. And then our... this contract was implemented against... without any fair negotiation. Thank you.

CHAIRPERSON NARCISSE: Thank you so much, thank you everyone for coming out. We appreciate your testimony. And we are looking forward to make sure that doctors stay in the hospital and not on the street. So, thank you so much, we appreciate you.

Next panel is Roberta Pikser, Dr. Marylouise Patterson, Adam Hill, Anne Bove, Osendy Garcia.

(PAUSE)

CHAIRPERSON NARCISSE: You may begin, thank you. And try to keep the time, because we have a lot more...

MS. ROBERTA PIKSER: Yes, I will make this extremely brief. I think you've heard all the subjects (INAUDIBLE) here... (CROSS-TALK)

CHAIRPERSON NARCISSE: Thank you, I appreciate you.

MS. ROBERTA PIKSER: My name is Ms. Pitzer, and I am here to support the doctors who work at the Health + Hospitals Corporation of the City of New York in their struggle to properly serve the people of the city and to be accorded the respect which they are due.

I'm here as a citizen of the City of New York and one who has, along with many other, received excellent and thoughtful care from these doctors. That those who take care of us in our neediest moments should themselves be mistreated is appalling.

I'm speaking also as a worker, and the mistreatment which these doctors are being accorded is not permissible. That they have neither job

security nor benefits nor even sick days and are notably underpaid is ridiculous.

To employ one doctor where four are needed to have one, and only one specialist on call 24 hours a day, seven days a week, with presumably no relief in sight is obscene. And to pressure these doctors to work this way is to practically demand that they make errors.

So now I come to my point: How can we ask these doctors to take care of us when we treat them with such disdain? Or perhaps, this is what the Health + Hospitals Corporation and the city of New York are trying to say, that those who take care of us do not matter precisely because we citizens do not matter.

In conclusion, and this is simple, the problem seems to be money, but money can always be found for what is considered important.

Thus, the question is, are these doctors considered important to the City and to the people of the city? (TIMER CHIMES) Are the people of the city important enough so that the doctors who serve them will be properly treated?

I leave it to you, the council members who work for us, to answer that question.

CHAIRPERSON NARCISSE: Thank you for your testimony. Yes, ma'am?

MS. OSENDY GARCIA: Hi, my name is Osendy Garcia, I am a community organizer based on Elario, the east side. I have quite a bit of a long story, but I started advocating for a houseless and transient community since 2014.

In 2019, when the death rate for the flu was about 16,000 a year, I went to the Public Advocate's Office to explain and try to get a better idea of the kind of support that our most vulnerable were getting at that time.

Shortly after that, about two months later, there was a news of what we now know as the COVID 19 pandemic. During this time, the Health + Hospitals did everything in their power to ensure that those that were most vulnerable, who were not able to actually get to shelters, who were able to actually get some hygiene support, because a lot of the vulnerable and transient individuals who were living in the street without access to bathrooms, without access to any medication, without access to any support to the services that they relied on ended in Health + Hospitals.

Unlike our Supreme Court, I defer to the professionals to the need of the contracts and to the details of what needs to happen for them to be happy and well. But I can tell you without a shadow of a doubt that if our doctors were to strike, this will mean death, continued death for our vulnerable individuals.

I am still very much holding on to the strength of the structure that was created during the pandemic, specifically around our shelters and the services that are provided to the community.

I also have a tremendous respect for this council and for the work that you've done to make sure that you hold the pharmaceutical companies accountable.

And please, I would hope that you continue this work in actually holding the insurance companies accountable for the lack of effort and for the lack of time (TIMER CHIMES) that they have put into actually caring for people and actually drowning our doctors in paperwork instead of actually supporting us. Please hold them accountable.

CHAIRPERSON NARCISSE: Thank you so much for your testimony.

ANNE BOVE: Hello, my name is Anne Bove, on a personal note, I'm a retired nurse from Bellevue Hospital after 40 years of service.

I'm here to represent CPHS, which is the Commission on the Public Health System, which has spent over 35 years advocating for access to care issue founded by Judy Wessler and Marshall Anglin.

And we're here in in support of Doctors Councils' concern in regards to the fact that they need to have that contract settled as quickly as possible.

In 1980, I went out on strike, Taylor rule was invoked and, you know, it was very difficult I was a young nurse, I followed my seniors. So I know how difficult it's a decision to make and you don't want to do that. It was a different time, different collaboratives there.

My concern is statistical analysis. All right? What the commission's concern is statistical analysis. You know, people say, oh, you know, the benefits of, you know, cutting the time down didn't... we didn't see any real deficits, but what was the sample size? You know, what was the patient population? What was the parameters that you looked at accordingly?

I remember years ago there was something with Harlem Hospital and saying that the Harlem community had a decrease in asthma. The reality was they looked at only hospitalizations. When they did a door to door, they actually saw a massive increase so that you could only guess that it was the Triborough Bridge as well as the bus terminals that was part of the reason you saw that incident. But they were doing better at secondary care.

So the concern is making sure that you have adequate statistics. I can't imagine that 20 minutes is going to help not even, you know, the HHC population, but populations in general. Because if a patient tells you something is wrong, you have to go into it. (TIMER CHIMES) You can't just say, okay, you know, we'll just look at that issue.

So I think in terms of looking at statistical analysis and making sure that those statistics are real and pertinent, and we can see how we can do better because I've lived through it. And I've had to, in this room, actually, had to show how those numbers were wrong and do the footwork myself.

So thank you for your time.

CHAIRPERSON NARCISSE: Thank you so much.

ANNE BOVE: Commission on the Public Health System.

DR. ADAM HILL: Hi, I'm Adam Hill, I am an emergency medicine physician currently Elmhurst Hospital, previously at Woodhull in my early career. part of the Elmhurst Bargaining Committee for this current contract.

I'm here to speak a little bit on the lack of adequate funding physicians, we've talked a lot about recruitment being key, retention being key. I'm not gonna talk about that.

But one thing that Council Member De La Rosa mentioned, asking Dr. Katz if he had any examples of ways that they've been able to improve recruitment in other agencies within H+H, but also outside - and they have. Within H+H, they got better a contract for the nurses. And he said himself, 3,000 nurses hired. The physician assistants got a better contract.

I work at Elmhurst. We haven't lost a physician assistant in years now since we have this new contract. The same thing can happen for our physicians. He talks about market wage. We know we're not gonna make market wage. The physician from King's Counter, he knows he's not making market wage. We

know all this, but what we're asking is that we need to have the funding for competitive wages that are at least comparable, to a degree, with the private, uh, profit driven hospitals that all doctors are gonna have to figure out where they take this mission.

And I believe in the mission, but a lot of new doctors, that mission might only get them so far.

So what I'm asking for this council is to help, uh, by helping fund the public health care system, fund H+H, invest in your fellow New Yorkers, and help me and all the other physicians here continue to take care of this city.

CHAIRPERSON NARCISSE: Thank you, and thank you to all of you, thank you for your testimony.

Next panel is Nozomi Ikuta and Nicole DeNuccio.

(PAUSE)

MS. NICOLE DENUCCIO: Thank you.

Honorable NYC Council Committee Chairs Narcisse, Schulman, and De La Rosa, thank you for calling this hearing today.

My name is Nicole DeNuccio; I am a midwife at NYC Health + Hospitals, Woodhull Hospital. I am here to testify that the failure of H+H and its subcontractor employers to offer fair and competitive contracts to

its physicians, is not only a labor issue, but also a patient safety issue, and an issue of systemic racism and medical apartheid.

At Woodhull Hospital, we continue to grapple with an increasing and devastating series of perinatal deaths in our care in recent years, all of which can be linked to issues of chronic understaffing and physician staffing shortages from the crisis of recruitment and retention; a dire situation that clinicians in our service have sounded the alarms about to our hospital administration for years.

The crisis has been deepened by a corporate style takeover of our current OBGYN leadership in 2023, using an autocratic and punitive leadership style that has sought to weed out staff who are not loyal to them by making it a hostile environment for them to work, blaming and punishing individual clinicians and scapegoating midwifery care for adverse outcomes that are truly rooted in underfunding and other systemic issues, and thus failing to address the real root causes of preventable death and iatrogenic harm to the people we are supposed to serve.

The most egregious and unforgivable harm caused by this crisis is the preventable deaths in recent

years of three Black mothers, one of them Afro Latina, as well as the other intrapartum deaths of a Black baby and a Latino baby.

In addition, the numbers of people that have suffered preventable morbidity due to this crisis at Woodhull Hospital are far more numerous and warrant further investigation.

During the COVID pandemic, my OBGYN physician colleagues took it upon themselves to take more shifts beyond their contract obligations to meet the need.

Simultaneously, a crisis of recruitment and retention in Woodhull's anesthesiology department due to severely noncompetitive pay allowed a dangerous anesthesiologist to remain in practice despite multiple reported safety concerns.

In 2020, Black mother, Sha-Asia Semple, was killed by a fatal error by this anesthesiologist. Since that time, the anesthesia department at Woodhull has been overhauled, (TIMER CHIMES) but this action came too late for the life of miss Semple.

As the crisis of physician shortages and chronic burnout deepened in March 2023, Woodhull OBGYN physicians issued a collective plea for help to the

Woodhull Hospital, H+H, and NYU Langone Affiliate Administrations, flagging the dire situation and demanding active physician recruitment, competitive pay to make recruitment efforts viable, and the temporary hiring of Locum Tenens physicians to fill coverage gaps and prevent more physicians from leaving or reaching dangerous levels of burnout.

These demands were not acted upon by the administration. Physicians were also forced to work shifts that they did not feel were safe for them to work. One key example being an OB physician in his seventies who faced health complications, who requested not to be scheduled on the night shift...

CHAIRPERSON NARCISSE: Please just summarize, please.

MS. NICOLE DENUCCIO: Pardon me?

CHAIRPERSON NARCISSE: Please summarize, because your time is up...

CHAIRPERSON SCHULMAN: Please summarize.

MS. NICOLE DENUCCIO: Okay, sure.

I have, I'm sorry, two more human lives that have been lost to discuss.

In September 2023, issues with unsafe staffing ratios and cultural norms formed in the setting of

chronic understaffing and burnout contributed to the substandard monitoring care that a Black mother in labor received leading up to the death of her baby that day.

In October 2023, a Latina mother lost her baby and uterus in labor to a uterine rupture. An OB attending worked sick with a packed surgical schedule that day and handed off the floor that night to the same attending who did not feel it was safe for him to work at night. Delays in this mother's cesarean birth resulted in the death of her baby (TIMER CHIMES) and loss of her uterus. The following morning, this attending again expressed his dismay that the safety concern was not honored. Two weeks later, he remained scheduled for a night shift, and that night he made a fatal surgical error and post surgical management decisions that resulted in the death of Black mother Christine Fields.

Some demands in the decision's March 2023 letter have now been met, but, again, far too late and only in response to these catastrophic losses.

In 2024, again, the Administration's prioritization of their bottom line over the lives of black and brown people came with deadly consequences

when a locum tenens physician had been reported for unsafe practice remained (TIMER CHIMES) on the OB schedule months later. Using up the remaining funds in our contract...

CHAIRPERSON NARCISSE: You heard you have three...

MS. NICOLE DENUCCIO: I'm sorry... I wanted to mention that as a result of this decision, Afro Latina mother, Beverly Garcia Barrios' care, let... received... she received substandard monitoring and delays in in in her necessary cesarean birth during which she died later that day.

The case study of Woodhull's OBGYN service is a warning to you in this moment...

CHAIRPERSON NARCISSE: You can share this testimony with us...

MS. NICOLE DENUCCIO: I will... I stand with the H+H physicians who have appropriately recognized the severity of this crisis.

CHAIRPERSON NARCISSE: Thank you for the testimony.

Now we... Thank you to all of you who came here to share your thoughts and experiences today.

If there is anyone in the Chamber who wishes to speak, but has not yet had the opportunity to do so,

please raise your hand and fill out an appearance card with the Sergeant at Arms at the back of the room.

Seeing no hands in the Chamber, we will now shift to the Zoom testimony. When your name is called, please wait until a member of our team unmutes you, and the Sergeant at Arms indicates that you may begin. We will start now with Sean Petty.

SERGEANT AT ARMS: You may begin.

NURSE SEAN PETTY: (NO RESPONSE)

CHAIRPERSON NARCISSE: Alright, if you hear your name and you are on, please raise your hand.

We are moving to the next. Jasmeet Sandhu?

DR. JASMEET SANDHU: Yes, hi.

CHAIRPERSON NARCISSE: Thank you.

DR. JASMEET SANDHU: Sorry, just give me one second.

I am a hospitalist at Elmhurst in Queens. As a hospitalist, I deal with patients in inpatient hospital setting. I practice... I started practicing since 2020 during the peak of the COVID pandemic, which Elmhurst was the epicenter. I have watched my colleagues work long hours every day desperately trying to save as many lives as we could. We could

hardly take... we hardly took any breaks with low resources, but the community needed us, and we did not hesitate to help.

Many people quit during the pandemic or retired early. I hope as amount of case... sorry... I hoped as the amount of COVID cases started to drop, we would finally get a break because we were so burnt out, but we did not.

The volume of patients did not decrease, and those who stayed were overwhelmed by this volume.

This is severe with the subspecialties, which include endocrinology, rheumatology, infectious disease, psychiatry, hematology, and oncology.

Because of the uncompetitive salary among these subspecialties, many have left leaving unfilled vacancies. I had one colleague who loved working in Elmhurst, but he had to leave because he was working overtime almost every day. He had a newborn and home and left because he had to help support his family.

The subspecialties work in the hospital and in the clinic, splitting their time between the two. The lack of staff is so severe that some departments are left with one physician. And when that physician

takes a much needed break vacation, we don't have that service available.

This impacts my work and my patients care directly. At times, consults are delayed because they're so overwhelmed by the volume of patients they are seeing in clinic. And because the clinic is overwhelmed, patients are waiting for months to see their provider.

Those with severe chronic illnesses can't wait that long and end up in the hospital. Something simple that could have been managed outside the hospital ends up in the ER because the patient is in severe pain or an acute crisis, impacting their daily function. "Doc, I can't go to work. I'm in severe pain. (TIMER CHIMES) I can't wait for the clinic...

SERGEANT AT ARMS: Your time has expired...

DR. JASMEET SANDHU: I had to (INAUDIBLE)..."

SERGEANT AT ARMS: Thank you.

CHAIRPERSON NARCISSE: You can summarize it, if you can finish in two sentences, please.

DR. JASMEET SANDHU: Basically, it's very frustrating to watch patients who could have been managed outpatient. It takes a it's a couple of hundred dollars for a clinic visit, and they get

admitted to emergency room. And in hospital admission, it's gonna be a couple of thousands of dollars. So it's a high cost of health care with low poor outcome.

The main thing is you're gonna hear recruit, retain, and respect. That's what we want.

CHAIRPERSON NARCISSE: Thank you.

DR. JASMEET SANDHU: We want a competitive salary to recruit, we want to retain the great physicians we have, and we want to respect with good faith bargaining.

CHAIRPERSON NARCISSE: Thank you so much.

DR. JASMEET SANDHU: Thank you.

CHAIRPERSON NARCISSE: Thank you.

The next person online is Petar Lovric.

SERGEANT AT ARMS: You may begin.

PETAR LOVRIC: (NO RESPONSE)

CHAIRPERSON NARCISSE: Alright, Petar Lovric? Nope?

The next, oh, Sean Petty is back on? Sean Petty?

NURSE SEAN PETTY: Hi. Thanks for hosting this hearing, everybody.

My name is Sean Petty, I'm a pediatric emergency room nurse at Jacobi Medical Center. We're the only pediatric trauma center in the Bronx.

I'm here to support my physician colleagues. There's no humans that I have had the pleasure to work with than my fellow nurses and my fellow attending physicians in this department. They would not be here if this fight were about... if this fight were just about money. They wouldn't be... they wouldn't be a Jacobi for all the time that they've been, and most of my attendees have been there for, five, 10, 15, 20, 25 years.

And things are on the brink of disaster, both in the inpatient and the outpatient setting.

I really, all due respect to Dr. Katz - and there's quite a bit of respect that I have for Dr. Katz for a whole host of reasons - but he's painting far too rosy of a picture in terms of what the actual issues are, what the nature of this crisis is.

And, really, it comes down to, he pointed out some of the obvious things about how there is a profound crunch about the patients that we need to take care of, and there is a funding issue.

But the reason why this struggle, their fight, and if it comes to a strike, the reason why that strike is necessary, is because somebody needs to draw a line.

The question of... previous testimony mentioned the medical apartheid. This, uh, how this plays out in terms of the examples the sister used, for the deaths of Woodhull, the other issues we have, uh, across (TIMER CHIMES)...

SERGEANT AT ARMS: Your time has expired.

NURSE SEAN PETTY: the...

SERGEANT AT ARMS: Thank you.

NURSE SEAN PETTY: (INAUDIBLE) with medical apartheid, these are... these need to be addressed head on...

CHAIRPERSON NARCISSE: Please wrap it up...

NURSE SEAN PETTY: These physicians are leading the fight in that right now. And their demands need to be respected, thank you.

CHAIRPERSON NARCISSE: Thank you so much for your testimony.

Petar Lovric? No? Gray Ballinger?

SERGEANT AT ARMS: You may begin.

DR. GRAY BALLINGER: (NO AUDIBLE RESPONSE)

CHAIRPERSON NARCISSE: Gray Ballinger?

DR. GRAY BALLINGER: Sorry. My name is Gray Ballinger. I'm a primary care physician at Queens Hospital Center.

I would... will post my full remarks in in text. I would like to read one paragraph from my statement and introduce to you the 22 patients that I saw yesterday - don't worry -together.

These are intelligent, hardworking, and compassionate New Yorkers, and they face incredible barriers to care.

One size does not fit all in this city, and what works in Coney Island or at Metropolitan, uh, in those boroughs does not work at Elmhurst or Queens, uh, the two sister hospitals of Queens.

I did a personal straw poll of, I believe, four (BACKGROUND NOISE) of my patients all chosen in sequential order, and I determined that 65% of my patients are functionally literate in English at an 8th grade level; 60% of them, no, I'm sorry, uhm, that 60% in English, and then 65% illiterate in 8th grade level in any language; 35% of them are with a formal translator. Our no show rates are very low

because these patients have nowhere else to go, compared to what I've heard, Dr. Katz describe.

These are individuals who cannot read (BACKGROUND NOISE) (INAUDIBLE) paperwork or their prescription bottles. They can't read a letter notifying them that a mammogram or a pap smear was abnormal and showed evidence of cancer.

They need our time, our attention, and our teaching. We owe them better. Thank you.

CHAIRPERSON NARCISSE: Thank you for your testimony.

Next is Yogangi Malhotra. If I butcher your name, you can correct it when you come on.

DR. YOGANGI MALHOTRA: (NO AUDIBLE RESPONSE)

CHAIRPERSON NARCISSE: Is she here?

DR. YOGANGI MALHOTRA: Hi, this is Dr. Malhotra, uh, can you guys hear me?

CHAIRPERSON NARCISSE: Yes, thank you.

DR. YOGANGI MALHOTRA: Oh, thank you. Thank you so much for, letting me speak. I'm sorry, I'm in my car because, anyways, it doesn't matter. I'm not gonna take that for my two minutes.

I'm here... I'm a neonatologist at Jacobi Medical Center. I've been here for seven years, and I truly

believe in the mission. This is where I found my wings. I came from Yale and Monty and came to Jacobi, and I was truly happy to find my home at Jacobi.

I've taken pride for the longest time in mentoring the next generation and believing in being that living example of showing what the best job in the world looks like. I've been caught many times saying that I had the best job in the world because I absolutely love what I do. And I work with most amazing colleagues who I believe are my friends.

But over the last couple of years, I've seen many of these friends leave, and I have seen the light and the spark leave the eyes of many of my dear friends who are still continuing to work, despite all the circumstances everywhere they are pulled in every direction.

I implore all of you on behalf of my part time colleagues who make themselves available 24/7 without payment, because they are covering the only level two pediatric trauma center, my psychiatrist friend who I try to stop in the hallway, and she's always running because she is trying to take care of the inpatient site unit staffed by four physicians instead of the 12 that are supposed to be there.

They're trying to recruit and cannot recruit, and they are trying to retain but cannot retain. So they are there, or, you know, or trying to care for 30 patients in a day in a psychiatric ED, which is very, very scary to think about for me, uh, or my very pregnant friend who is now just finishing covering her long week long neonatal ICU shift and now has to come back at night to (INAUDIBLE) (TIMER CHIMES)... (CROSS-TALK)

SERGEANT AT ARMS: Thank you, time has expired.

DR. YOGANGI MALHOTRA: (INAUDIBLE) level provider shift.

In summary, I would really thank you for your time, and I support everything that has been said so far about this. Thank you very much for your time.

CHAIRPERSON NARCISSE: Thank you for your testimony.

Next is Debra Lynn Bergen, Debra...

MS. DEBRA BERGEN: Yes, yes.

CHAIRPERSON NARCISSE: Thank you.

MS. DEBRA BERGEN: Can you hear me?

CHAIRPERSON NARCISSE: Yes, we can.

MS. DEBRA BERGEN: Oh, hi, my name is Debra Bergen, I live in New York in Manhattan. I'm here in

support of the members of the Doctors Council, the attending physicians at the Health + Hospitals, because I am ex-staff member of the Doctors Council. I worked there from 1987 to 1991 under the leadership of Dr. Barry Leibowitz. And while I was there, I represented the very same physicians at the hospitals that are under siege now, and I organized the doctors as the lead the lead organizer for the doctors at Coney Island Hospital.

I'm retired from the labor movement in New York now after 30 years. But having represented the attending physicians at the Doctors Council, I know firsthand the dedication that they have and the level of expertise that they bring to their patients every day. They face much more rising living costs than they did when I represented them in the, 87 to 91, longer hours, increased stress, and more burnout due to chronic understaffing.

That is why it's so important to recruit, retain, and pay these doctors fairly.

So in closing, I must state, knowing that one of the city negotiators here actually represented the members of the Doctors Council at one time, if the City truly cared about providing quality care for

some of the most vulnerable New Yorkers, it would start negotiating in good faith and do all it can to ensure H+H and its affiliates invest in a fair contract to these physicians. Thank you for your time.

CHAIRPERSON NARCISSE: Thank you.

The next person is Osvaldo Garcia.

MR. OSVALDO GARCIA: Hello, everyone, my name is Osvaldo Garcia. I was raised in the South Bronx, born in Washington Heights, and currently live in East Harlem, and I'm here in support of the Doctors Council.

When I was about four years old, I had my first asthma attack, and I'll never forget the horror on my mother's face as she ordered a taxi to take me to the nearest public hospital - sorry, let me just take off my mask real quick - And she ordered a taxi, and I wanna emphasize a taxi because calling an ambulance was too expensive. And this is a harsh reality for many South Bronx residents who face many burdens, including environmental health injustices and financial insecurity.

Public hospitals are a lifeline for families like mine, serving not only individuals with chronic

conditions, but also some of the most vulnerable members of our community.

These doctors at our facility is working tirelessly to care for a number of vulnerable populations - asylum seekers, people experiencing homelessness, New Yorkers with mental health challenges, new immigrants, and more.

And their dedication ensures that these populations receive the care that they need, and preventing them from ending up in our city jails, shelters, or on the streets, where managing their needs may cost taxpayers far more in the long run.

So if the city... if City Council truly does care and is truly committed to making our city safer and managing taxpayer dollars responsibly, it must ensure that Health + Hospitals and its affiliates invest in a fair contract for these physicians so they can continue to deliver the quality care that vulnerable New Yorkers depend on. Thank you.

CHAIRPERSON NARCISSE: Thank you.

Next is Cheryl Smith.

DR. CHERYL SMITH: Good afternoon, everyone, and thank you for the opportunity to speak. As stated, I'm Dr. Cheryl Smith, I'm a primary care as well as

an HIV expert. I saw my fellow, colleague from years back, Dr Jenny there, as always fighting the good fight.

I'm an attendant physician at Sydenham with Gotham Health Center. I began my medical career 30 years ago training at several New York City H+H facilities such as Jacobi, North Central Bronx, Bellevue Hospital. I have just dedicated my career to ensuring that New York's residents receive high quality health care services.

Throughout my years of service, particularly during the devastation of COVID 19, my colleagues and I have consistently gone above and beyond to meet the needs of our patients. However, the health care providers who, uhm, supported our city during its most challenging times now find themselves undervalued and underserved by the very system they work tirelessly to uphold.

One critical issue is the chronic understaffing of both physicians and frontline administrative staff. The persistent shortage, uh, place the... persistent shortage places an undue burden on existing personnel compromising the quality of care we thrive to serve.

Administrative staff are essential to keeping our clinics running smoothly while physicians need time to address the complex medical, social, and mental health needs of our patients.

Additionally, the reduction in new patient appointment times from 40 minutes to just 20 minutes only exacerbates this strain. This change undermines the core principle of the patient physician relationship... (TIMER CHIMES)

SERGEANT AT ARMS: Thank you, your time is expired.

DR. CHERYL SMITH: I'm closing.

Our patient population often faces multifaceted challenges and addressing their needs comprehensively requires more time, not less.

I urge you to address these staffing shortages and consider the impact of policy changes on both patient care and provide... and provider morale.

Let us work together to ensure that New York City's health care system remains a beacon of quality and compassion for all. Thank you for your time and attention.

CHAIRPERSON NARCISSE: Thank you, Dr. Smith.

Next is Kathryn McFadden.

MS. KATHRYN MCFADDEN: Hi, my name is Kathryn McFadden (INAUDIBLE), I am a midwife and a former NICU nurse at SUNY Downstate. I was pushed out of that position in retaliation for providing testimony about patient care conditions in a setting much like this several years ago.

I'm here to speak for the mothers and the babies who are dying and will continue to die preventively, uh, because of the conditions that have been elucidated by so many of the speakers who have come before me.

We know that New York City has the largest racial disparities in infant and maternal outcomes. It is one to... four Black babies die for every one of their white counterparts, whereas eight to nine... and eight to nine Black women die as, uhm, for every one of their white counterparts.

Research from Dr. Elizabeth Howell has shown that this disparity would drop by half if Black, uh, infants and mothers were receiving care at the same institutions or institutions that were as safe as the institutions that a majority of white birthing people use. And that research further says that essentially half of this disparity is because of a poor level of

care at a concentrated set of minority serving hospitals, uh, and was anonymized for the research, but everyone here can recognize that we are talking about Kings County, Woodhull, SUNY Downstate, and other, uh, other hospitals that serve upwards of 80% of Black patients.

The conditions that cause the care at those hospitals to be poor are not new. Many people have spoken to that today.

An article in the Times from 1988 says, "Many women seek prenatal care at city facilities and are forced to wait weeks to be seen. When they receive care disaster and rough rushed and impersonal." (INAUDIBLE) Hospital and maternity (TIMER CHIMES)... (CROSS-TALK)

SERGEANT AT ARMS: Thank you, time is expired.

MS. KATHRYN MCFADDEN: Uh, in summary, recommendations, uh, it's already been said we need to make the pot bigger. Uh, $1 billion, uh, we heard in testimony comes from the City budget, whereas the City gives $11 billion the NYPD. And I promise you we will have a healthier and safer New Yorker with diversion of funds to the hospital system as opposed

to systems that have proven not to keep New Yorkers safe.

Also, the private hospital systems are... do not... are not charities, do not operate as charities, and should not receive tax deductions as if they are charities. Taxing them could fund the public hospital system. They have also influenced legislation, which causes a $billion misappropriation of federal funding that should go to the public hospitals but instead go to the private hospitals. That would go a long way to expanding the pool to cover more doctors.

And if you, the City Council, is not willing to take the steps to drastically increase the H+H budget, I would encourage you then to put more pressure on your colleagues at the state level to pass the New York Health Act, because as described by other activists, that would also solve many of these core issues that underlie New York City system of medical apartheid.

CHAIRPERSON NARCISSE: Thank you so much for your recommendations.

Next is Jose Perez. Jose Perez, going once, raise your hand? No? Okay, Pranayjit Adsule? No? Alright, Max Fisher? Max Fisher?

MR. MAX FISHER: Can you hear me?

CHAIRPERSON NARCISSE: Yes, I can now.

MR. MAX FISHER: Great.

So my name is Max Fisher, I'm a New York City resident, and I'm testifying as a community member in support of our city's H+H doctors.

I think a lot of the previous speakers have elucidated the issues at the heart of these negotiations as well. So, I don't feel the need to go deeper into those, but I do just want to say that Dr. Katz, the H+H CEO, said both bargaining parties want the same thing, an equitable contract that meets physician's needs, achieving adequate recruitment and retention. Unfortunately, he said the health system and bargaining issues are complicated, they're multifaceted, nuanced, convoluted, and so on.

If I were on his side of the bargaining table, this is exactly what my rhetorical strategy would be. But while I think we can all acknowledge this complexity, the core issue is clear from having heard all the testimony today.

Prioritizing cost cutting over patient care is jeopardizing the well-being of our city. These doctors provide vital services to our poor and working class neighbors who deserve high quality medical care regardless of income or life circumstances.

This work not only makes our city safer, but also helps prevent higher long term social and financial costs associated with lack of treatment.

This is especially critical in a city with more millionaires and billionaires than any other in our country.

Finally, the Council should seriously consider the following: If doctors walk out, New Yorkers will stand unequivocally with the physicians who keep our city safe and healthy. This is what we saw when (BACKGROUND NOISE) (INAUDIBLE) nurses who had a strike two years ago, and this is exactly what we'll see this time. Thank you.

CHAIRPERSON NARCISSE: Thank you for your testimony.

The next person is Mamta Purohit. Mamta?

DR. MAMTA MAMIK: Can you hear me?

CHAIRPERSON NARCISSE: Sure.

DR. MAMTA MAMIK: Sure, thank you.

My name is Mamta Malik, and I'm a member of the OBGYN Department at Jacobi Hospital.

And, I'm speaking on behalf of the OBGYN Department, that, you know, the conditions, uh, the work conditions are so difficult that there's difficulty in recruiting enough number of OBGYNs leading to having them perform many, many calls and then having to have burnout as a consequence and then a lot of people leaving. So there will be a mass exodus if this problem is not addressed urgently.

In addition, I also want to voice my concerns for the primary care doctors who brought up their issues of recruitment and retention and also the working conditions, because seeing a patient that is supposed to be seen in 40 minutes, in 20 minutes is a very, very hard task. Not only are you seeing a patient, not only are you getting a history, you need to review their past medical history, you need to review their charts, their labs. It's a very difficult condition. In addition, if you have language barriers, I doubt that people are able to really thoroughly do that in 40 minutes. So reducing that amount to 20 minutes is, I think, not a wise thing to

do. The thing to do is to recruit more doctors to be able to see these patients and to help cut down on the waiting list instead of cutting down on the time taken to see these patients.

Thank you very much for listening to me, I appreciate it.

CHAIRPERSON NARCISSE: Thank you so much.

Now I am calling Mamta Purohit? Mamta Purohit, are you on?

Okay, next is Oluwakemi Adegoke.

DR. OLUWAKEMI ADEGOKE: Hi, can you hear me?

CHAIRPERSON NARCISSE: Yes, I can.

DR. OLUWAKEMI ADEGOKE: Hi, my name is Oluwakemi Adegoke, I'm one of the OBGYN providers at Jacobi Medical Center in North Central Bronx. And I just wanted to say, thank you for the my midwife colleagues who testified today about some of the hardships that we have been facing (INAUDIBLE) as OBGYN providers.

Our patients are very, very medically complex, coming from all over the world to seek care. And since we are down... we are personally down four OBGYNs at Jacobi Medical Center. We are often double

and triple booked trying to see these medically complex patients.

I know that Dr. Katz mentioned before about, you know, offloading things with PAs and nurse practitioners and midwives. We don't actually have those either. I personally participated in a protest outside of Jacobi Medical Center because our midwife colleagues have not had a contract in two years.

So I just want to say that we need to recruit the best and the brightest and more experienced providers at Jacobi Medical Center to offset the horrible, you know, maternal mortality that we have in our black and brown population.

So cutting our benefits, including our vacation, sick time, making us some work extra 10 years to have four more days of sick time, uh, slashing... basically not giving any compensation for seniority is not gonna recruit the brightest and best patient people to take care of our very complex patients. That's it.

CHAIRPERSON NARCISSE: Thank you, Doctor. Thank you for your testimony.

Next is Robby F. Short. Short? No? Okay, moving right along, next is Sirajum Munira? Sirajum Munira? Sirajum Munira? Okay, Ahmed Amer? Ahmed Amer?

DR. AHMED AMER: Yes, hello?

CHAIRPERSON NARCISSE: Thank you.

DR. AHMED AMER: Hi, good afternoon. I'm Ahmed Amer, I'm an ER physician at Kings County Hospital.

I'm just gonna keep it brief and just add on to some of what my colleagues were saying by just kinda telling you a brief story.

Last month, I saw a lady in her sixties that came in with very high blood sugar, not feeling well, vomiting. She was diabetic. Turns out she had a very bad diabetic emergency called DKA. She wound end up getting admitted to the hospital on IV fluids, insulin infusion, spent a couple of days. Luckily, fortunately, she made it out.

The story behind this patient that I saw can highlight everything that you need to know about what's going on in our system right now, because we in the ER are considered what's called downstream of all the health care decisions that are taken before the patient gets to our doors.

So this lady was from Brooklyn, she's from Flatbush, where my hospital is located. She had just moved back from Philly in October to live closer to her daughter so that she can meet her basic needs. She tried to get an appointment with the primary care doctors at Kings County. She called the hotline. They gave her an appointment in March of 2025. So she waited, and after a month, she called again. And they told her, "We're sorry, the earliest we could do is March 2025. If you have an emergency, call 911 or go to the ER." So she did the sensible thing. She tried to manage that on her own, and then eventually, she couldn't, so she wound up in the hospital.

Now, see, our patients want to see their doctors, and their doctors want to see them. The only way to do that is by increasing the resource, and the most valuable resource in the health care system are the health care workers that work in the system. It's not the machines. It's not the buildings.

And the only way to make sure that the patients have access to the care that they need in their hospital (TIMER CHIMES) (INAUDIBLE)... (CROSS-TALK)

SERGEANT AT ARMS: Thank you, your time is expired.

DR. AHMED AMER: that we give them the resource.

And in summary, what I would say is, if you want to help us address these issues, what we need is a fair contract. A fair contract that allows us to hire and retain the doctors that we need to staff this whole system properly. There is no amount of goodwill or sacrifice that can make sure that these patients get the care that they deserve.

And in our negotiations with H+H, they went out and they hired one of the most notoriously union busting law firms out there to come and negotiate with us. (TIMER CHIMES) So that already shows you that we are not on the same page. Our mission is to take care of the patients and the (INAUDIBLE)... (CROSS-TALK)

SERGEANT AT ARMS: Thank you, your time is expired.

DR. AHMED AMER: we can. Thank you

CHAIRPERSON NARCISSE: Thank you so much for your testimony.

Now calling on Sharon Peter. Sharon Peter? Sharon Peter? Sharon Peter? Can you hear us, if you can, if you can hear us put your hand up, please. So, I have three Sharon Peters, apparently. So, one of you, can

you raise the Zoom Raise Hand Function? There are no hands up. I am making the final call for Petar Lovric. Jose Perez? Pranayjit Adsule? Mamta Purohit? Robby Short? Sirajum Munira? Sharon Peter?

I guess, going once, you're not here, raise your hand?

If you are currently on Zoom, and you wish to speak, but have not yet had the opportunity to do so, please use the Zoom Raise Hand Function, and our staff will unmute you.

(PAUSE)

CHAIRPERSON NARCISSE: I have a hand, I guess, who is that?

(PAUSE)

CHAIRPERSON NARCISSE: Use the Zoom Raise Hand Function, and our staff will unmute you.

Okay, now, since you're with me, you ready to speak, to testify? Are you ready?

DR. PRANAYJIT ADSULE: Yes, I am.

CHAIRPERSON NARCISSE: Okay, we are listening.

DR. PRANAYJIT ADSULE: Hi, my name is Pranayjit Adsule, I'm a psychiatrist at Jacobi Medical Center, and I don't wanna take too much of your time, but thank you for giving us this opportunity.

I just want to voice the same concerns that my colleagues have said before me and as well as the other allies and supportive organizations, and members of the community that have spoken for us.

Just wanted to bring up that in Jacobi, I worked at the in the psychiatry department for 10 years. When I worked... when I started working there, there were 10, uh, there were 12 psychiatrists in the inpatient unit where we take care of the most severely mentally ill, sometimes violent, sometimes high risk patients. And currently, there are three full time psychiatrists there, and we've been struggling to recruit and retain doctors for all of this time.

In the psychiatric emergency room, we are four doctors short. We don't have a director. We don't have an associate director. We have to find a solution to these issues.

There is a there are physician compensation reports that are available online. One of them, for example, is MGMA, there's a lot of data about what the fair market value is. If it's not vacancies, it could be that. It could be a lot of other things that

we should look into to see if doctors are fairly paid.

If we need to, we can get external organizations to sort of help with this, if it's that much of a problem. And we were able to find... we were able to ask doctors at Jacobi Medical Center about the vacancies, and we have currently 62 vacancies at Jacobi medical center from, Doctors Report that we could get on our own.

So that's the situation that we're in, and I really hope that the Council here is able to help (TIMER CHIMES)...

SERGEANT AT ARMS: Thank you, your time has expired.

DR. PRANAYJIT ADSULE: Thank you.

CHAIRPERSON NARCISSE: Thank you so much, Doctor.

If you are currently on Zoom, and wish to speak but have not yet had the opportunity to do so, please use the Zoom Raise Hand Function, and our staff will unmute you.

(PAUSE)

CHAIRPERSON NARCISSE: One more hand, the doctors are serious. And what’s the name? Since you raised your hand, can you unmute? Can you hear us?

DR. ANNA LIVERIS: Yes, I can you, can you hear me?

CHAIRPERSON NARCISSE: We are listening.

DR. ANNA LIVERIS: Great, my name is Dr. Anna Liveris. I am a trauma surgeon at Jacobi Medical Center, and I've seen firsthand the impact that the lack of multidisciplinary care really has on our patients.

You've heard from my colleagues, and I had... there are critical gaps in specialties amongst my colleagues. And trauma care requires a team of diverse specialized professionals working together. Without the support of that team, we really can't provide the level of care that our patients deserve under this essential Level 1 trauma center at Jacobi Medical Center.

Our talented colleagues are leaving around us, and we're struggling to recruit new expertise that helps us take care of these vulnerable patients in some of the toughest times of their lives and for their families. And, really, those gaps in care directly harm.

We're calling for a fair contract, as you've heard, that allows us to build that team, attract the

right talent, and deliver the quality of care that our patients, the city's most vulnerable, need and deserve.

When I began my career, I started right at the beginning of the COVID pandemic. At that time, I wanna remind everyone our work was celebrated and recognized. There were pots and pans ringing every night. And I think that what you've heard and what you know of our work, we deserve that same respect and support to continue fulfilling the mission that we signed up to fulfill. Thank you.

CHAIRPERSON NARCISSE: Thank you so much. And working in the ER, I know what you are talking about. Thank you.

No hands? Any other hands? If you are currently on Zoom and wish to speak, please raise your hands right now. This is the final call. Final call? No hands? Alright.

Seeing no other hands, I would like to thank everyone, if you did not have a chance to submit your written testimony, you can do so at testimony@council.nyc.gov within 72 hours after the close of this hearing.

Before I finish, I want to say thank you so much to Dr. Katz for staying in the room throughout the process. We appreciate you.

To conclude, I would like to thank my colleagues who a here with me, and everyone who is in the room, and everyone who testified, that's what we call New York City. You come out, you testify.

Thank you, all the health workers, all of the professionals. I know you care, thank you to all the fellows, and all my fellow New Yorkers. And thank you to all the staff who participated.

Rie Ogasawara, Legislative Counsel, thank you. And my dear colleagues Chair Schulman, Chair De La Rosa, and all of the Sergeant at Arms who make it possible. So, thank you everyone. And the union, of course! Unions...

CHAIRPERSON SCHULMAN: We want to particularly thank Doctors Council and... Go ahead, finish...

CHAIRPERSON NARCISSE: And NYSA who was here. So, thank you, everyone, all the doctors, we appreciate you. We want you to stay in the hospitals, not outside of the hospitals. So, thank you, everyone.

CHAIRPERSON SCHULMAN: Thank you, everyone, we appreciate it... (CROSS-TALK)

CHAIRPERSON NARCISSE: Thank you to all my staff, thank you. God Bless, thank you. And good evening.

(GAVEL SOUND) (GAVELING OUT)

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 January 29, 2025