CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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March 5, 2024
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HELD AT: COMMITTEE ROOM – CITY HALL

B E F O R E: Mercedes Narcisse, Chairperson

COUNCIL MEMBERS:
Selvena N. Brooks-Powers
Jennifer Gutiérrez
Kristy Marmorato
Vickie Paladino
Carlina Rivera

A P P E A R A N C E S

Dr. Mitchell Katz, CEO of New York City Health and Hospitals

Dr. Patsy Yang, Senior Vice President of New York City Health and Hospitals

John Ulberg, Senior Vice President and Chief Financial Officer of New York City Health and Hospitals

Nevien Swailmyeen, Health Justice Advocate with New York Lawyers for the Public Interest

Medha Ghosh, Senior Policy Coordinator for Health at CACF, the Coalition for Asian American Children and Families

Ginger Davis

Julie Lam, MaskTogetherAmerica.org

Dr. Lucky Tran, member of COVID Advocacy New York

Elana Levin, Jews for Racial and Economic Justice

Anna Pakman, self

Myra Batchelder, COVID Advocacy Initiative

Greg Levine, freelance journalist

Paul Hennessy

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

Ngozi Alston, disability justice trainer organizing with Mask Bloc NYC

SERGEANT-AT-ARMS: This is a microphone check for the Committee on Hospitals recorded on March 5, 2024, by Layla Lynch in the Committee Room.

SERGEANT-AT-ARMS: Good afternoon and welcome to the New York City Council Preliminary Budget Hearing on Hospitals.

At this time, can everybody please silence your cell phones?

If you wish to testify, please go up to the Sergeant-at-Arms' desk to fill out a testimony slip.

At this time and going forward, no one is to approach the dais. I repeat, no one is to approach the dais.

Chair, we are ready to begin.

CHAIRPERSON NARCISSE: [GAVEL] Good afternoon, everyone. I'm Council Member Mercedes Narcisse, Chair of the Committee on Hospitals. Thank you for attending today's hearing on the City's Fiscal 2025 preliminary budget and the New York City Health and Hospitals Corporation's five-year operating and capital plans for 2024 to 2028. During today's hearing, we'll review H and H operating

Fiscal 2025 budget of 3 billion dollars, which represents nearly 3 percent of the City's budget.

First and foremost, I would like to thank everyone that has joined us today, and my Colleague, Councilwoman Schulman.

H and H's budget is 97 percent funded by City funds to provide services for New Yorkers including, but not limited to NYC care, mental health services, and asylum seeker services. Asylum seeker services, in particular, are funded for 1.8 billion in the Fiscal 2025 Preliminary Plan, which makes up 60 percent of H and H's budget. Even though H and H's budget is mostly made up of asylum seeker funds in the preliminary budget, it's difficult to determine what direct services are provided with this funding. We would definitely like to hear from the Administration about the services they provide as well as additional context on the 1 billion PEG to asylum seeker services in the Fiscal 2025 Preliminary Plan. I would also like to learn more about the sickle cell services that H and H provides. As you know, sickle cell disease is a very important topic to me, and we have a long way to go with ensuring equity with how we treat and even discuss sickle cell

disease. In relation to my bill, Local Law 163 of 2023, we'd like to discuss H and H's current status when it comes to sickle cell disease as well as some details about the current planning process for implementing the bill. It's important to take care of New Yorkers, especially with their health, but we should not forget to take care of our medical professionals as well. We held a hearing on February 29th on the topic related to medical residents in H and H, and their working conditions are very alarming. Our residents are overworked, often underpaid, and are burned out as a result. New York City residencies are notoriously difficult to match into despite their high cost of living and low starting pay, but there are still vacancies in H and H residences Program. To top it all off, H and H residents are paid less than residents at private hospitals for doing the same work. The hearing was the first step, but we must take action immediately to improve the quality of life for those residents as they are the doctors of the future. New Yorkers depend on their services.

I'd like to thank my Committee Staff, Committee Counsel Rie Ogasawara, Policy Analyst

Mahnoor Butt, and Finance Analyst Danielle Glants, Unit Head Florentine Kabore for their work on this hearing. I would also like to thank my Chief-of-Staff Saye Joseph and the rest of my Staff, of course, for their hard work.

I will now turn it over to Committee Counsel to administer the oath.

COMMITTEE COUNSEL: Thank you. Good afternoon, everyone. We will now hear testimony from the Administration.

Before we begin, I will administer the affirmation. Panelists, please raise your right hand. I will read the affirmation once and then call on each of you individually to respond. Dr. Katz.

CHIEF EXECUTIVE OFFICER DR. KRATZ: (INAUDIBLE)

COMMITTEE COUNSEL: Dr. Patsy Yang.

SENIOR VICE PRESIDENT DR. YANG: Yeah.

COMMITTEE COUNSEL: Mr. John Ulberg.

SENIOR VICE PRESIDENT ULBERG: (INAUDIBLE)

COMMITTEE COUNSEL: Thank you. You may begin.

CHAIRPERSON NARCISSE: Dr. Katz. Welcome. Thanks. You can begin.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Good afternoon, Chairperson Narcisse (INAUDIBLE). We're so honored to be before you. I think it's so terrific that this Committee is headed by a nurse who understands the health of New York City. Happy to see Council Member Schulman who has been a great public health advocate and advocate for healthcare in Queens.

I'm Dr. Mitch Katz. I'm a primary care physician and I'm President and CEO of New York City Health and Hospitals. I'm joined today by John Ulberg, who I think is one of the smartest CFOs I've ever worked with in healthcare, and Dr. Patsy Yang, who does a great job running our Correctional Health Services throughout the city. I'm happy to report on our finances. As you know, we're the largest system, municipal, in the country. Every day, our 40,000 employees live our mission of providing high-quality healthcare with compassion, dignity, and respect to all regardless of income, gender identity, race, sexual preference, or insurance status. We have, since we've last seen you, had a really terrific year. That included connecting 300 patients to permanent housing, converting our medical units which

provided life-saving treatment during COVID back to psychiatric units, expanded our services for survivors of domestic violence, earned Medicare-shared savings for reducing costs and providing high-quality care. We continue to grow our Virtual Express Care, and I'm very proud that we are the only public system in the entire nation to provide abortion care through our telehealth virtual care system. We opened the new Ruth Bader Ginsburg Hospital. I remember the Chair being there and what a great day that was celebrating by the statue of her. The first ever re-entry service center at Rikers. We also at Rikers have been able to distribute free smartphones so that we can make sure that people leaving Rikers are able to get the care they need. We opened ground on 93 apartments at Woodhull on an old parking lot, and one of my goals when I first came here was to change every parking lot into a supportive housing project for our patients. Our Metro Plus Health Plan grew to 750,000 members and New York City Care enrollment reached 125,000 members, which I'm particularly proud of having created Healthy San Francisco in San Francisco and LA Care in LA. This is a larger, more comprehensive program than either of those, and I'm

very proud of it. Our hospital on Staten Island SeaView was ranked as the number one nursing home in all of New York State. We continued the journey with Planetree International for patient-centered care. We distributed a million dollars to 27 behavioral health providers in the way of off their student loans in exchange for them committing to serve our system for three years. This is something that we hope to extend throughout our system and, as the Chair has already made reference to, we have been a critical part of the City's response to the asylum seeker crisis in New York City. Our financial performance has done very well, and that's what's enabled us to maintain our services, even with the need to participate in the City's PEGs and markedly increase salaries to our nurses but because we keep generating additional patient care revenue from insurance companies, not from patients, we're not interested in billing patients, we're very interested in billing insurance companies, and that's what enables us to keep expanding our services. Our closing cash was 500 million at the end of December, which is 18 days cash on hand. As we look at our Preliminary Financial Plan, I'm very proud that our fiscal picture remains

stable. We will continue to work with the City Council, with the Mayor's Office, with OMB to handle whatever challenges are out there. We appreciate that the City has been our advocate in maintaining a Disproportionate Share funding, which we are very reliant on. We also continue to work with the State to make sure that they understand our fiscal needs. As we look into the outyears, there are challenges. We are projecting operating losses because those DSH cuts are in the budget, but we hope that with the support of the City Council and the Mayor, we are able to forestall those cuts. It's our goal to continue to expand our services, not to contract them.

With that, Madam Chair I look forward to your questions and your recommendations for us.

CHAIRPERSON NARCISSE: I have been joined by my Colleague, Council Member Marmorato.

Before I start, I have to say thank you to you. In a time that is so difficult, I always wonder about you, and I have to really honestly say thank you. This is one of the largest structure of a medical system in our nation, and it's a lot of pressure and asylum seekers and all the things are

going around us so, honestly, thank you for your work.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Thank you.

CHAIRPERSON NARCISSE: H and H currently budget for asylum seekers is 1.8 billion in Fiscal 2025, which make us, makes up nearly 60 percent of the system budget. In the last Fiscal Year, the City relied most heavily on the Department of Homeless Services to provide shelter services for asylum seekers. In the current year, there has been a shift with H and H budget having the majority of asylum seekers funding, and H and H becoming the larger provider of shelter services for asylum seekers. Why has H and H and a provider of health services been leaned on so heavily by the Administration for provision of shelter to the asylum seekers?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Thank you, Chair. I think it's been an interesting history through the City. First, our excellent colleagues in HRA and within the Department of Homeless Services and the Mayor's Office of Immigrant Affairs were able to meet the challenge of asylum seekers, but as the number of buses kept growing and the number of people

coming to our city, they reached a point where all of the shelter rooms were full and there was no place for people to go. At that moment, we volunteered because Health and Hospitals had done a lot of work creating hotel rooms under COVID, and we knew how to do it and we knew how to do it quickly so we opened up a large number of homeless hotels and then also outdoor shelter areas with tents in order to meet the needs of asylum seekers. I see the City right now in a different place, a more mature place, with the number of asylum seekers, while it hasn't decreased, it's stable, we're no longer seeing markedly increased numbers. The numbers of new asylum seekers equal the number of asylum seekers who we've been able to help to get to their next step in the city, and also, the City is in a mature state with regard to doing RFPs for services. At the beginning, when we were literally trying to create thousands of rooms for people in a period of weeks, we had to use emergency provisions to get the necessary food and laundry and rooms and services. Now that we're stable, we're able to look at, okay, we need to put out RFPs to get the City's best possible price. We need to look across all of the Departments and

standardize the prices and also Health and Hospitals can take a less of a major role in this. Again, we got involved because the City needed an emergency response. Now that it's stable, I think we will be less involved. Our major roles will continue to be the intake center. I think that's an important role for us because of the health screening, especially making sure that people are screened for tuberculosis and treated if they have tuberculosis, making sure that people are appropriately vaccinated, making sure that if they're eligible for health insurance, they get health insurance so the City is not covering the cost of their medical care and then assigning them based on whether they're a single adult or an adult with young children to the appropriate housing place.

At the other end of the process, we'll continue to run the case management services, which interact with everybody regardless of whether you're in our shelter system or in our sister agency shelter systems. We work with individuals and families to figure out where their next stop is, what are the obstacles for them to get out of shelter, what do they need to go into the next spot. I think those two are the most critical. Right now, we're still running

14 different shelter sites, both indoor and outdoor. Over the next period of time, we are going to continue to transition those to our sister agencies. Our focus should always be providing services. I don't see us as having to carry leases. That's not necessarily our expertise but, again, we'll always do what the City needs. We see ourselves in part because we're a health system, we're used to the idea of triage. We run 24 hours, 7 days a week. We're used to the idea of people needing something at 3 a.m., and so in that sense, our involvement will always make sense on an emergency basis. Again, as things get more and more stable, we see ourselves as having a smaller role in providing overall services.

I'll give you one more example. We have done the food RFP for all of the different sites because, again, this was necessary to be done quickly. As the system matures, that might not be a sensible role for Health and Hospitals to play. Food provider is not our number one expertise.

CHAIRPERSON NARCISSE: Thank you, Dr. Katz. One of the things that we like to see more non-profits take over the bid that we have in is open bid. That's what we would like to see too.

Does this shift of the asylum seeker funding have anything to do with the H and H procurement process, and how it differs from the process of other City agencies?

CHIEF EXECUTIVE OFFICER DR. KRATZ: It does in the sense that Health and Hospitals was created as a public benefit corporation by New York State, and so our procurement rules are somewhat more flexible than the City's procurement rules and, again, I think that's very relevant in an emergency. I don't think it's as relevant once you stabilize the system. I think if you need something and when the City needs something in four, five weeks, we're a good agency to call on. I think when we're talking about, this is what we need for the next three years, that should be done through the City's usual process.

CHAIRPERSON NARCISSE: Thank you. H and H includes its costs for delivery of services for asylum seekers, indirect rate of 15 percent. In Fiscal 2023, the City paid H and H 62 million for the indirect rate. How much has been paid in Fiscal 2024? Why is the City subsidizing H and H budget, leaving less funds for provision of services to asylum seekers?

SENIOR VICE PRESIDENT ULBERG: Hello, my name is John Ulberg. Nice to see you. First, I'd like to say we very much appreciate it. Health and Hospitals, my staff had a chance to go through the report that was generated by the Committee, and it's reassuring from our standpoint that we are communicating and people are following the vast numbers that are transacting on and off the Health and Hospitals ledger so I do want to say thank you for that. Our numbers for the most part do in fact tie out.

In answer to your question, indirect is always a component of the reimbursement that we get from the City. It's really intended to cover our administrative costs, and any dollar that we don't use for that purpose, we give back to the City or we will use for the program. We're very sensitive to that. The indirect rate is really a common grant funding mechanism to cover the cost of our staff and all the overhead expenses.

CHAIRPERSON NARCISSE: What direct services does H and H provide for our asylum seekers?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Right now, we are the intake, we are the case management at

the other end, and we are providing shelter at 14 different sites, we're doing all of the food for all of the sites, and at our sites we are involved in the laundry and the security issues as well.

In addition to that, of course, we provide the medical care, but that we do as part of our regular mission. The cost of that medical care is not part of this budget because we view that as our mission for the City to provide care to everyone, regardless of their insurance status.

CHAIRPERSON NARCISSE: That's why I appreciate it even more.

CHIEF EXECUTIVE OFFICER DR. KRATZ: We have as one happy note that you'll appreciate, we've delivered a lot of babies, which makes us very happy.

CHAIRPERSON NARCISSE: In the Fiscal 2025 Preliminary Plan, H and H received a PEG of over 1 billion to asylum seeker services. How does this PEG amount determine, was the reduction in funding for asylum seekers due to updated population projections? Are there going to be changes in services delivered and with the population projection shifting, will the number of contracts be modified, lessened, or if so,

what was, for what services? I think some of them you answered, but you can clarify a little bit.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Sure. We've been working, I think, very productively with our sister agencies and OMB on how do we reduce the cost so that it does not impact other City services and still provide the services that asylum seekers need, and I think the formulas that we have found are that we can now through the use of non-profits, through the use of RFPs to get more competitive prices, now that we can have a predictable amount, know what we're looking for, we've been able to drive down the prices so people are getting the same services, but the City is paying less for those services, and also the initial projections assumed that the number of asylum seekers was going to keep growing, and that does not seem to be true, and that's enabled the dollar amount to decrease as well.

CHAIRPERSON NARCISSE: Yeah, I'm praying for decrease too.

The November Plan included an additional 2.6 billion for asylum seeker services. When this amount was added to H and H budget, did you anticipate reducing one billion shortly after?

SENIOR VICE PRESIDENT ULBERG: Yes, I would say that the 2.6 billion is that the FY24 and FY25 numbers, which is noted in the report. The billion dollars in savings is really the amount for FY25, and I guess the best way to look at it is without those reductions, the program would've grown by another billion so we did anticipate, right, that we were going to have to find savings as part of the budget process so, as Mitch just said, we believe those are all good numbers for the year and we'll have to track it as the year goes on.

CHAIRPERSON NARCISSE: How many contracts for asylum seeker related services does H and H currently manage?

SENIOR VICE PRESIDENT ULBERG: We would have to provide you with that number. We have that available. I don't have it here.

CHAIRPERSON NARCISSE: So you would provide it to us.

CHIEF EXECUTIVE OFFICER DR. KRATZ: There are several security contracts, several project management contracts, several food contracts, and then there were individual leases so I'd we're in the

ballpark of 12 to 15, but we'll get you the exact number.

CHAIRPERSON NARCISSE: Thank you. We have been joined by Council Members Paladino, Brooks-Powers, and Rivera. Thank you.

Vacancies in H and H. There are several terms and conditions that require H and H to provide headcount updates to the Council quarterly broken down by job title. The quarterly headcounts don't provide budgeted headcount in comparison to the actual amounts. What is H and H current vacancy rate? Can you provide the vacancy rates by job title, such as for physician, registered nurses, and residents?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I'll let John talk about the technical, but I think it's important for transparency to explain to people who are listening that because of Health and Hospitals is an agency, our positions are not the same as the City positions, right, so the City traditionally, a true city department will say department A, you have 800 positions, department B, you have 1,000 positions and then those positions are filled or vacant. Health and Hospitals, because we are primarily a revenue department, we primarily get revenue from insurance

companies for taking care of our patients, and we have to have the appropriate staff so all of our nursing, for example, a topic you're passionate about, is based on ratios of this many patients should equal this number of nurses. If we don't have that number of nurses in permanent positions, we're going to first ask people if they want overtime, then we're going to go to our internal registry, then we're going to go to an external registry. Same with doctors, we're going to ask them to do sessional work. If we can't get sessional work, then we will go to a locums or a contract. So for us, a vacancy is not exactly a vacancy because we can't have a trauma center and I'm sorry there's a vacancy. There always has to be a doctor, a nurse, a social worker, right? Can you provide a better sense of the actual numbers?

SENIOR VICE PRESIDENT ULBERG: Yeah, we do report a number of about 9 percent for nursing but, as Dr. Katz had indicated, we've moved more to a dynamic budget so we try to make sure that there's enough resources at the bedside all the time, and the nurse ratio is I think a good example of that. We actually appreciate budgeting based on a ratio where we have to have a prescribed number of nurses to meet

the needs of that bed, and as our volumes go up and we have more discharges and admissions, we allow the budget to go up with it, and that's a little bit different, as Dr. Cassidy had indicated, versus other City agencies or maybe even the way other hospitals develop their budget, but we think it's very important that there's always the resources needed at the bedside, and that's nursing and food service and all the other services that are required to meet and provide quality care.

CHAIRPERSON NARCISSE: Is that possible you can break that down by hospitals?

SENIOR VICE PRESIDENT ULBERG: Break down the vacancies.

CHAIRPERSON NARCISSE: Yeah.

SENIOR VICE PRESIDENT ULBERG: Sure. We can break that down.

CHAIRPERSON NARCISSE: What is the average current length of the onboarding process for H and H positions?

SENIOR VICE PRESIDENT ULBERG: Varies, of course, by field. For nurses, our largest, it's about three months of training once they sign, and we do job fairs where we sign right at that fair so you

want to be a nurse at Woodhull, sign the form, you're a nurse at Woodhull, start training on Monday, three months.

The physicians have often a longer time to credential because it's not only our determining that they have the appropriate license and specialty, but every insurance company requires separate credentials. For example, I, as a primary care at Gouvernier, I'm not only credentialed by Health and Hospitals, but I'm credentialed by 12 other insurance programs that we work with, each of which requires an individual form and signature so the there's usually about a three-month period for a physician before they can even start work and then how long it takes for them to be able to take a patient load is very dependent on which area, whether they're a surgeon, a dentist, but I'd say in general it's four to six weeks.

CHAIRPERSON NARCISSE: Would it be possible for H and H to provide budgeted headcount along with the information provided as per the terms and conditions?

SENIOR VICE PRESIDENT ULBERG: Yes.

CHAIRPERSON NARCISSE: So we'll get that?

SENIOR VICE PRESIDENT ULBERG: Yes.

CHAIRPERSON NARCISSE: Okay. On the parity. On Thursday, February 29, we held a hearing on resident working conditions and concern. H and H residents brought to our attention that they are holding contract negotiations with the Administration. According to the various report, the average medical school debt for resident in 2020 was approximately 215,000 dollars, and the median annual salary for residents in New York City was 67,311 dollars. For first year residents at H and H facilities, the median annual salary was under 66,469 dollars. Considering the incredibly high cost of living in New York City, how are you ensuring living wages for residents? How does H and H plan to address the pay parity within the residence?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Thank you. I was obviously a medical resident myself and a proud member of CIR at the time. I consider myself a resident advocate because I know that the quality of care my patients get depends invested heavily on the residents because of the volume and the amount of care they do. The City negotiates our contracts with CIR. We believe that the negotiations are happening

and are going well. It's not unusual for the City to lag in terms of when it signs its contracts and often does retroactive raises going backward. I do think that there is no matter what a challenge around living in New York, especially for people moving here, who don't have an established family home. New York City is an expensive place to rent. I feel that one of the best solutions is loan repayment for people who come to work for us because of the patients that we care for. They will get loan repayment if they choose employment with us, but I certainly hope that coming out of the City, OLR, CIR negotiations are equity and, as you know, with nurses, you helped me tremendously to achieve a contract that delivered equity. I don't believe there's any glory in paying people less. I think you want to pay people a fair salary, and you want to expect a lot of them and, to me, that's always the right answer.

CHAIRPERSON NARCISSE: Thank you. Being a doctor, I'm expecting for you to be advocating for those residents because you know exactly what we're talking about, and the rent is, I don't want to say the word high, but anyway I'm an experienced mom

because my son graduated from medical school in Downstate so it has been difficult and he could not even stay in New York. He has to go outside of New York after he finished totally because the cost is too high. Yes, Dr Katz, thank you.

It has been reported that 2,300 residents have been working at in NYC H and H hospitals without a contract since December 2021 when their previous agreement expired. These residents make up approximately half of all physicians in the public hospital system in New York. What is the delay in renewing their contracts, and when do you estimate them to be renewed. You answer that partly already but, like I said, I'm expecting for you to do your very best on that one because it's unfair to them.

CHIEF EXECUTIVE OFFICER DR. KRATZ: I got it.

CHAIRPERSON NARCISSE: Are you being involved right now in the process?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We are very much involved, and I think for a long time the City was not yet engaged with CIR and CIR and the City now are very engaged, and I feel certain that this is going to get resolved soon.

CHAIRPERSON NARCISSE: Okay. The following question you (INAUDIBLE). Has H and H assessed the impact on care for New Yorkers if H and H residents decide to go on a strike?

CHIEF EXECUTIVE OFFICER DR. KRATZ: For the ones who were employed by the City, as you know, they cannot strike. The ones that are employed through affiliations, they could strike. I certainly don't think that's what is going to happen, and I don't think that's the best outcome for union strikes because the management is unresponsive, and I don't think that's going to be the case here.

CHAIRPERSON NARCISSE: We cannot afford that either. Has H and H assessed the impact? You said yes. You've seen the impact already. If they go on strike, would H and H hospital, particularly for emergency room services, so what would you do?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I'll be working in that emergency room. I can assure you of that. We had to weather at Elmhurst a strike that occurred for residents that were not in our employment, and we kept the hospital open. There are always emergency provisions for diversion, for cancelling elective surgeries, for having

administrative physicians clinically, but none of these are good solutions, but we are always prepared, for a crisis. Again, I think every health system, as you know in your area, when Woodhull flooded, we moved 135 patients safely to other Health and Hospitals facilities without anyone getting hurt. Would I like to do that again? No, but part of being a large healthcare system should be the ability to respond to an emergency. I think in this case it's in everybody's interest to come to a fair settlement with the residents, and because I believe it's the right thing, I think we will achieve it.

CHAIRPERSON NARCISSE: Thank you on that, and I want to say thank you for the strike at Elmhurst Hospital. We were able to talk and try to get it and thank you for helping me because I don't want the doctors to be on the street. I want them to be in the hospital, but we need more as usual. You have to get those residents in a good shape. The usage of temporary nurses has brought about additional issues with staffing our hospitals as temporary nurses are paid higher than H and H nurses. How many additional temporary nurses have been hired since adoption, and what is the current total?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I'm going to let John give you the numbers, but what I'll tell you and, again, I appreciate your support. Because we got that nurse contract signed and achieved nurse parity, we have now been extremely successful in hiring nurses who work for H and H, and every week we have fewer registry nurses, and my goal is to use registry nurses the way it was meant, which was for unexpected leave so somebody needs family leave, somebody is on disability. That's a perfect use of a registry nurse, because it's not a permanent position. You're not going to hire somebody else for the next four months, but the reliance on registry nurses I don't want to say are bad because our number one focus is to take care of patients, and because we work on a registry, if I cannot hire my own nurses, I'm not going to let anybody go without care so then I have to go to registry nurses, but now that I have fair wages for my nurses, now I can hire nurses, and each week we diminish the number of registry nurses. Do you have the numbers, John?

SENIOR VICE PRESIDENT ULBERG: Yes, I would say that last year at about this time, over 20 percent of the nurse workforce when we spoke here was

registry nurses, and we're happy to report that we've hired over 850 new H and H nurses, and that's allowed us to start to decant the number of registry nurses, and I think thus far we've probably had about 350 that have had fulfilled their contract and left. The amount remaining, I can get you the exact number, but I would say roughly 800 to 900 registry nurses remain.

CHAIRPERSON NARCISSE: 800 to 900?

SENIOR VICE PRESIDENT ULBERG: Yeah, but we'll get you the exact number. It decreases every week as the new nurses come out of training, right, so the moment we hire the new nurse, we can't let go of the registry nurse because we have to train the new nurses so once we train the new nurse, then as soon as that new nurse can start on the ward, then we can end the contract with the registry nurse.

CHAIRPERSON NARCISSE: By the way, I appreciate that program, residency nurses. It's a good program.

Has this number been impacted by hiring freeze?

CHIEF EXECUTIVE OFFICER DR. KRATZ: No, Health and Hospitals is not subject to the hiring freeze.

CHAIRPERSON NARCISSE: Okay. How much have you spent on traveling nurses since Fiscal 2024 adapted?

CHIEF EXECUTIVE OFFICER DR. KRATZ: A large number.

SENIOR VICE PRESIDENT ULBERG: It's a large number, and it's one that’s always moving, down at this point, as Dr. Katz had mentioned, but we can provide you with the numbers for ’23 and ’24 and even what we're projecting. We call this internally the glide path, right? It's an 18-month period by which we've set targets for each of our facilities to try to reduce the number that we have and, again, I think the good news, certainly the good news for me from a financial perspective and I think a good news right for the hospital, is that we have hired 850 new nurses and really the reason for that is the contract we think with the nurses is a good one and it's attracting high-quality nurses that are permanently going to be ours, but in answer to the number, we can certainly provide to the Committee the amount of

money that we have spent. It is a tremendously large number.

CHAIRPERSON NARCISSE: As being a registered nurse, I have to say that based on the amount of money that you had to pay those nurses, so when you have the resident nurse working, I hope they get a pay that almost or equal or even more because the fact they're staying in the City of New York so at least we can uplift them and they can stay in our city.

How much have you spent on traveling nurse, I said that in comparison to, have you analyzed how much funding the City will save if hired permanent nurses instead, which I was leading to?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yeah, I'll say it's an interesting budget concept. It's not that we're saving money we're actually bringing spending back down to what the budget affords, and last year when we met, I think we reported a number of 150 million dollars in expenses that was not included in our budget so what we're really trying to do is bring those expenses down to meet the budget targets that we can afford.

CHAIRPERSON NARCISSE: Do you foresee H and H relying more on temporary nurses in the near future and, if so, why?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Less and less.

CHAIRPERSON NARCISSE: Less and less. I like that.

CHIEF EXECUTIVE OFFICER DR. KRATZ: We set a system goal again, get down to using registry only for unexpected absences.

CHAIRPERSON NARCISSE: I'm going to take you back a little bit. Follow up on the indirect rate. For FY24, how much did H and H return to the City? How much did it use for staff course?

SENIOR VICE PRESIDENT ULBERG: Yeah, we can provide you those numbers. That's not a problem, but again we don't take money that we don't need from the City. The 10 percent as a planning number. Obviously, we have expenses at Health and Hospitals to implement the program and keep track of the expenses. 10 percent is a common number, but we can give you something more specific.

CHAIRPERSON NARCISSE: We have been joined by my Colleague, Council Member Gutiérrez. Thank you, Jen, for being here.

B-HEARD, PEG, and future reporting. In November and Preliminary Plans, B-HEARD received a PEG. During the November Plan hearing, Budget Director Jiha stated that there was not any more anticipated funding reduction to B-HEARD. At what point was this funding reduction considered? Second, was this PEG exclusively to pause the expansion or were there additional reasons for why it was put in place?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Conceptually, Chair, we believe in B-HEARD, and we believe that it is better to send a social worker to someone having a mental health crisis than a police officer.

Having said that, the social workers that are on our budget are paired with an EMS person from Fire Department, and so our staffing will always reflect the number of Fire Department EMS personnel, and so when the City froze the number of increases to EMS at Fire, there would be no purpose of hiring the social worker because there's no EMS person for them

to go out with so right now the B-HEARD program is stable, it's not planned to increase, it's not planned to decrease. I hope someday the City does increase it because I think from a policy point of view it's the right thing.

CHAIRPERSON NARCISSE: How much money would the expansion have cost, and what services would it have provided?

SENIOR VICE PRESIDENT ULBERG: We can provide you that number. As Dr. Katz had mentioned, it was really an alignment of our budget with the FDNY budget. The value of the PEG, I think was five to 6 million dollars. We can make sure that number is accurate.

CHAIRPERSON NARCISSE: In what locations would this expansion have taken place?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Again, remember, our role as Health and Hospitals is to provide the social workers so I don't know the specific areas where the additional social workers were going to be paired to the EMS people, but I think that's learnable. We will work with our Fire Department Colleagues to find out what the expansion areas were planned to be.

CHAIRPERSON NARCISSE: So you never had that information?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Right. Again, our role is if the City says we want to have 30 teams instead of 20, we'll hire the social workers and train the social workers for those 10 additional teams, but we don't determine where those teams go.

CHAIRPERSON NARCISSE: Gotcha. With the third round of PEGS effectively cancelled, can you re-anticipating the planned expansion of the programs to resume? If yes, will expansion focus on reaching more geographical areas or making the program 24 hours?

CHIEF EXECUTIVE OFFICER DR. KRATZ: If the City can forward with the EMS expansion for B-HEARD, we would be proud to provide and train the social workers.

CHAIRPERSON NARCISSE: Going back to that expansion focus, what about the Department of Health, do they have ideas of what?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Department of Health…

CHAIRPERSON NARCISSE: Is input in there?

CHIEF EXECUTIVE OFFICER DR. KRATZ: For the B-HEARD program.

CHAIRPERSON NARCISSE: Yeah. You don't know?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I can't answer, but spiritually, I know they would support B-HEARD. We're all in favor of sending medical health professionals rather than police whenever possible.

CHAIRPERSON NARCISSE: Okay. How many people currently work in B-HEARD, do you know, and what is their vacancy rate?

SENIOR VICE PRESIDENT ULBERG: Yeah, I think the current number is about 39 staff.

CHIEF EXECUTIVE OFFICER DR. KRATZ: But that's our staff?

SENIOR VICE PRESIDENT ULBERG: Yeah.

CHIEF EXECUTIVE OFFICER DR. KRATZ: That's 39 social workers that we're providing. That's not the people at the Fire Department EMS.

CHAIRPERSON NARCISSE: And do you know about their vacancy, the vacancy rate in there?

SENIOR VICE PRESIDENT ULBERG: No, I don't.

CHIEF EXECUTIVE OFFICER DR. KRATZ: To the best of my knowledge, we've filled all of the teams that are currently running.

SENIOR VICE PRESIDENT ULBERG: Yeah.

CHAIRPERSON NARCISSE: Okay. In last year's Preliminary Plan hearing, you had mentioned an interest in adding indication for B-HEARD in the Mayor's Management Report and assessing the effectiveness of B-HEARD services. Has there been any further discussion of this issue? Should we expect to see those indication in the MMR?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yeah, there is definitely an evaluation going on the effectiveness of B-HEARD, but it's not yet complete.

CHAIRPERSON NARCISSE: Because, you know, a lot of people have question about B-HEARD.

SENIOR VICE PRESIDENT ULBERG: Yes.

CHAIRPERSON NARCISSE: Okay. DISTRESS HOSPITAL FUND. The State created the Distress Hospital Fund to support safety net hospitals that disproportionately treat Medicaid patients and populations. H and H is not statutorily excluded from receiving funding due to their work with Medicaid populations but, based on determinations made by the

State Commissioner of Health and the State Budget Director, H and H has not received any Distressed Hospital Funding. Did the State provide a specific reason for why H and H hospitals are excluded?

CHIEF EXECUTIVE OFFICER DR. KRATZ: No.

CHAIRPERSON NARCISSE: Did you ask?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We try to work closely with the State. The State has made it clear that they have their own budget challenges, and that there are a number of distressed hospitals in New York City and that it's a fixed pool, and so if they gave us more money, they would have to give less money to other hospitals, and many of those hospitals are in a more precarious financial position than Health and Hospitals, which has been doing pretty well of late.

CHAIRPERSON NARCISSE: And yet again, I want to say thank you because H and H is serving the underserved population.

Part of New York City sales tax extended to fund this project. How much City funding is taking annually for the Distressed Hospital Fund? Do you know?

SENIOR VICE PRESIDENT ULBERG: Yeah, it's currently at 150 million, but I think issues really that don't directly affect our budget. They're more of an OMB issue, but we do follow the discussions with the State, but 150 million is the value.

CHAIRPERSON NARCISSE: How much funding would your H and H hospitals hypothetically receive if they were part of the fund?

SENIOR VICE PRESIDENT ULBERG: They’re discretionary dollars, and they’re funds that the State decides how they want to allocate those funds. There's no formula that I'm aware of, but we've yet to receive those dollars or any portion of them.

CHAIRPERSON NARCISSE: Okay. Now, coming back to sickle cell disease. The Council held a hearing on September 20th related to sickle cell disease, it’s impact on the City, and evaluating access to sickle cell care in the City. The hearing introduced Local Law 163 of 2023, which would establish guidance to improve health outcomes to individuals with sickle cell disease. What's the current status of sickle cell funding?

CHIEF EXECUTIVE OFFICER DR. KRATZ: First, I just want to commend you on that legislation.

CHAIRPERSON NARCISSE: Thank you.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Again, for everybody to understand how important your legislation is, there was a movement that was well-intentioned in the U.S. to decrease opioid use among people with chronic diseases for good reason and we saw many overdoses in New York City, but there was a failure to understand that sickle cell is not one of the diseases for which pain medication should be held. It is a chronic disease, but it's a chronic disease with acute exacerbations that have to be treated adequately with pain medication, very different than the diseases people were trying to help people to get off of, where the opioids are not particularly helpful because people are taking them every single day for months on end and those medications don't work. So much I think is about working individually with patients. We don't have a set budget by disease because we'll do whatever is necessary to care for any individual patient, and one of the most helpful things that we've done is Kings County invited one of the patients to come and talk to them about her experiences in their emergency room and other emergency rooms around the city, and they

together made a video, as a teaching video, to help for practitioners to understand what it feels like to be in a pain crisis, what you're looking for in a pain crisis, what is good treatment by doctors and nurses, what is insulting treatment by doctors and nurses, and we're using that video throughout our system as a teaching tool. We will provide whatever services people need. Kings County is one of our centers of excellence. There's also quite a lot of care provided to this population at Jacobi, at Harlem, at Bellevue, but all of our hospitals are used to providing good care for people with sickle cell disease.

CHAIRPERSON NARCISSE: So there is no specific funding?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We don't budget by illness. The idea is that our job should be to meet every patient's needs, whatever their illness is.

Okay. I'll come back to that. How much funding is in H and H’s Fiscal fiscal 2025 budget for sickle cell services?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I guess a different way that we could go back and look

at it is, while we don't budget for any specific disease, it might be possible for us to look at our patient population with sickle cell and answer the question of how much we've spent.

SENIOR VICE PRESIDENT ULBERG: Yes, I would say that we could do that and, as Dr. Katz mentioned, and many of our patients have comorbidities so it's not just sickle cell, it's coupled with something else, but we've been asked this question before, it's been asked by the Council as it relates to behavioral health, and we can take our best shot at developing a number, but you'd have to understand we don't budget that way, but we can dig into the data and come up with our best estimate.

CHIEF EXECUTIVE OFFICER DR. KRATZ: And if you or other Members of City Council or other people in the city family recognize holes in our care, we will fill those holes, and that's why we don't budget by specific disease because we see ourselves as needing to fill whatever there is in terms of need of our patients so if we need more nurse educators over here or we need more psychologists over there, that should be our job to meet the need of our patients, whatever they have.

CHAIRPERSON NARCISSE: I do understand, Dr. Katz, but sickle cell disease has been really addressed in New York City the way it's supposed to be for many, many, many decades, and it's mostly black communities and people are really suffering. When the crisis hit, I used to work in the ER, and I know how it looks like. I have two nieces with sickle cell disease, and I'm a sickle cell trait. My daughter is a sickle cell trait. It's very important. I understand that we have to take care of everyone, but this one has been neglected for far too long.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Understood.

CHAIRPERSON NARCISSE: The bill will go into effect one year after it has been signed into law. Have you begun preparations for education process to guide medical professionals on sickle cell detection and treatment? Please describe what this process will look like.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes, we have, again and again, we're big fans of the bill. We like to believe that because of who we take care of, we are ahead of other hospitals, and we'd be

happy to provide the training materials that we're using to you.

CHAIRPERSON NARCISSE: Because from my understanding, even from nursing school, we don't have that much of talking about sickle cell disease, probably one hour and, in medical school, from my understanding, since I have two doctors in my life, not that much either, but we talk about any other diseases, but not sickle cell disease much.

Which H and H facilities provide pre- and post-conception genetic testing for sickle cell disease? If it is not yet available, when do you expect these services to be available at H and H facilities?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We provide them at all of our facilities currently, all of our hospital facilities.

CHAIRPERSON NARCISSE: All the hospitals?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Right, so, for some of those services, if they were at a Gotham clinic, they would need to be referred to the hospital, but that's typical. We do that for all sorts of things. Primary care clinics were not meant to be full-service operations.

CHAIRPERSON NARCISSE: What is the expected cost of including the services at all H and H facilities?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Here too, we'd have to do a run to find out, but we're not limited by dollars. Again, this is a very important part of our mission is that we don't limit needed services. We have no rationing of any kind of service in Health and Hospitals. If it's medically needed, we medically provide it. If ever our needs exceed our budget, it's our job to advocate for a sufficient budget to meet the need.

CHAIRPERSON NARCISSE: Okay, so I'm expecting you to fight for sickle cell disease more because it's a special approach for sickle cell, unlike other diseases, it's very special.

What is the current timeline for planning and implementation of this bill?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We're certainly going to meet all of the timelines in the bill and have already started work, but that will be part of presenting you with the curriculum to show you the dates for the different trainings.

CHAIRPERSON NARCISSE: Thank you. Now, I'm going to turn it over to my Colleagues who asked a couple of questions. Councilwoman Schulman.

COUNCIL MEMBER SCHULMAN: Hello, Dr. Katz. It's always good to see you. Nice to see you. I have a couple of questions. Different topics.

One is I'm just going to go back to the residents for a little bit. According to OLR and OMB's numbers provided to the union, they're budgeting approximately 292 million dollars over five years as the pension cost for the resident physician bargaining unit. Residents are only voluntarily enrolled in the pension plan and it takes five years to vest in the City pension while most residency programs are three to four years long. Does H and H or the City pay into the City pension plan for residents and fellows at the rates OMB, OLR are budgeting for?

SENIOR VICE PRESIDENT ULBERG: Yes, I would say that we do and, certainly, many of those residents, I think it's attractive to have a pension, and we would like many of those residents to stay on with us with a permanent job she answer to that is yes.

COUNCIL MEMBER SCHULMAN: Okay. Last year, Dr. Katz, during a Preliminary Budget hearing, you stated that residents are some of the lowest paid workers in hospitals when you look at pay per hour because of the hours they work. Has the situation changed for residents and taken into account inflation and other cost of living increases?

CHIEF EXECUTIVE OFFICER DR. KRATZ: No, because there has not been a recent contract so it would actually be a little worse this year.

COUNCIL MEMBER SCHULMAN: Okay. I'm going to ask you a couple of different things. One is about hospital bed utilization. One of H and H terms and conditions reviews bed utilization in all 11 H and H facilities. The bed utilization rate ranges between 55 and 85 percent, so there's the low and the high. The Metropolitan Hospital is 55.2 percent occupancy, and Harlem Hospital is 57.5 percent occupancy. What factors can affect a hospital's low occupancy rate?

CHIEF EXECUTIVE OFFICER DR. KRATZ: It's a good discussion for all of us to have because there's so many misconceptions. Let's talk about Metropolitan just for a minute since you raised it. Very valuable resource for the community, Spanish Harlem, very

well-loved institution, lots of four bedrooms that are really not ideal for infection control, adequate privacy, but we don't take them off the license because in times like COVID, you never quite know when you might need to use a space that you haven't previously used. To me, what matters most in a hospital is the combination of physical space and staffing so in your area, Queens Hospital and Elmhurst are landlocked, like I can't open another ward in either place. I just don't have any physical space. Metropolitan, I have physical space, but it's not cheap to renovate four-bedroom rooms into appropriate modern rooms, and it's not just the fact that they're four bedrooms, there are a variety of things, bathrooms, people do not expect to go to bathroom in the hall anymore. Fortunately, we've stopped that. Although, again, just so everybody understands until we opened the Ruth Bader Ginsburg Hospital, South Brooklyn, then Coney Island had a ward with a bathroom in the hall. That's how it used to be, but none of us think that's a good standard anymore so we have rooms that don't have bathrooms. We have rooms that don't have all the gases so for quick speed, if somebody gets sick, you want to be

able to immediately do oxygen or other necessary gases, and it is very expensive to renovate an existing hospital while you're using it. Our licensed beds are not always a very good indicator. We don't staff Metropolitan for its licensed beds. We staff it for its 55 beds, and then we look for opportunities to use it so, overall, the hospitals in our system, in the Queens' two hospitals, as I said, there is no more physical space, the hospitals that are most crowded in terms of over their historic census are Kings and Bellevue where Council Member Rivera was born, and we think that that's related to recent hospital closures or diminishments. Kingsborough closed in Brooklyn and also University Hospital has been diminished somewhat because of the physical plant. In the case of Bellevue, Beth Israel has been diminished because of physical plant issues. Those two hospitals are substantially over their pre-COVID census. Metis is at their pre-COVID census. Jacobi is a little bit over their pre-COVID census. Our other hospitals, Harlem, Woodhull, South Brooklyn are pretty much at their pre-COVID census now.

COUNCIL MEMBER SCHULMAN: Can I just ask a couple questions? You mentioned Kings County, so what

happens if SUNY Downstate closes because they're almost at capacity?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Sure. We have already been talking to the State, and we believe that Kings and Bellevue need to do renovations and, fortunately, both of those hospitals have physical space that could be renovated. Again, it's making the distinction between say Elmhurst where I have nothing to renovate, every inch is taken. In the case of Bellevue and Kings with the appropriate amount of money, I can renovate a ward at King's to take another 50 to 70 patients if that becomes necessary and expand the ED. I need to do the same thing at Bellevue if there's going to be continued diminishment of Beth Israel.

COUNCIL MEMBER SCHULMAN: The last question I have is about Rest in Peace Medical Debt, which you're familiar with, the Mayor's program, to make sure that people who are in debt have the ability to pay off their medical debts and all of that. My understanding is H and H is not part of that program. Is there a reason for that?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We are not part of it because we never sue patients for the money (INAUDIBLE)

COUNCIL MEMBER SCHULMAN: That's what I thought. I just wanted to put it on the record.

CHIEF EXECUTIVE OFFICER DR. KRATZ: First we're very assertive about trying never to send someone a bill that they can't pay to start with. Occasionally, it might happen because someone has not provided us any financial information and so we have just no idea but, regardless, we don't sue, we don't send people to court because of unpaid bills.

COUNCIL MEMBER SCHULMAN: Okay. Thank you very much. Thank you, Chair.

CHAIRPERSON NARCISSE: Thank you. My pleasure, Council Member.

Next is Council Member Rivera, born in Bellevue.

COUNCIL MEMBER RIVERA: This is a great place. What can I say? And my niece was born there, receiving excellent care. I just want to say, Bellevue, my grandmother's going there for treatment for dementia and Alzheimer's and they've been absolutely wonderful, and my uncle just went for his

first appointment at King's for liver cancer treatment and they were just incredibly welcoming besides the wait times, but you're working on that. I have to say only rave reviews.

Just a couple of things. I want to follow up on a question asked earlier by the Chair regarding indirect rates paid for asylum seeker services. H and H included a 15 percent indirect rate, but you said that it's a 10 percent indirect rate. Does the current cost for asylum seeker services include a 15 percent rate or a 10 percent rate built in for H and H?

SENIOR VICE PRESIDENT ULBERG: Yeah. At one point in time, it may have been 15 percent. We realized we didn't need 15 percent and lowered it down to 10 percent, and we're re-evaluating what we need today as we continue to downsize the program but, again, it's important to us. We're grateful for the money when we can get it. If we don't need it, we return it.

CHIEF EXECUTIVE OFFICER DR. KRATZ: I would say for our board, it's important that we've assured them that our participation in the asylum seeker work was not meant to diminish healthcare for

low-income people, and there is work, like each contract is a huge scope of work to the legal people, the contract people, the procurement people and, if we don't hire additional staff to do that work, then we would diminish healthcare services to do asylum seeker work, and part of the City arrangement, and OMB has been very good about this, was the idea that this was not our specific mission and so we would be held harmless. We're not trying to make a profit. If we don't have to hire the people, we don't hire the people but, if we do, we think that it's right for the cost of the asylum seeker work to be separate, and we also have always hoped that there'd be an opportunity to get federal dollars for that work and that, by keeping it separate, the City would be able to say what it was costing because, again, writing the contracts, doing the legal work is real work, and otherwise the services don't happen.

COUNCIL MEMBER RIVERA: You mentioned vacancies. Do you know how many, and I know you spoke about this with the Chair, do you know how many vacant positions there are at H and H, specifically for doctors?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I don't have a number. It would be in the hundreds but, again, I'd say…

COUNCIL MEMBER RIVERA: What's the plan to fill the slots?

CHIEF EXECUTIVE OFFICER DR. KRATZ: So just to explain, just because it's vacant doesn't mean the service isn't provided because we do sessional services, and I think many people appreciate the additional session because the City work week for a doctor is 40 hours. Many doctors in outside practice work 60 hours and people, because of New York, are happy to have the opportunity to work an additional 20 hours and earn additional salary. The issue is hiring. Generally, it is almost impossible to recruit people to New York City because of the cost of housing so if you're here already then it's possible for us to hire you. Very hard, and we lose people all of the time even at doctor's salaries to people saying it's just too expensive to live here and the quality of life, especially people with young families, people who have two children, very, very difficult so we rely on sessional work.

COUNCIL MEMBER RIVERA: Chair, may I ask one more: I just want to mention, I know that when we asked about residents at the last hearing and about on-call coverage, it was said that in some spaces a medical director would step in if a resident couldn't cover so I'd love to hear about which programs have a protocol where a medical director or associate director are pulled to cover residents who are out sick and then, in the spirit of paying people, ensuring that on-call coverage is treated like overtime, I think that's really, really important, and you did mention Beth Israel, so you said you could open up space, I know that's one question. Sorry, Madam Chair. The other question is you said you were going to open up space hopefully in Kings for 50 to 70 patients. Are you thinking of opening up space in Bellevue to accommodate more patients because of Beth Israel and their impending closure even though they have not been approved yet despite their elimination of services slowly? How does that impact Bellevue's actual budget and do you have estimates on expense for taking on additional beds and capacity? Have they talked to you, Beth Israel, have they talked to you…

CHIEF EXECUTIVE OFFICER DR. KRATZ: We'll try to do it all backwards. The way we budget is we budget for volume so if a hospital has more patients we need to provide more dollars and, fortunately, because we've gotten good at billing insurance companies, generally more patients come with more dollars, especially if you're not opening any more bricks and mortar so a major concept of all hospital finances, the difference between a fixed cost and a variable cost. Bellevue has a fixed cost. It costs a certain amount to keep the lights on, keep the utilities, keep the administration, to mop the floor. If I have more patients, then I provide only the variable costs, additional doctors, additional nurses, additional social workers. Generally, we can break even if I only have to have incremental costs. I'm not concerned about so much with any of the hospitals where I have physical room to grow. I'm not concerned about the operating costs. I am very concerned for capital costs for Bellevue because it's such an old building. It's extremely expensive, so because it's so large, there is still room that's usable, but it's very expensive to rehabilitate. On the order of a ward opening in Bellevue, depending on

which one, could easily cost 40 or 50 million to get it, again, because it was built at a standard way different than what modern healthcare is requiring so we are never in favor of hospital closures, right? The City doesn't regulate hospital closures. It's a State issue, but I feel like my job is to make sure that none of my hospitals are ever overrun, which means being prepared for things that might happen. I think that if Bellevue has more patients, they will get more dollars and that will help us, but I have to worry about how quickly the renovations can occur, how quickly I can staff up, and these are all challenging issues.

One comment on the previous just so people understand, doctors cannot earn overtime, not literal overtime. They are FSLA exempt so doctors get sessional rates, which means we determine what is the rate by which we pay for an additional eight hours in the hospital or additional eight hours of phone call. It's all set up according to specialty and what type of call you get.

COUNCIL MEMBER RIVERA: Thank you, Madam Chair. I understand. I just want to make sure that

they receive the compensation that they deserve. Thank you, Madam Chair, for the time.

CHAIRPERSON NARCISSE: Not a problem, former Chair of Hospital. You get into it.

COUNCIL MEMBER RIVERA: I appreciate you.

CHAIRPERSON NARCISSE: Majority Whip Selvena Brooks-Powers.

MAJORITY WHIP BROOKS-POWERS: Hi, Dr. Katz, always good to see you.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Same.

MAJORITY WHIP BROOKS-POWERS: Just two really quick questions. First last year, Health and Hospitals announced a 30-million-dollar investment in a new Gotham Health Center in the Rockaways. Can you talk about what the timeline is for completion of the health center and when it will be operational and ready to receive patients?

CHIEF EXECUTIVE OFFICER DR. KRATZ: January 26th. To your fellow Council members, I just want to commend you, Majority Whip, for having done a really beautiful process in the Rockaways with the community to look at how we can provide trauma care, and we heard over and over again from a wide variety of community members how much they wanted trauma

care, what the harms of not having trauma care. I was very pleased the Council Member took me and a bunch of community people in a van and we went and looked at a variety of sites, and I really liked the idea and I thought that more healthcare planning should be done with community people in a van looking at different sites and the best moment and I think the Majority Whip would be too humble to tell you was she was out, we were near the ocean, we ran into some community constituents and they were asking what we were doing there, and she said we're trying to figure out what is most needed in this area in health services, what do you think, and he says, without missing a beat, trauma care, and it was the most amazing sort of affirmation, right? We're just like walking along and he's there with his dog and a family member, but there's no replacement for listening to constituents and I really admire the way you did the process.

MAJORITY WHIP BROOKS-POWERS: Thank you for that, Dr. Katz and, with your help and under the leadership of our Hospital Chair, I know we will be successful so it's not if, but when we will secure a level one or two trauma facility in Rockaway.

My last question for you is, can you update us on the status of the contract negotiations with the doctor's Council at CIU? We want to ensure safe levels of staffing and work conditions for our healthcare workers providing care to New Yorkers, and I know you and I talk all the time in terms of the staff at Health and Hospitals and you've always been tremendously compassionate to the staff so just wanted to understand the update there.

CHIEF EXECUTIVE OFFICER DR. KRATZ: As you know, happy doctors and nurses make happy patients. It's a very simple formula. If your doctors and nurses are not happy with your system, they are not going to deliver the best care. We are very much in negotiations. The doctor's union is a complicated one because it's separate negotiations with the City for the City-employed doctors, Mount Sinai for the Mount Sinai-employed doctors, NYU for the NYU-employed doctors, and PAGNY for the PAGNY-employed doctors so it's really a sort of simulcast. These are all doctors who work for us but in four different systems so it's not easy to resolve. The goal is fair compensation, equity across our sites, and I'm very optimistic that we will be able to achieve it. We

have a great group of doctors. I love if you see our doctors, we're the only system where the doctors actually look like our patients. Many of them have incredibly inspiring immigrant stories of going with their parents, serving as translators as little children and, something we would never allow anymore, but people who made a commitment that when I grow up, I'm going to become a doctor. We did a profile recently of one of our doctors who never thought she would be a surgeon but learned to sew with her grandmother in India and, because she had learned how to do this fine stitching, when she was in the OR, the surgeons were just amazed at her ability as a medical student to stitch things up because, of course, it's really the same skill and they told her you should become a surgeon and she became a surgeon and works in our system so we're very proud of the doctors that we have and we're committed to fair and equitable salaries for them.

MAJORITY WHIP BROOKS-POWERS: Thank you so much, Dr. Katz.

CHAIRPERSON NARCISSE: Thank you, Majority Whip.

Before I pass it on to my Colleagues, I want to Piggyback on what you started. Do you believe the lack of pay increase since 2020 is impacting residents' morale and H and H's ability to result in retaining physicians, especially those who come from the communities H and H serves?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I think so. I think it would be in the City's interest to always not let contracts lag too far but, again you know better than anyone, this is a complex city. OLR has a lot of unions that it needs to come to agreement. There is a specific cycle and it does seem like this one sort of fell out of the cycle, right? We have other contracts that just expired a few months ago. I think part of it is when you do pattern bargaining, some contracts are going to have just run out and some would have run out longer ago, but I think the important part is, and I see the consensus across the table, we're going to get this resolved.

CHAIRPERSON NARCISSE: Yeah, and it's a city town and we're proud of that too.

Now, I'll pass it to my Colleague, Council Member Marmorato, for questions.

COUNCIL MEMBER MARMORATO: Thank you, Chair.

The most interesting thing that you said today to me and what I got from this whole hearing is listen to your constituents. My constituents spoke to you, and you did not listen to them as far as housing needs are concerned in my community. Last week we met with your residents, and it's very disheartening to hear how they were overworked, they had financial concerns, and they were very concerned about the lack of housing. There's plenty of housing on the Jacobi campus. Why is there no housing for your residents?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I think the City at one time did housing for nurses and residents. It's a model that I would support. I would also support vouchering if the City does not want to be in the business of being a landlord. I think that was part of why historically most cities stopped doing their own housing so you could do it either way, you could build your own housing, or you could stipend people into housing.

COUNCIL MEMBER MARMORATO: So if the City doesn't want to be a landlord, why are we providing housing on the Jacobi campus?

CHIEF EXECUTIVE OFFICER DR. KRATZ: If you're talking about the Just Home Project, as you know, this City Council specifically gave us a million dollars a year for the Just Home Project so I understand that people may not support it now, or they may support it now, but this was a City Council Mayor's Office directive that came with funding specifically for creating the project. My view is, and it fits the same as asylum seekers, we're part of the City family. If the City Council wants us to do a program like Just Home, we'll do it. If the City Council does not want us to do a program like Just Home, we will not do it. We are here to serve. I realize on complex issues, different people have different views, different constituents have different views. This is the process.

COUNCIL MEMBER MARMORATO: Listen to your constituents, and the constituents have spoken in the community and in the District so it's unfortunate that you were not absorbing and taking in what they were voicing to your board.

Now, you do have two projects coming to the Jacobi campus. One will be housing for residents of Montefiore, not Jacobi residents, and there is

another site that's going to be rezoned, and I was just wondering if you can provide any information as to what that site is going to turn into, what the building is going to look like, will it be commercial will it be residential?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I don’t know. I'd have to get back to you on that. I don't have a sense.

COUNCIL MEMBER MARMORATO: Okay, thank you.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Thank you.

CHAIRPERSON NARCISSE: Thank you, Council Member.

Before I move to Jen Gutiérrez, our Council Member, I want to say I'm still waiting for a medical center in my community, the 46th District.

CHIEF EXECUTIVE OFFICER DR. KRATZ: I think we have a few suggestions for you.

CHAIRPERSON NARCISSE: (INAUDIBLE) Because we don't have any hospital, no hospital, no centers. Council Member Gutiérrez.

COUNCIL MEMBER GUTIÉRREZ: Thank you, Chair. Good to see you all again. How are you doing, Dr. Katz?

I have a couple of questions. I love the story you shared about homegrown medical team. At last week's hearing, we heard a really great story from one of the residents that testified, Dr. Jordan, who said she grew up here, went to public housing, the first time she left public housing was to go away to school, and it was really rewarding. My sister, also an example of that, was a resident at SUNY Downstate and Kings County, born at Elmhurst. These are all really important stories and really valuable experiences to highlight, but I find it problematic, Dr. Katz, that they have very little incentive to continue to stay in our safety net hospitals, in our H and H hospitals. I mean we heard firsthand from them a myriad of reasons why there are jobs outside of the obvious stress factors and scheduling but we heard things from pay parity being top, we heard things from issues of access to rideshares working late hours, and I'm particularly concerned about the residents at Elmhurst. We were all supportive of their strike and their fight for pay parity last year

and so I just want to get confirmation because I don't want to misquote anything, but is it correct that starting next academic year, all incoming interns for Elmhurst and Queens Hospital will now be employed by H and H?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes.

COUNCIL MEMBER GUTIÉRREZ: Okay.

CHIEF EXECUTIVE OFFICER DR. KRATZ: I'm not sure what the start date is. Not this July.

COUNCIL MEMBER GUTIÉRREZ: Okay. It's 2025.

CHIEF EXECUTIVE OFFICER DR. KRATZ: I think it's one more year.

COUNCIL MEMBER GUTIÉRREZ: Okay. Great. Thank you.

CHIEF EXECUTIVE OFFICER DR. KRATZ: But I'm not 100. I'll have to check. It’s definitely moving, but I'm not sure whether it's July 1, 2024, or July 1, 2025.

COUNCIL MEMBER GUTIÉRREZ: Okay, so they're no longer employed by Mount Sinai.

CHIEF EXECUTIVE OFFICER DR. KRATZ: They will no longer be employed by Mount Sinai.

COUNCIL MEMBER GUTIÉRREZ: Depending on when that start time is?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Correct.

COUNCIL MEMBER GUTIÉRREZ: Are they expected to receive the same first year salary that was negotiated with Mount Sinai of 81,207.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Once they move, they would have to receive whatever salary the City negotiated for CIR, right? I wouldn't be able to pay a differential rate for a City resident who was at Elmhurst versus a City resident at Woodhull. It would all be one rate, and I think the reason it's set for ’25 and not ’24.

COUNCIL MEMBER GUTIÉRREZ: Okay. Do you know what that rate is?

CHIEF EXECUTIVE OFFICER DR. KRATZ: No. That's the new rate we're all talking about that we want. The City is way behind on that particular negotiation and so, once it's approved, there'll be a retro payment, and people will be brought up to some salary, but that salary is not yet negotiated.

COUNCIL MEMBER GUTIÉRREZ: Okay. I just want to elevate their whole mission last year of

wanting to get a little bit closer to pay parity. I understand what you're saying, so please keep us posted.

Can I ask just one more question, Chair?

I just want to now skip to the therapeutic unit, particularly at Woodhull. Late last year, we had a joint hearing, and I'm sorry if I missed this in your opening statement, I was a little late but I'm particularly interested in just getting a finite timeline if you can regarding Woodhull. I know that from the questions and from the notes there were some commitments of the therapeutic units being completed by 2024 and I believe now that's pushed back so I just want to know if you can confirm that and what are some of the delays, barriers that you're facing that's pushing this time.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Just to make sure I'm answering the right question, you mean the outposted units?

COUNCIL MEMBER GUTIÉRREZ: Yes.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Okay, so I was very pleased to see the announcement yesterday by the Mayor in collaboration with the City Council that the outposting units are going forward.

Up until yesterday's announcement, the decision had been that Bellevue was going forward, but we were stopped for the construction of the outposted units for Bellevue and North Central Bronx and, with yesterday's announcement, it goes forward.

Now, let's see if Dr. Yang can answer the question of what is a realistic date now that we're restarting?

SENIOR VICE PRESIDENT DR. YANG: Sure. Thank you. Patsy Yang. For Woodhull, the goal here is if we are able to finalize design for those outposted units by the summer of 2024 and issue a solicitation for the construction bids by late summer or early autumn, the hope is that we'll complete construction by the summer of 2027.

COUNCIL MEMBER GUTIÉRREZ: Okay. I'm sorry, and Woodhull was approved prior to yesterday's announcement?

SENIOR VICE PRESIDENT DR. YANG: Woodhull is part of the approval yesterday to proceed.

COUNCIL MEMBER GUTIÉRREZ: Okay.

SENIOR VICE PRESIDENT DR. YANG: We have been doing work at Woodhull in preparation for that. As you know, we've moved and renovated and upgraded

many of the units, pediatric unit, substance use unit, some of the administrative and resident areas, and we're into phase two of that work as a prerequisite for the outposted work.

COUNCIL MEMBER GUTIÉRREZ: Okay, thank you.

CHAIRPERSON NARCISSE: Thank you, and we're moving on to my Colleague, Council Member Paladino, I have a question.

COUNCIL MEMBER PALADINO: Thank you. It's a pleasure to meet you.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Nice to see you.

COUNCIL MEMBER PALADINO: Absolute pleasure. It's my first time serving on this Committee so I think what struck me the most was your reality. When you dealt with what's really going on in the hospitals and the way in which you have to cover pay and costs and everything that it takes to run a building as old as Bellevue. How old is that? 200 years old? Bellevue was built like in the early 1900s, yes.

CHIEF EXECUTIVE OFFICER DR. KRATZ: (INAUDIBLE) Created prior to the signing of the

Declaration of Independence at the site of City Hall was the original and then moved to its current location, different parts. I don't think any functional part is now 200 years old but certainly 150 years old.

COUNCIL MEMBER PALADINO: Because I'm a bit of a history buff and I love old structures and I study architecture and all of that. Getting back, I'm going to just go back to something, salaries. When we were talking about salaries earlier, you said that we all know what the residents make, they make 67 and change. The doctors and the nurses in residence, what do they make?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Of course it depends. The nurses with the new contract, I think average just over 100,000 dollars for a starting nurse, more depending upon certifications and number of years.

Physician salaries can vary tremendously from what I am, I'm a primary care doctor, primary care doctors tend to earn the lowest, which usually some of our positions might be like 180 to 220.

COUNCIL MEMBER PALADINO: That's why everybody became specialists.

CHIEF EXECUTIVE OFFICER DR. KRATZ: But a cardiac thoracic surgeon might be 900,000.

COUNCIL MEMBER PALADINO: The reason why I'm asking is because you said so many people leave New York because of the cost of living and, if you're making that kind of money, that's a good living. Why don't they stay?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I actually said that it's hard to recruit into New York.

COUNCIL MEMBER PALADINO: That's very true.

CHIEF EXECUTIVE OFFICER DR. KRATZ: As opposed to leave. I feel like people who, like us, who grew up, I grew up in Brooklyn. New York is my hometown, right? I'm here.

COUNCIL MEMBER PALADINO: Correct.

CHIEF EXECUTIVE OFFICER DR. KRATZ: What we find is when you tell somebody who's in Ohio as a doctor and lives in a four-bedroom house and with yard all around that you'd like them to move in with their two children to the two-bedroom apartment.

COUNCIL MEMBER PALADINO: You and I talk the same language. Very plain, very clear, and deal

only with reality, and that's what the reality sadly is. Also, I'm curious because we have a lot of, I come from District 19, it's my neighbor's District, but we have used to have Parsons Hospital there, we have Flushing Hospital there. If you may give me just a couple of minutes, these buildings and I know of several other buildings. I know Elmhurst is very tight. Are you looking to go into these buildings that have once been used as a hospital, that have since been boarded up for a great many years? I was born in Flushing Hospital, and my whole family was born in Parsons Hospital. Is there any way in which to increase the volume and the bed space that you would be interested in looking at any of these spaces?

CHIEF EXECUTIVE OFFICER DR. KRATZ: It depends on the state that they're in. One useful piece of data is that SUNY said that it would cost 3 billion to build a new university hospital, but 4 billion to fix the existing building, which is just a way of saying hospitals are so highly regulated that they can be incredibly expensive to renovate. It’s a sad fact, and I think that's why a lot of hospital building conversions go to housing because housing at

least allows you to keep more of the existing thing and this is very difficult with the cabling that you need for the wi-fi in order for the systems to work, the gases, it just becomes almost prohibitive to rehab, which is a shame because old buildings have a value…

COUNCIL MEMBER PALADINO: That’s exactly right.

CHIEF EXECUTIVE OFFICER DR. KRATZ: But I think that the reality is generally new is cheaper to build.

COUNCIL MEMBER PALADINO: And hearing that Beth Israel, which I just learned last week was going to be closing that, that took me quite by surprise as well. They say that it's also a lot influenced by building failure, that these are buildings that were built in the 1960s and that they don't function with modern hospital protocols anymore.

COUNCIL MEMBER PALADINO: And it's not reasonable to try to take a hospital such as Beth Israel and just refurbish what needs to be done? This City operates on over a hundred billion dollars, and we're looking at what we need most, which is care.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes.

COUNCIL MEMBER PALADINO: And it's just getting worse and worse, and yet we cannot find the money to do what we need to do to a building like Beth Israel. I don't understand that. That's another historic hospital. I understand it takes billions to do what we need to do, but why not? It boggles my brain whenever I go to these things, because I keep seeing, for example, I was just in a meeting earlier, Government Ops, where I learned that security guards that are in our migrant centers are getting paid as high as 119 dollars an hour. Yeah. I did the same thing. Could not believe my ears. They are being hired by private security companies.

CHAIRPERSON NARCISSE: Council Member.

COUNCIL MEMBER PALADINO: Yeah. What's that?

CHAIRPERSON NARCISSE: Can we focus on that?

COUNCIL MEMBER PALADINO: What?

CHAIRPERSON NARCISSE: I said, can you wrap it up for me, please?

COUNCIL MEMBER PALADINO: I can wrap it up, but I'm just saying, when you take that kind of money and you're applying it to a security guard and

you're not paying a resident, you understand that, 67,000 to 119,000, it just boggles my brain.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Understood. I'd like to talk to you about something else later in private if I could.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Very good.

COUNCIL MEMBER PALADINO: Thank you.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Thank you.

CHAIRPERSON NARCISSE: Thank you, Council Member.

We're going to go to Bellevue bariatric surgery. On February 7, 2024, the Committee on Criminal Justice and Hospitals sent a letter. We sent a letter to Bellevue administrators in regard to their bariatric surgery practices. In the letter, the Committee requested information on the number of surgeries, the policies governing the recruitment and performance of the bariatric surgeries, the followup care for patients who have undergone bariatric surgeries, the recruitment of bariatric surgery patients for Rikers Island, the financial incentives surrounding the surgeries, and the accreditation of

Process for Bellevue Hospital Center for Obesity and Weight Management. Do you have any updates on whether administrators have been able to collect the information requested by the Committee Chairs?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes, Madam Chair. The letter was approved and released yesterday or today, this morning.

CHAIRPERSON NARCISSE: Yes.

CHIEF EXECUTIVE OFFICER DR. KRATZ: I have it here. I hope you have it. If not, I have copy.

CHAIRPERSON NARCISSE: I have a copy. It came from our letter. Go ahead.

CHIEF EXECUTIVE OFFICER DR. KRATZ: So I just would like to say know as a clinician I care for many people with diabetes, hypertension, and many of them suffer from obesity at levels that they cannot control, and you talk to them. This can be heartbreaking. People say, I eat almost nothing, and I say it's not your fault. Your body just happens to be really good at pulling every calorie out of what you eat, and people reach a point where they cannot lose weight because their weight prevents them from moving very much because their knees begin to hurt, their feet begin to hurt so they become less and less

active and then use fewer and fewer calories, and bariatric surgery has been found to be life-threatening, and I, and I think many people found the New York Times articles insulting, that they basically seem to say, look, you're poor, what are you doing with getting this surgery for body stuff, that's superfluous, that Bellevue should be handling trauma care without realizing that this is life-threatening.

CHAIRPERSON NARCISSE: It is life threatening?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Life threatening when people have BMI's, body mass index, of 45 and have sugars that are out of control and hypertension that isn't controlled by multiple medications, and many of the charges like the idea that a surgeon would be paid for productivity, that's American medicine. All of American medicine is based on productivity. There's nothing nefarious about productivity. There were criticisms of the idea that patients who were in the criminal justice system would get bariatric surgery but, again, our whole goal is to provide a single standard of care to people. We don't go around saying, I'm sorry, you're

in the criminal justice system and we're not therefore going to provide life-saving treatment. There was criticism that we didn't require the same number of visits as the private systems. You know what? The private systems get paid for each of those visits. Those visits are money-making. On the other hand, my patients often don't have sick leave. If I tell them that they have to come for nine appointments before their surgery, it's a non-starter. They won't be able to comply so, yes, we've created a program that was designed to meet the needs. Everyone did not have a perfect outcome because that's bariatric surgery. It is life-saving. Sometimes it doesn't work. Sometimes people still are able to consume enough calories, but our numbers are as good as anyone's and I really think that it was a sort of misunderstanding of what it's like to be poor and what it's like to have people not really recognize how serious a problem obesity is for people. We don't feel defensive at all about this issue in the sense of, this is not to me something that anybody needs to apologize about. We want to be transparent. We want everybody to see the data, but we don't see anything that requires us to say we're

sorry or we did the wrong thing. We stand by the outcomes of the program, and we stand by the right of low-income people who are seriously obese, and we're not talking about people who want to look better in their summer swimsuit. We're talking about people who have uncontrolled diabetes or hypertension or heart disease because of their obesity. We're happy that the letter got released and happy to provide anyone with information and transparency about the program.

CHAIRPERSON NARCISSE: It's preventive care?

CHIEF EXECUTIVE OFFICER DR. KRATZ: It is preventive care.

CHAIRPERSON NARCISSE: As a nurse, I focus on preventive care. This is preventive care, but when you let someone's obese and then life-threatened, hypertension, heart disease, cardiac arrest, when they come to the hospital, you put them in ventilator, that's a lot of more money.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes.

CHAIRPERSON NARCISSE: Than doing a surgery and trying to get the person to live a healthier life, and it should not be about money. It's a right for everyone to have healthcare.

Does a hospital receive funding based on the number of bariatric surgeries that are performed and, if so, where does the funding come from and what is the money allocated toward?

CHIEF EXECUTIVE OFFICER DR. KRATZ: For bariatric surgery, it's as we do everything that we do. We bill insurance, and we try very hard to collect from insurance, not from individual people. The money goes to the overall pool of services that we provide so, again, we've never set specific dollar to a specific service. Another way of looking at the importance is not all our hospitals have equal percentages of private payers. Some of our hospitals have more private payers. Some of our hospitals have fewer. We don't want to provide more care at the hospitals that have better insurance. We want to provide the same care to everybody and so, for that, it's important that all of the revenue we collect goes back into the money and then we distribute it by volume. You have more patients, we're going to send more money to your hospital. It all follows a formula of X patients equals X nurses equal X doctors equal X medications, and it should all be based on what people's actual needs are.

CHAIRPERSON NARCISSE: Thank you. Mental health services. Suicide is currently the leading cause of death for male residents and the second leading cause of death for female residents. H and H testified that they have taken strides to increase access to mental health support for residents, such as resident wellness work groups, dedicated spaces and retreats, and Helping Healers Heal program. Does H and H have a schedule on how often mental health resources are offered to residents? Second, how many residents take part in each program?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I don't think we have that information. I have to figure out, obviously sometimes people seek out help without telling anyone and we would support that, right? We would support anonymous seeking of help. I can find out, Helping Healers Heal does track contacts separately by residents. Do you know, John?

SENIOR VICE PRESIDENT ULBERG: No, I've been told that the privacy is a major issue, and it could be a barrier if we have too much tracking.

CHIEF EXECUTIVE OFFICER DR. KRATZ: So we've tried to not track too closely who in our system seeks care so that nobody, because remember,

numbers could get small, even if you said no names, if you said two residents at Woodhull sought care, I think they would wonder which two sought the care, so we've tried to not enumerate. We want people to feel that they can go as often as they want, that they can seek as much care and also that they should seek the care they want. Some people want to talk to a peer. Some people want to talk to a psychologist or a psychiatrist. We try to say both are good. Sometimes people want to talk to their program director. There's someone who went through residency. It's a difficult thing. It was difficult when I did it. It's difficult now. It's a very stressful time in people's lives for a variety of reasons, and we are never going to succeed in making it not stressful. Our job has to be able to meet people when they're feeling stressed and prevent suicide so that people never feel that's the only choice that they have.

CHAIRPERSON NARCISSE: I understand what you're saying about privacy and stuff, but I'm saying like, if the program is being used or not actively, because, like I said, we have a program and nobody goes in that room at all, is that being effective things? That's what I was (INAUDIBLE)

CHIEF EXECUTIVE OFFICER DR. KRATZ: I understand.

CHAIRPERSON NARCISSE: How does H and H offer additional support to residents that may need outside counseling of requests leave? What additional options do residents have to seek mental healthcare needs?

CHIEF EXECUTIVE OFFICER DR. KRATZ: All of our residents do have health insurance so they would be able to seek care, and I think that's also important because that they can seek without us knowing anything about it which is an important feature. Again, people differ. Some people want to go talk to their program director. Some people want their program director to have no idea that they're struggling, and our system should allow for both. We thought that the Helping Healers Heal was nice because that's a third model. That's not your supervisor, that's not your doctor, that's your peer, and sometimes the peer is the only one who can assure you, yes, I felt the same way, or, yes, I feel bad in that kind of way as well. Again, our job is to provide as many choices as possible. I'm sure there will always be people who take advantage and people

who should take advantage but don't. All we can do is try to make it as stigma-free as possible.

CHAIRPERSON NARCISSE: Thank you. It sure is a stigma.

Has there been a partnership with other mental health facilities to support residents needing more support or medications? What percentage of the Health and Hospitals' budget goes towards supporting resident and nurses with mental healthcare needs?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Again, probably the largest portion people get through their health insurance, so we wouldn't be able to track that. Health and Healers is a peer program so we don't pay specifically, and I think people wouldn't like it as much if it was a paid program. They want to feel that they're talking to a peer who's volunteering based on similar types of experiences. The program directors to which people also go is baked into the budget for residency so I don't think we have a separate dollar figure.

SENIOR VICE PRESIDENT ULBERG: Not a specific number, yeah.

CHAIRPERSON NARCISSE: (INAUDIBLE) Okay. To follow up on the question regarding the Helping

Healers Heal program, staffing from the recent hearing on residents, can you please provide the number of staff along with their title and responsibility who run and coordinate the program at each hospital?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes, that we can provide. We can provide the administrative item. We can provide the numbers and the different professions. Some are doctors, some are nurses, some are social workers, some may be EVS workers, right? It's open to anyone to volunteer.

CHAIRPERSON NARCISSE: The well-being of our resident. In addition to the concerns I mentioned earlier, residents have additional concerns about their housing and food. Many residents struggle with finding affordable housing or caring for their families. What type of housing is provided for H and H residents? I think I overheard you talking (INAUDIBLE)

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yeah, unfortunately, that era passed. We're not currently doing any housing for doctors or nurses. Again, it's a broader policy issue for the City. When I've raised it before, I think most of the housing people have

thought a voucher system, taking advantage of existing stock would be more efficient, but I'm not a housing expert.

CHAIRPERSON NARCISSE: Okay. You don't think housing will be helpful because the complaint I'm hearing a lot because some other countries I think try to help out with residents and nurses and doctors to make sure that they can have the staffs.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yeah. For example, NYU own a lot of buildings, and they rent them out. I think the question for the City is City as landlord. Does the City want to be landlord for those buildings or does the City want to voucher people into things, and that's what I'm not, again, I'm not the right person to answer the question. I think you can accomplish the goal, either you can give someone a voucher and say here's a voucher for finding housing because what people are complaining about is the lack of affordability, right, so a voucher solves the lack of affordability. Whether the City wants to be a landlord for nurses or residents, I can argue both sides of it, but I don't think I'm the right person to make the decision.

CHAIRPERSON NARCISSE: Thank you for the effort of giving me some of your thought or your opinion.

What restrictions are there for, you don't have any, you don’t have an ER resident because (INAUDIBLE)

Okay, let's come to the food vouchers. Do H and H residents receive food vouchers? If so, how much money do they receive daily or weekly for food?

CHIEF EXECUTIVE OFFICER DR. KRATZ: It depends greatly on the program and usually it's not a daily, it's an amount different when you're on-call from the amounts on a regular day so if you're having a regular day, the amount you're going to get is very different than if you're overnight, and each program is currently different, and they all work on voucher systems rather than, sadly the age that you and I trained in where there is a hospital cafeteria, no more hospital cafeterias. I know, and it was nice, doctors and nurses would hang out together. It was a social thing. It was a dating thing.

CHAIRPERSON NARCISSE: Oh, I didn't say dating. I didn't say yes to the dating. I said yes to everything else. Okay, got it.

CHIEF EXECUTIVE OFFICER DR. KRATZ: There's no social center to hospitals anymore. There are no cafeterias. It's all gone.

CHAIRPERSON NARCISSE: That was a fun thing.

CHIEF EXECUTIVE OFFICER DR. KRATZ: I know. It's terrible.

CHAIRPERSON NARCISSE: She's a social worker so she used to be around.

CHIEF EXECUTIVE OFFICER DR. KRATZ: People do get vouchers, and we try to maintain some selection of healthy food at the hospitals.

CHAIRPERSON NARCISSE: That's a tough one for me. They receive discount for meals to purchase in their hospital, but you don't have no cafeteria.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Right. They get vouchers.

CHAIRPERSON NARCISSE: They get vouchers to go, and you cannot tell me the actual vouchers. Is it based on programs?

CHIEF EXECUTIVE OFFICER DR. KRATZ: It's based on program, based on what your shift is.

CHAIRPERSON NARCISSE: Okay. I'm shocked with that cafeteria thing so I cannot get over it.

Food is so expensive because I heard one of the residents testify, after he finished paying his rent, he didn't have money to buy food, and then he went to the hospital and got a sandwich that labeled just restricted for patient, and he took one, knowing it's for patient because he was hungry. We should not have our residents in that situation. It bothers me.

CHIEF EXECUTIVE OFFICER DR. KRATZ: I totally agree. I think that's why we all want a fair resolution to the resident contract.

CHAIRPERSON NARCISSE: Okay. I cannot ask you about cafeteria. I had so many questions around cafeterias, what time and everything. Okay.

Vacancies. Residencies are notoriously difficult to get into. New York City residencies are among the most competitive because so many students want to practice here? Despite this, there are still vacancies in residency positions at H and H. There were 18 vacant resident positions in 2023. Can you elaborate on how this happens, and even with the last minutes scrambling to match students with empty residency because we know they need that spot.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Even with the scramble, remember that we have hundreds of

hundreds, more in the thousands, so 18 is a pretty small number. You can have mismatch, so you can have a residency that you have people who want to say a surgical residency and they didn't match, they're looking, but what you have is pathology or psych and they're not interested in that so you do your best, but I think 18 is pretty good for a system our size because you're never going to get 100 percent. Also, of course, we have standards, and there are people who graduate from medical school who have terrible recommendations. If we read that someone did not have a history of being nice to their patients in medical school, we would not accept them even if we had a vacancy so it'll never be 100 percent. We want programs to maintain standards. We don't want them to say, okay, you're, you have a pulse come join us.

CHAIRPERSON NARCISSE: So it's a process that prevented (INAUDIBLE)

CHIEF EXECUTIVE OFFICER DR. KRATZ: It's a process, right.

CHAIRPERSON NARCISSE: Yeah. My son said I brainwashed him to become an orthopedic surgeon, like he was good sewing with my grandmother so now he should be telling me thank you, right?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes, I hope he's a grateful son.

CHAIRPERSON NARCISSE: What step will H and H take to lower this number to zero vacancy residency?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I don't think it's realistic for it to be zero.

CHAIRPERSON NARCISSE: It's not realistic?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I don't think that's realistic.

CHAIRPERSON NARCISSE: Okay. Have you spoken recent with the State to see if they will include H and H hospital in the fund in the future?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I talked to the State about the importance of both Health and Hospitals being financially viable and the other safety nets being viable because, as we've talked about, if other hospitals close, it has a negative impact on us. My job I feel is to advocate for all New Yorkers to get the care, whether it's with us or them so I've never said to them you must give the money to us instead of from another hospital that might need it a little bit more than we do so I want to always keep us whole and, again, especially

due to John's work, our finances have been pretty good. We've basically through successful billing of insurance have brought in 2 billion more in the last six years on a year-to-year basis. The State tends to look to us to teach other hospitals how to be financially viable.

CHAIRPERSON NARCISSE: You're a better man than many. Many people say, give me, give me, give, but you understand we're having a crisis, and we're counting on H and H and you're doing a great job with that.

COVID-19. The COVID-19 pandemic still affects our healthcare system and especially affects our hospitals. It is important that we ensure that there are adequate preventive products for COVID-19 transmission to ensure that patients and medical professionals don't get sick. Does H and H provide free masks for all healthcare practitioners and patients? What type of masks are provided? Do you have different sizing options for people that won't fit in a standard mask comfortably, such as children?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes to all and, as an addition, also to visitors. We provide free masks, and we have everything from surgical

masks to N95 masks. The practitioner gets to decide what kind of mask and we do fit, we have pediatric sizes, also many women's faces require for an N95, a different size mask, and we have the various sizes.

CHAIRPERSON NARCISSE: Is it in the budget to distribute masks to the general public?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We don't have a specific distribution program. It's been done in the City primarily by DCAS and by our sister agency, DOHMH, but when there's been a crisis, like when we had the bad air, we were part of giving masks. We're not part of the regular process, but if there were an emergency, of course, we would respond and give the masks that we have.

CHAIRPERSON NARCISSE: So you don't have a set-aside money for that?

CHIEF EXECUTIVE OFFICER DR. KRATZ: No, because it's done by DCAS and DOHMH.

CHAIRPERSON NARCISSE: Gotcha. Do you supply hand sanitizer to healthcare practitioners and patients?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes.

CHAIRPERSON NARCISSE: How do you keep track of which areas in the hospital require more hand sanitizers?

CHIEF EXECUTIVE OFFICER DR. KRATZ: It's Environmental Services. They're in charge of that.

CHAIRPERSON NARCISSE: Is there adequate funding allocated for budget for the distribution of tests? If yes, how much money does this cost?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Just like all other things, we don't track specific COVID tests that we do in the emergency room, right, so we consider it part of standard of care. We are no longer part of the distribution of home tests, which we once were. That's being done by the sister departments. All the supplies that we bought during the COVID pandemic have either expired or have been distributed.

CHAIRPERSON NARCISSE: Thank you. Now I'm going to ask you for one of my bill, Introduction 1020 of 2023 sponsored by me seeks to establish a website for New Yorkers to request free COVID-19 rapid antigen tests and personal protective equipment. Do you have funding in the budget to officiate this policy?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I think first it's a great idea. I do know that there are tests available because I recently did for a constituent at the libraries still have as a distribution site. Fire houses have masks from the last bad air, but we are not, again, I think this is more at this point a DOHMH, DCAS initiative because it's all population-based, but if people run out, we will always be available to give whatever the City needs.

CHAIRPERSON NARCISSE: Okay. Do you have the budgetary logistical means to distribute educational materials to the public in the event that there is an uptick in cases or surge of new infectious diseases?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We would certainly do it with DOHMH. I see them as the lead on public information campaigns around infectious disease.

CHAIRPERSON NARCISSE: Okay. Thank you. Medicaid transfer and reimbursement. H and H received 145 million from HRA in the Fiscal 2025 Preliminary Plan through an intracity transfer. This additional funding is a baseline starting in Fiscal 2024 and is

part of a routine transfer of Medicaid initiative funds. Can you provide additional information on this initiative?

CHIEF EXECUTIVE OFFICER DR. KRATZ: This is part of the matching of Medicaid, there has to be a local match, and HRA is the part of the City that does this scope of work. They provide the match that then goes up to the federal government and brings down Medicaid services.

CHAIRPERSON NARCISSE: Okay. What services will H and H provide with this funding, and how will these services assist HRA?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Okay. The money goes to the federal government, gets matched, and it's how the federal government reimburses us for all Medicaid services so it's any service that is paid for through Medicaid.

CHAIRPERSON NARCISSE: It goes through Medicaid? In the HRA's Expense and Revenue Charts, they outlined that H and H projects decreased of nearly 90 million in Medicaid revenue. Can you elaborate more on this decrease? What impact will an increase in Medicaid reimbursement have on this revenue?

SENIOR VICE PRESIDENT ULBERG: Yeah, I'll say this is an adjustment that pertains to the H and H budget. We know that as we're looking forward to FY25, we've done very well with our risk pools. Those are capitated payments that we receive from MetroPlus and Health First, and what we're anticipating in the budget that there will be a decline in the number of members, people participating because of the Medicaid recert process so it's just we're anticipating there will be less revenue coming to Health and Hospitals, and that's the adjustment.

CHAIRPERSON NARCISSE: Okay. H and H strives to provide great services to all New Yorkers and aims to have their hospital be locations that patients can rely on consistently. What form of quality assurance does H and H have to lower potential cases of medical malpractice or negligence?

CHIEF EXECUTIVE OFFICER DR. KRATZ: We have a very robust plan that includes our board and quality improvement for cases that are seen throughout the system. Each hospital and clinic has a quality improvement director. As long as healthcare is done by humans, or maybe even if it's not done by humans, there will always be things that don't go the

way you want them to go. Nobody's perfect, but we strive to provide the right care every time, and there have been some major initiatives including timeouts in the surgical field, which didn't exist when you and I were in training, but now they would never do surgery without a timeout to ask everybody, the nurses and the doctors, do we know what surgery we're doing, do we know which side we're doing it on, does anyone have any questions about what we're doing? The modern electronic health systems, every time I prescribe a medication, if that medication has an interaction with another medication that the patient is taking, I immediately see it on the screen. They say, do recognize that drug A is associated with an interaction and drug B, right, so you remember in New York, there was the famous Libby Zion case, a young woman who died at a private hospital due to a medicine interaction. In modern times, you would prescribe a medicine and you would immediately see that interaction. I think that the right policies and procedures are in place to try to drive that number as low as possible.

CHAIRPERSON NARCISSE: What are the rates of complaint that H and H receives?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Complaints are also a little bit of a challenge in that we try to encourage them. We try to encourage the idea that people complain. We want them to, first, because that's how we learn, and second, because that's the only way you can make a service recovery is if people complain. We get lots of complaints, the food, lack of private room, waiting times and, again, we don't view increased complaints as necessarily a bad thing. We view failure to service recover as a bad thing, and obviously there's a difference between a complaint as in I don't like the food or my meal arrived cold or I wish I was in a private room from my surgery was wrong. The surgery went wrong. That's a quality improvement issue that has to be very tightly reviewed. Complaints can be like, we already know that right now there are close to your home there are more complaints about the wait times at King's Hospital because in the emergency room because it's a lot busier than it used to be. These things are directly predictable so I don't have a specific number. Do you?

SENIOR VICE PRESIDENT ULBERG: No, I don't.

CHIEF EXECUTIVE OFFICER DR. KRATZ: But they are tracked. Every single hospital and each hospital has it by food, space, wait time, other, and we're happy to provide that.

CHAIRPERSON NARCISSE: As a nurse, I'm going to ask about the malpractice. What's the number look like?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Our overall malpractice is lower than other systems as a total dollar amount. I believe one reason is that we don't do unnecessary surgeries. We are a system that exists only to take care of people's needs because nobody is making money in our system or over doing more so I think that accounts for we're doing a much higher percentage of emergency cases. For example, we don't do plastic surgery unless there's a medical reason for plastic surgery so we don't do a lot of the things that tend to bring you the large malpractice suits.

CHAIRPERSON NARCISSE: How do you manage misdiagnosis?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I'm sorry, could you say the last word?

CHAIRPERSON NARCISSE: Misdiagnosis.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Misdiagnosis. There was a recent JAMA Internal Medicine paper that looked at patients who were, this was national data, looking at patients who had been transferred from a regular floor to an ICU and found that 22 percent had a misdiagnosis or mistake. National data. I mention that just to say doctors, nurses, we're all human. Healthcare is a very hard thing. Even the best doctors, best nurses don't always get it right. What we do have is we have great decision support from our electronic health record. We have free and easy to use UpToDate, which is the modern textbook. We are, we try very hard to empower our nurses to question doctors. We don't want nurses to say yes, doctor. We want nurses to independently if the doctor says, I recently reviewed a case where I was so thrilled because the doctor ordered a medication and the nurse refused. I'm like that's exactly what we want. We want the nurses to feel fully empowered to say, no, I'm not giving that medication. I think that this is as much as the national people have come up with to try to prevent misdiagnosis, but it does happen in our system and every other system I know.

CHAIRPERSON NARCISSE: Thinking about my days, we didn't have much to say. We did not have that autonomy, and I love that that we can tell the doctor, but at the same time, I think one of the things that improve us a lot, we start having round with the doctors.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes.

CHAIRPERSON NARCISSE: So that way the communication is understanding and see where I'm going with you, I'm here to care for the patient with you, not for you.

CHIEF EXECUTIVE OFFICER DR. KRATZ: We are very big believers in equals, and interdisciplinary rounds are rounds of equals.

CHAIRPERSON NARCISSE: Yeah. When medical malpractice occurs, what step does H and H take to ensure that it should never happen again?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Every case where something goes wrong, including what we call good catches, where something could have gone wrong so even if nothing has gone wrong, say someone is misidentified. I reviewed a case recently where someone goes into a waiting room, calls a name, and

the wrong person answers, and there was no check of date of birth until much later. Nothing bad happens.

CHAIRPERSON NARCISSE: Thank God.

CHIEF EXECUTIVE OFFICER DR. KRATZ: But we still look at that case. That is a good catch. Someone caught the case and realized, oh no, you're not this person. Nothing happened. No negativity. Every case where either something goes wrong or there is a good catch where something could have gone wrong, someone ordered a medication that was contraindicated, someone ordered an amount that was contraindicated, each of those is reviewed at the facility and then, as a system with our board, we review a set number of cases at every single hospital, and every case where something went wrong or could have gone wrong has to have a correction plan of how do you make sure that it never happens. Often it can be a teaching program so, for example, reminding people names are a terrible identifier. People have the same name, people change names. Two identifiers. Everybody has to have two identifiers. If you're in a healthcare system and you're not asked your name and date of birth each time, there's a problem. There should always be two identifiers so

it's constantly reminding people, did you ask what their date of birth is? Not sufficient to just ask their name. Sometimes it's putting a process in place. We're not going to use this catheter. We're going to use this catheter. Each case is very individual but each one is reviewed with and required to have a plan of how to prevent this in the future.

CHAIRPERSON NARCISSE: Thank you. We usually do date of birth, name, and check the ID.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes.

CHAIRPERSON NARCISSE: Because that way you know it's that person.

I think my Colleague have another question, Council Member Marmorato.

COUNCIL MEMBER MARMORATO: When you speak about complaints, is this information coming via the way of a patient experience survey?

CHIEF EXECUTIVE OFFICER DR. KRATZ: A variety of ways. We have signs all over the place. If you have an issue, please call and it's the Patient Relations.

COUNCIL MEMBER MARMORATO: Okay.

CHIEF EXECUTIVE OFFICER DR. KRATZ: And then we're part of the national survey so every

patient gets a survey. When my mom was hospitalized at Bellevue for a hip fracture, she gets a survey, comes to her house, confidential. She can say whatever she wants. We never see the response. It goes directly to this national response that then sends you your grades based on all of the patients.

COUNCIL MEMBER MARMORATO: What organization is that through?

CHIEF EXECUTIVE OFFICER DR. KRATZ: It's HCSIS. What is it? We all call it HICSIS, but it's a federal agency.

COUNCIL MEMBER MARMORATO: Is it just through the mail or is it through email as well?

CHIEF EXECUTIVE OFFICER DR. KRATZ: I think they do both.

SENIOR VICE PRESIDENT DR. YANG: I've gotten emails.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Have you gotten emails?

It's all hospital systems use the same one so it sounds like they do emails as well.

COUNCIL MEMBER MARMORATO: Is this public knowledge and where can we find that?

CHIEF EXECUTIVE OFFICER DR. KRATZ: Yes, absolutely. You could find on the web for any hospital that you go to. The slight problem, and you might've guessed this problem, low response rates so you tend to get the most satisfied and the least satisfied and you lose a lot of the middle.

CHAIRPERSON NARCISSE: Thank you. Now, Dr. Katz, I just want to say thank you from the bottom of my heart and all the team, and we appreciate you came out to answer those questions. It was a pleasure to have you in this room and all your team so thank you all and continue making sure that we uplift people and address the inequities and you serve the underserved and seeing the hospital balance economically, that's a great thing, but we need to address the rest of the things that we need to address, like sickle cell disease, to make sure that we have more centers around, to make sure that we help New York City. That's it. Thank you all.

CHIEF EXECUTIVE OFFICER DR. KRATZ: Thank you.

COMMITTEE COUNSEL: We will now turn to the public testimony. We will be limiting public testimony today to two minutes each.

For in-person panelists, please come up to the table once your name has been called.

For virtual panelists, once your name is called, a Member of our Staff will unmute you and the Sergeant-at-Arms will set the timer and we'll give you the go-ahead to begin.

Please wait for the Sergeant to announce that you may begin before delivering your testimony.

For in-person panel, we will be calling Nevien Swailmyeen.

You may begin.

NEVIEN SWAILMYEEN: Good afternoon, Chairperson Narcisse. My name is Nevien Swailmyeen, and I am the Health Justice Advocate with New York Lawyers for the Public Interest, NOPI. At the outset, we want to thank the City Council for continuing the Immigrant Health Initiative, which has directly supported NOPI's programs aimed at improving the health and well-being of immigrant New Yorkers and their families through health education, outreach, and sustained policy advocacy. In this budget process, we call on the Council to continue defending vital City services investments from budget cuts that will inevitably lead to loss of access and

inequitable healthcare outcomes. We want to thank Chairperson Narcisse for sponsoring and introducing legislation that would create a new Office of Organ Transplant Equity within the Department of Health. The Office would handle providing accessible information and specialized care coordination to all New Yorkers about life-saving organ transplant options available in every borough. Currently, many of NOPI's immigrant clients with renal disease are forced to depend on long-term dialysis treatments, which are debilitating, less effective, and far more expensive than kidney transplants. In 2021, NOPI launched a pilot transplant pipeline with the Kidney Transplant Program at SUNY Downstate Medical Center. In the years since its establishment, this program has trained hundreds of healthcare and legal service providers and, as a result, seven formerly uninsured people have received kidney transplants in the past year and several more are expected to be listed or transplanted this year, which is really exciting for us. We're really happy. We hope to continue our partnership with SUNY Downstate, and we are alarmed by the sudden news of its restructuring, seeing as it is the only safety net hospital in New York City with

a kidney transplant program and the only organ transplantation program located in Brooklyn. The proposal put forth would relegate SUNY to a subsidiary role within a designated wing at Kings County Hospital Center, and such a reconfiguration would lead to the termination of SUNY Downstate's operation. The closure would worsen health inequities throughout the city as SUNY Downstate serves a predominantly low-income, medically underserved population, including patients grappling with end stage renal disease who face immediate repercussions. We urge the Committee to take oversight steps to ensure that kidney transplant patients from across the city who are currently receiving care at SUNY Downstate continue to receive life-saving care. We extend deep gratitude to Chairperson Narcisse for the opportunity to provide testimony today. We look forward to continuing our partnership with the City Council to advance health, immigrant disability and environmental justice to all New Yorkers.

Thank you.

CHAIRPERSON NARCISSE: Thank you for your time. Now we have question with Downstate being closed so we are going to continue fighting.

NEVIEN SWAILMYEEN: Yes, we do. Thank you.

CHAIRPERSON NARCISSE: Yeah. Alright. Thank you for your time.

COMMITTEE COUNSEL: Thank you, Chair.

Now, we'll move to the Zoom testimony. I will call on Medha Ghosh.

SERGEANT-AT-ARMS: Time starts.

MEDHA GHOSH: Good afternoon, my name is Medha Ghosh, and I'm the Senior Policy Coordinator for Health at CACF, the Coalition for Asian American Children and Families. Thank you very much, Chair Narcisse, for holding this hearing and providing this opportunity to testify. Founded in 1986, CACF is the nation's only pan Asian children and family's advocacy organization and leads the fight for improved and equitable policy systems, funding, and services to support those in need.

The Preliminary Budget for FY25 fails to fund key initiatives that will fund the FY24 Adopted Budget, including 5 million in FY24 for the Mental Health Continuum. The Mental Health Continuum is an innovative, evidence-based model for supporting students with significant mental health needs by integrating a range of direct services and developing

stronger partnerships between schools and hospital-based mental health clinics. We want to stress in particular the social emotional needs of AAPI young people in our New York City public school system to emphasize importance of maintaining funding for the Mental Health Continuum as well as ensuring the budget properly supports mental healthcare for our youth. To ensure mental healthcare for all, the City needs to invest in developing a continuum of care that incorporates both nontraditional and traditional forms of care, identify a range of access points, and look to redefine safety away from the absence of crime and towards a presence of wellness across communities. We would also like to uplift the need for more language service support in our hospitals for asylum seekers' community. We have heard from many AAPI communities that are crossing the southern border and then arriving in NYC and facing huge language barriers. For instance, we have spoken with groups working with families coming from Afghanistan requiring language support in Farsi and Pashto. It is critical that our hospitals have enough language service funding to support the additional language need of asylum seekers. CACF is grateful to already

be partnering with H and H on issues of language access, and we look forward to continuing that work and know that is of utmost importance in the well-being of all New Yorkers. Overall, we see a need for more intentional collaboration between the City and community-based organizations to better identify language access and mental health services gaps in our communities and to find and implement solutions that will have a direct positive impact on the well-being of all of our communities.

SERGEANT-AT-ARMS: Time expired.

MEDHA GHOSH: Thank you for the opportunity.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: Ginger Davis.

SERGEANT-AT-ARMS: Time has started.

GINGER DAVIS: Good afternoon, everyone. Good afternoon to Chair Narcisse and to Chair Schulman and all of the Council Members. This has actually been a really great meeting to be able to hear all this information and to hear what. Dr Katz is saying about the changes and the improvements that are being made within HHC, and I also want to echo what Chair Narcisse said about it being way overdue

to provide quality care and continuity of care for sickle cell disease, particularly in adult medicine. We are losing our young people who age out of pediatrics and not all of the hospitals have adult programs, and it is very painful to be seeing our young people between the ages of 19 and 35 dying because they don't have continuity of care and the biggest problem is that healthcare providers aren't properly educated about sickle cell. I think doctors know more about the stigma and consider adults with sickle cell disease to be drug seekers and drug addicts rather than to deal with the emergent issue that they are being faced with at the time, and we have things like Project ECHO with both CBO to provide an education, which Dr. Katz is aware of through Jacobi Hospital and Stigma ECHO and also John Hopkins, who were part of their network, has a provider to provide ECHO, and we go on these things, the doctors who show up are the doctors who are already caring for the population. We need internists and specialists from other disciplines to come on to these provider ECHO education programs so they can begin to learn more, and particularly we would like to see that the American Society of Hematology's

clinical guidelines for sickle cell be adopted across HHC to give proper care for this population. Thank you for this opportunity to speak and, Dr. Katz, I look forward to meeting with you one day to further this conversation.

CHAIRPERSON NARCISSE: Thank you, Ginger. You have been a great partner in sickle cell disease, and I appreciate you. Thank you.

GINGER DAVIS: Same here. So have you. Thank you.

COMMITTEE COUNSEL: Thank you. Julie Lam.

SERGEANT-AT-ARMS: Time has started.

JULIE LAM: My name is Julie Lam. As founder of Mask Together America, a grassroots awareness campaign created to support public health and people with weakened immune system, I testify today to emphasize the urgency for New York and the rest of our country to embrace a layered approach in mitigation. Please fund Bill 0332. New York City needs free COVID 19 rapid antigen test and masks to promote prevention. Vaccination and treatment don't stop transmission as we know. In general, pharmaceutical interventions are not applicable to everyone due to their immune systems and medical

conditions. We need to promote the usage of non-pharmaceutical intervention to ensure health equity. The cost of COVID-19 rapid tests and masks generally discourage people from using them. Providing free access to masks and tests give people more options and the community as a whole more protection. COVID is a serious threat to the high-risk community which I am a part of. I am immunocompromised because of an autoimmune disorder. I know that each infection will exacerbate my underlying condition. My condition prohibited me from taking the mRNA and protein-based vaccine. Many people like me can't survive without mask protection. COVID-19 has already killed millions of people. At least 65 million people have long COVID around the world. Roughly three quarter of U.S. adults are at high risk of severe COVID because of medical conditions and disabilities. People who get long COVID require comprehensive care and a complicated diagnostic process. Our country doesn't have safety nets or universal health coverage. Most people don't have paid sick leave. Hospital and medical costs can make a person without adequate health insurance homeless. Ventilation is poor in

most buildings. Viruses spread in the air. I am suffering from two long COVID conditions.

SERGEANT-AT-ARMS: Time expired.

JULIE LAM: I have gone through hell and I really don't want to get infected again. I hope that we will pass the bill and we can get free high-quality N95 and KN95 masks through the mail and that will help normalize mitigation and keep New York City safe. Thank you.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: Thank you. Next is Dr. Lucky Tran.

DR. LUCKY TRAN: Good afternoon, everyone. My name is Dr. Lucky Tran, and I am a scientist and public health communicator who works at Columbia, and I'm also a member of COVID Advocacy New York. I'm testifying today to urge the City to continue funding and implementing COVID prevention efforts. I am concerned about the prospect of COVID budgets being cut because as the World Health Organization reminds us, we are still in a pandemic. The data tells us this too. This winter surge is actually the second largest of the pandemic according to wastewater levels, and we are still seeing high levels of death

and chronic illness caused by COVID. One of the most important public health problems that isn't being meaningfully addressed is that people who are most vulnerable or high risk have to delay medical care because of the lack of COVID protections. This, to me, as someone who works in healthcare, is absolutely unacceptable. You can do something tangible to address this crisis. You can require a mask in healthcare settings. I appreciate that H and H having a mask requirement in place for a few weeks. However, this came weeks too late, and it's already been lifted despite COVID levels still high. No one should have to risk getting sick in order to access healthcare. You can also do more to make sure that staff and patients and visitors have access to N95 and high-quality masks in healthcare settings. In practice, too often, I've experienced myself, and I've heard the same from others, that many people, including staff, have trouble accessing high-quality masks when in healthcare settings. I really think we can do better on this. You should also be providing funding to help all New Yorkers access high-quality masks, tests and other COVID prevention tools for free. Many still want to take action to protect

themselves and their communities, but they can't afford the tools needed to do so. The federal programs for masks and tests have ended and weren't sufficient in the first place. The City already spends money to provide important health tools like condoms, hygiene products, and harm reduction items. COVID is still around and causing harm so the city should continue to spend money on COVID prevention tools to. On this, thank you to Chairperson Narcisse for introducing bill, Int. 332, which would provide free mass, other PP, and rapid tests to all New Yorkers through the mail. I urge the New York City Council to pass it. Your actions right now will be recorded in history. You can choose to acknowledge that we are still in a pandemic and COVID is still around and causing harm or you can deny things and make things worse. You all have the ability to take actions that could make an incredible difference to the lives of many New Yorkers, particularly the most marginalized. I urge you all to go down in history for the right reasons. Thank you for your time.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: Thank you. Next is Elana Levin.

SERGEANT-AT-ARMS: Time starts.

ELANA LEVIN: Okay, you can hear me now. My name is Elana Levin. I'm a member of Jews for Racial and Economic Justice. I got COVID in December 2022 despite being in excellent shape, having all the boosters and Paxlovid. My COVID still became long covid and I can't return to the active life I had. Long COVID can happen to anyone, and it's happening to at least 15 percent of New Yorkers still, many of whom will become too sick to work, and each time you get COVID, the risk is over and over and compounding. The only reason I was able to tell that I had COVID and take steps to prevent spreading it was because H and H used to have a free testing truck right outside my apartment. My home tests, I was negative on all of my home rapid tests. The only positive test I had was that free PCR that I got at one of your trucks, and now those trucks are gone. Those testing sites were outdoors, which also meant that I could get tested without spreading COVID or catching COVID. Now, New York has ended the mask requirement in healthcare settings. That means in order to pursue medical care, we have to put ourselves at risk of getting COVID again. Even when I wear my N95 mask, which I do all

the time, studies show that I have a two-hour time before I can inhale an infectious dose of COVID, and that's assuming I don't have to take my mask off to drink water or have some test where my mask can't be on. I saw in your hospital report that there's been a steep increase in the number of people going to hospitals who are leaving without getting care. I constantly hear from people that when they go to the hospital, the waiting rooms are full of people who are not wearing masks and are coughing and they leave because they are in danger. The flimsy surgical masks that are handed out, which is the majority of what people are being given, I know because doctors are telling me that they don't get N95s at work, those flimsy masks don't filter the air, they're not comfortable, and when you give people tools that don't work well, they don't use them. I don't see how it is ADA compliant that medical settings in New York are inaccessible to people like me. Where am I supposed to get care without getting sicker? Most immune compromised people don't even know their status. I have nowhere I can get medical care safely in New York. If you've ever wondered what you would…

SERGEANT-AT-ARMS: Time expired.

ELANA LEVIN: At the start the AIDS crisis, not the end, the start, you are doing it now. There are things we can do now even without federal support. Things like respirator mask distribution, thank you Council Member Narcisse, requirements in healthcare settings, and getting air filtration even if it's just running a HEPA machine that I can freaking buy, I don't know why you guys can't, and opening windows. These are all things that can be done now so that people are no longer getting COVID and becoming more disabled, too disabled to work (INAUDIBLE) attending medical settings and trying to get healthcare.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: Anna Pakman.

SERGEANT-AT-ARMS: Time starts.

ANNA PAKMAN: Hi. I'm here in my personal capacity and I am a New Yorker. I'm disabled and I am here in support of the new bill that would allow any New Yorker who wants them to be able to access high-quality K95 and N95 masks and rapid tests through a website. It's incredibly simple and smart. It's been successful for the federal government and New York needs to lead in this area, especially as the federal

program has wrapped up. I have personally spent about 1,000 dollars on personal protective equipment like masks and tests and HEPA filters in the past year. It's an incredible privilege and sacrifice to be able to do that. There are many, many New Yorkers who could not afford to even entertain that idea and deserve to have the same level of protection that these life-saving materials can provide people, especially as most people now are not testing, not masking, and none of us here on the Island, it's important not only for me to have these items to protect myself but also for people who I'm in contact with to be able to protect me. Going back to that time at the beginning of the pandemic when we all heard that message, I protect you, you protect me, that's who we are as New Yorkers, that's what we need to be about, and we need to give people the opportunity to do the right thing and for everyone to be able to access it, no matter their financial status. I also would like to second the support for year-round mask requirements in New York City H and H facilities at the bare minimum. As a person with a disability, it is too dangerous for me to go get care in hospitals. It's something that could easily be

done, and it's something that would ensure that people like myself and others who are testifying here have our ADA rights met, which are mandated by federal law, and the City should be doing more to enforce. Thank you.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: Thank you. Next will be Myra Batchelder.

SERGEANT-AT-ARMS: Time has started.

MYRA BATCHELDER: Hi, thank you. My name is Myra Batchelder and I lead COVID Advocacy Initiative (INAUDIBLE) COVID Advocacy in New York. We are still in the midst of the COVID pandemic. We are still losing around 1, 00 to2, 000 people in the U.S. every week to COVID. Millions of people are still struggling with long COVID and other serious health issues brought on by COVID. As New York City Council discusses the budget, there are a number of things New York City should do to improve COVID prevention. I'm here to highlight several. First, New York City must continue to provide funding for free, high-quality N95 and KN95 masks and COVID tests. Everyone should have access to the tools needed to protect themselves and their families and others from COVID.

Many New Yorkers can't afford to purchase high-quality masks and tests. In 2022, approximately 23 percent of New York City residents were unable to afford basic necessities like housing and food. Your ability to protect yourself and your family from getting COVID and to know whether you have COVID should not depend on your bank account. CDC's decision to end the five-day COVID isolation guidance puts even more people at risk. Free high-quality masks and tests should be provided at H and H facilities, to community groups, at public locations across the city, and also directly to the public, and these programs should continue. I also urge New York City Council to provide funding and pass bill, Int. 0332-2024 that will provide free masks, other PPE, and rapid tests to New Yorkers through the mail. Thank you, Chairperson Narcisse, for introducing this important bill. Masks and rapid tests should be distributed through the mail so that everyone can access them, including those at higher risk who are avoiding indoor public spaces. The federal government ended their free masks and rapid test programs, and people need to have access to these essential tools. In addition, New York City Council must do everything

it can to require masks and other COVID prevention efforts in healthcare settings that New York City Council has oversight of including New York City H and H. Ending the mask requirement in healthcare settings has led to more unsafe medical settings and more people postponing needed medical care, particularly people at higher risk. Polls indicate that healthcare settings are the top place the public supports requiring masks. No one should have to risk their life and health to access healthcare. It was great to see New York City reinstate their mask requirements at H and H during the worst of the winter surge, but that is not enough. I urge the New York City Council to do everything they can to ensure masks continue to be required at New York City H and H facilities and that other COVID prevention efforts are also taken. I urge New York City to provide funding and support for these and other COVID efforts. Thank you for your time.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: Greg Levine.

SERGEANT-AT-ARMS: Time started.

GREG LEVINE: Hello. I'm Greg Levine. I'm a freelance journalist and, in January of 2023, I

caught COVID. I was still limiting public activity at the time. I was still wearing masks in public settings, but so very few others were. When I finally tested negative and came out of isolation, my illness did not seem to end. I had shortness of breath, chest pain, tachycardia, elevated blood pressure, extreme fatigue, what we now understand to be long COVID. My life ever since has been defined by this disease. In a way, I'm lucky. I live in New York City. We have two good programs here that are looking at long COVID. It took me months, but I finally got in to see qualified caring professionals who had the experience to treat my illness, but here's the wild thing. Even though I was already sick and I was aware that another infection could make me sicker, even though I was in two of the country's best hospitals, every trip to the doctor, at every trip, I was surrounded by people who were not taking even the most basic precautions to protect themselves or to protect others. Patients, many of them coughing, sniffling, unmasked. That was me in crowded waiting rooms. While in the early months of 2023, maybe staff and doctors mostly wore masks, by summer, masking became the exception rather than the rule. Around the country,

tens of thousands are still hospitalized with COVID. Hundreds, sometimes thousands, are dying every week. This is still true to this day. But in these hospitals, the abandonment of mask requirements reminded me of a quote from the late Supreme Court Justice Ruth Bader Ginsburg. It was like throwing away your umbrella in a rainstorm, because you weren't getting wet. Here I was, suffering, yet every doctor I visited required me to make a bargain with myself. What's more risky, not getting the care I need or chancing a reinfection by going to places that were hell bent on being back to normal? In November, after having spent about 90 minutes in an imaging center, where I was masked, but absolutely no one else was, not patients, not staff, I contracted an upper respiratory infection. At first it was not COVID, or at least I tested negative, but after several weeks…

SERGEANT-AT-ARMS: Time expired.

GREG LEVINE: I wound up testing negative again. Is this where we want to be back to? The recent trend, as exhibited by the CDC, is to adopt the fatalism that sounds like Yogi Berra. We can't make rules because no one will follow them. That

doesn't make sense. It's like saying, don't wear seatbelts. Some don't wear seatbelts, so we shouldn't require them. Obviously, that's not how government should work. You have the power to require masks at public hospitals. You have the means to fund the program, give New Yorkers access to high-quality masks. You could even start to require cleaner indoor air. You could fund more access to better testing.

CHAIRPERSON NARCISSE: Can you try to wrap it up?

GREG LEVINE: I will wrap it up. Current policies assume that there are sick people and there are healthy people and it's only the sick people who need to take care, but that's not the way life works. At some point, we will all be vulnerable. At this moment, the SARS-CoV-2 virus is presenting the challenge, so let's meet it. Let's each and every one of you give us the help to help others, like with masks, like with rapid available testing. We are all each other's keepers, and this is a simple step that is in your hands to help us. Thank you so much for listening to me.

CHAIRPERSON NARCISSE: Thank you so much.

COMMITTEE COUNSEL: Thank you. Paul Hennessey.

SERGEANT-AT-ARMS: Time starts.

PAUL HENNESSY: Hi. I'm calling in strong support for NYC to provide the funding for free N95s and tests. Council must fund bill, Int. 0332. This is an incredible bill that will keep New Yorkers safe from COVID as well as other airborne illnesses, pollution, and wildfire smoke. I also urge the City to mandate respirators and clean air in all healthcare settings, pharmacies, schools, and public transit, and forced congregate setting, respirators, not baggy blues. New Yorkers deserve filtered air and safe access to healthcare. Consider funding hospitals more for ventilation upgrades. Anything less is medical negligence and puts vulnerable patients at risk. My grandma was infected by COVID at a cancer treatment center because the staff wasn't masked. Hospital-acquired COVID infections will result in more lawsuits as well and rightfully so. A great way to save money is respirator and clean air investments. I, for one, will certainly be suing if I catch a hospital-acquired infection. Finally, I would encourage the Council in New York's healthcare system

to condemn the recent CDC's decision of reducing COVID isolation policies to one day. This is a dangerous decision not based on any science or fact but convenience. It downplays the seriousness of a BSL-3 pathogen, ignores the contagious period of 10 days or more, and ignores the long-term effects of COVID. New York deserves better than this and should issue a statement condemning CDC's anti-science and anti-health policy. Thank you.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: Thank you. Ngozi Alston.

SERGEANT-AT-ARMS: Time starts.

NGOZI ALSTON: My name is Ngozi Alston. I'm a disability justice trainer and currently organizing with Mask Bloc NYC. I am disabled and, to my knowledge, I have never had COVID. That said, I'm constantly experiencing barriers, self-advocating basically every time I leave my house, I look, insert a list phrase here, bringing individually wrapped masks for other providers to my doctor's appointments and plugging my air purifier in. The City of New York has been doing an abysmal job at keeping New Yorkers safe. Instead of following the line of the fascist

cop, Mayor Eric Adams, you need to be making sure black, poor, disabled New Yorkers are safe. High-quality respirators and high-quality tests are expensive and the City has neglected us. Local community groups such as Mass Bloc NYC and People's PPE have been filling the very large gaps that the state has left us with. We are still in a pandemic and we are still fucking dying. Bad air, the air quality was well over 110 on February 10th, and I know this because I had planned to enjoy a local day at the park, but like the City cannot wait for a bad air day to hand out high-quality respirators. Be fucking proactive. With the CDC dropping its guidelines, we have been completely left to fend for ourselves. It is difficult to find remote work. Employers and society are hostile to us, to those of us who continue to mask. Masking needs to be normalized, and the City owes us access to resources. We're currently still in the surge of 780,000 COVID cases per day in the United States. As layers of mitigation continue to disappear, everyday basic tasks become burdensome with trying to avoid catching COVID. I'm often the only person masking in the grocery store, the pharmacy, medical facilities.

Leaving the burden on disabled people is trash, not to mention eugenics. Over 1,500 people continue to die from COVID every week and nobody fucking cares. It is exhausting being gaslighted by medical staff from receptionists to providers from asking whether I have COVID because I'm wearing an N95, which literally happened at a doctor's appointment this morning, to being outright hostile for asking providers to wear N95s to help mitigate the transmission of COVID. This is on top of the fact that incarcerated folks in New York City jails do not have access to high-quality masks. Free them all.

SERGEANT-AT-ARMS: Time expired.

NGOZI ALSTON: You all need to step the fuck up or bodies will start piling on your doorsteps, I promise.

CHAIRPERSON NARCISSE: Thank you.

COMMITTEE COUNSEL: Thank you. If anyone else in the chamber or on Zoom wishes to speak, please raise your hand.

Seeing no hands, we would like to note that written testimony, which will be reviewed in full by the Committee staff, may be submitted to the

record up to 72 hours after the close of this hearing by emailing it to testimony@council.nyc.gov.

Seeing no other hands for participants at this time, I will now turn it to the Chair to do her closing remarks. Thank you.

CHAIRPERSON NARCISSE: First, I want to say thank you to everyone that show up today, the Administration that came today, Dr. Katz. I appreciate every single of our team that actually put all the work together for us to be here. It takes a whole village of the staff here, Mahnoor, you have been excellent. I don't know what to say about Ms. Glantz has been excellent. My team, Saye Joseph, being on top of it, and Florentine Kabore that's leading the team so I am so much appreciative for everyone, Sergeant that’s present to the people that testify. It takes the whole of us for us to continue advocating for addressing the inequities in healthcare and the budget time is the best way to do it to make sure that we spend the money wisely and to protect New York City healthcare so thank you all. God bless and we're finished. [GAVEL]

C E R T I F I C A T E

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

Date March 13, 2024