CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

THE COMMITTEE ON HEALTH, JOINTLY WITH THE
COMMITTEES ON HOSPITALS AND LAND USE

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Monday, September 19, 2022
Start: 1:33 P. M.
Recess: 3:37 P. M.

HELD AT: Council Chambers - City Hall

B E F O R E: Hon. Lynn Schulman, Chair
Hon. Mercedes Narcisse, Chair
Hon. Rafael Salamanca Jr., Chair

COUNCIL MEMBERS:

Joann Ariola
Charles Barron
Oswald Feliz
Crystal Hudson
Marjorie Velázquez
Kalman Yeger
Selvena N. Brooks-Powers
Jennifer Gutiérrez
Rita C. Joseph
Francisco P. Moya
Carlina Rivera
Joseph C. Borelli
Erik D. Bottcher
Kamillah Hanks
Ari Kagan
Shekar Krishnan
Farah N. Louis

THE COMMITTEE ON HEALTH, JOINTLY WITH THE
COMMITTEES ON HOSPITALS AND LAND USE

COUNCIL MEMBERS: (CONTINUED)

Darlene Mealy
Kevin C. Riley
Pierina Ana Sanchez

THE COMMITTEE ON HEALTH, JOINTLY WITH THE
COMMITTEES ON HOSPITALS AND LAND USE

A P P E A R A N C E S

Dr. Andrew Wallach,
Ambulatory Care Chief Medical Officer for New York City Health + Hospitals

Rishi Sood,
Executive Director of Health Care Access & Policy at New York City Department of Health and Mental Hygiene

Dr. Manuel Saez,
Senior Vice President of Facilities and New York City Health + Hospitals

Dr. David Silvestri,
Assistant Vice President, Emergency Management at New York City Health + Hospitals

Jamal Westmoreland, Registered Nurse at Woodhull Hospital; New York State Nurses Association [NYSNA]
Speaking on behalf of
Dr. Judith Cutchin, MSN, RN, Vice Chair of NYSNA Board of Directors; President of NYCHHC Mayoral Executive Council

Dr. Anuj Rao,
The Committee of Interns and Residents, Service Employees International Union [SEIU]; Internal Medicine Resident at Bellevue Hospital and NYU

Dr. Colleen Achong,
The Committee of Interns and Residents, Service Employees International Union [SEIU]; Internal Medicine Resident at One Brooklyn Health

Judy Wessler,
Director at the Commission on the Public's Health System Board [CPHS]

THE COMMITTEE ON HEALTH, JOINTLY WITH THE
COMMITTEES ON HOSPITALS AND LAND USE

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

Medha Ghosh, MPH
Policy Coordinator at Coalition for Asian American Children and Families (CACF)

Amanda Dunker,
Health Policy Director at The Community Service Society of NY

Taras M. Czebiniak
Public Testimony

SERGEANT LUGO: Check, check, this is a sound check for The Committee on Health, Land Use, and Hospitals. Today's date is September 19, 2022, located in the chambers. Recording done by Pedro Lugo.

SERGEANT AT ARMS: Good afternoon, and welcome Committees on Health, jointly with Hospitals and Land Use. At this time, we please ask to place all phones or vibrate or silent. Thank you for your cooperation, Chairs, we are ready to begin.

CHAIRPERSON SCHULMAN: Thank you, I now call this hearing to order.

[GAVELING IN] [GAVEL SOUND]

Good afternoon, I am Council Member Lynn Schulman, Chair of The New York City Council Committee on Health. I want to thank all of you for joining us at today's joint hearing with The Committee on Hospitals, Chaired by Council Member Narcisse, and The Committee on Land Use, Chaired by Council Member Rafael Salamanca.

We are also joined today by Council Member Brooks - Powers, Council Member Louis, Council Member Hudson, Council Member Kagan, Council Member Rivera, Council Member Velázquez, and Council Member Mealy.

Today we are here to... Oh, and Council Member Bottcher, I'm sorry.

Today we are here to talk about a very important issue, the glaring inequities in access to healthcare within our city. COVID-19 has been the biggest public health crisis of our lifetime. The virus exposed the deepest vulnerabilities of our community. At the height of the pandemic, there were clear disparities in resources, capacity stress, and quality of care between health care providers and hospitals across the City. For that reason, the purpose of today's hearing is to look back the issues that arose as the City battled COVID-19, so that we are better equipped to handle future emergencies and prevent the needless loss of life.

As we all know, the situation in the City's hospitals was dire in late March and early April of 2020. The City experienced an increase of around 1,600 new hospitalizations per day, while hospitals struggled with limited numbers of ventilators, access to personal protective equipment, and staffing shortages. To increase the number of beds, all general hospitals, surgery centers, surgery practices, and diagnostic and treatment centers were

required through Executive Order to cancel elective surgeries and procedures. As a result, access to non-COVID related healthcare was greatly impacted. Nearly half of adults reported delaying or avoiding medical care, including urgent or emergency care and routine care. According to the American Cancer Society's Cancer Action Network, nearly one in four cancer patients reported delays in their care due to the pandemic, including access to in-person appointments, imaging, surgery, and other services. This is something I know firsthand. When I was diagnosed with breast cancer during my 2021 campaign, I became an advocate for other breast cancer patients who couldn't get their tumors removed as a result of these restrictions.

The pandemic also further exposed the stark disparities in access to health care for communities who were most and risk. In the summer of 2020, of the 10 zip codes with the highest death rates in the City, eight had predominantly Black and Hispanic populations. Data showed that residents of The Bronx, Queens, and Brooklyn had higher rates of hospitalizations and death than both Manhattan and Staten Island.

It comes as no surprise then that the difference in hospital capacity between the boroughs is drastic. While Manhattan has approximately five hospital beds for every 1,000 residents, The Bronx, Brooklyn, and Queens each have less than half that number available. And I just want to make mention that Queens is the lowest of those.

I believe that healthcare is a human right. All New Yorkers should have access to affordable and equitable healthcare.

The issue of hospital capacity and disparate recourses predates the emergence of COVID-19. Over the past two decades, Queens and other boroughs have lost an alarming amount of hospitals and other resources. From 2003 to 2014, the number of hospitals in New York City dropped by more than 20%. The pandemic has only underscored the need for improved local access to quality care within our communities. New Yorkers can’t afford to not have emergency care locally available when we need it most.

I have dedicated my personal and professional life to healthcare advocacy. As someone who has had firsthand experience working in the healthcare field,

I believe these issues must be addressed to ensure that New Yorkers' lives are not put in jeopardy because of a failing system. Not only are we in desperate need of additional hospital capacity, but we need a system that can provide affordable, preventive, and primary care and have the ability to respond to public health emergencies. We cannot be left with another fatal shortage of hospital capacity in the midst of a crisis. No matter what zip code you live in, you should be able to have access to quality affordable healthcare. This is literally a matter of life and death.

I want to conclude by thanking the committee staff for their work on this hearing: Committee Counsels Harbani Ahuja and Sarah Sucher, and Policy Analyst Mahnoor Butt, as well as my amazing team, including Seth [INAUDIBLE], my Deputy Chief of Staff, legislative staffer, Kevin McAleer (sp?), and my Communications Director Javier Figueroa.

I will now turn to my colleague, and Chair of The Hospitals Committee, Council Member Mercedes Narcisse.

CHAIRPERSON NARCISSE: Thank you, Chair Schulman. Good afternoon, everyone. I am Council Member

Mercedes Narcisse from the beautiful 46th district, Chair of The Committee on Hospitals. Thank you for joining for this very important hearing.

The COVID-19 pandemic has shown us the vulnerabilities and the inconsistencies in our public healthcare system. In New York City alone, about 42,000 people have lost their lives to this virus. Data shows that the top 10 New York City zip codes, with the greatest death toll, predominantly housed Black and Hispanic communities reflecting the systemic healthcare disparities still plaguing our city.

The Health + Hospitals network, the backbone of The New York City public health system, serves the most vulnerable members of our society, including low income families, homeless individuals, and undocumented individuals, free of course.

H+H provides over 58% of the uninsured healthcare, addressing the needs of the City's most marginalized members while being severely underfunded by the state.

During the early days of COVID-19, the hospitalization rates surged up to 12,000 per day creating a great bed shortage, along with a lack of

necessary healthcare professionals, PPE, and ventilators -- all things crucial to serving our patients in the middle of a public health emergency. However, these conditions were not just the result of an unprecedented pandemic. It was the outcome of years of neglect of our public healthcare system. I understand some issues are beyond our control -- like this morning, I apologize -- but for those we can control, let us do our very best.

H+H is funded by the shrinking state and city grants, and tax subsidies, and Medicare reimbursement, known for their low rates and slow repayments.

As a former nurse at Elmhurst Hospital Emergency and Trauma Center, one of the 11 H+H hospitals, I have personally experienced the shortfalls of funding and the lack of resources that effect a hospitals ability to serve its patients.

Hospitals are chronically under staffed and over crowded, working beyond their capacity. During COVID-19, the hospitals' patient to workers ratio, which should ideally remain at a four to one ratio, in some hospitals jumped as high as 23 to one. Thankfully, COVID-19 hospitalizations are now down. But, we must

learn from our mistakes. We must make investments in primary and preventive care in our communities, invest in FQHCs and community clinics, and address the root causes of chronic health conditions and health disparities, which were made disturbingly clear during the pandemic. We must make an investment in Black and Brown communities to improve healthcare outcomes, and we must support our public and safety net hospitals so that they will have the resources they need to do their jobs.

I look forward to hearing from the administration today about how we can work towards a more equitable healthcare system for all New Yorkers.

I want to conclude by thanking the committee staff for their work on this issue. Before I do that, I want remind you all today [INAUDIBLE] 46th district has no community health centers, no hospitals. And the hospitals that serves us are way underfunded.

So, I want to conclude by thanking all of you and the committee staff for their work on this issue, Committee Counsel Harbani Ahuja, and Policy Analyst, Mahnoor Butt, as well as my wonderful Chief of Staff,

Saye Joseph, and my Deputy Chief of Staff, Frank Shea, thank you.

I will turn it over Chair Salamanca to give his opening statement, thank you.

CHAIRPERSON SALAMANCA: Thank you, Madam Chair.

Good afternoon, I am Council Member Rafael Salamanca, I am the Chair of The Committee on Land Use.

As my colleagues have described, the peak of COVID-19 pandemic stressed the capacity and capabilities of New York City's hospitals and healthcare system as never before. This unprecedented stress on the system called attention to issues of healthcare capacity, access, and equity that are no longer overdue for a more comprehensive approach. New data accumulates daily showing ongoing several racial and socioeconomic disparities in COVID-19 mortality rates, and a grave disparity in care received at different hospitals across the City. Communities like my district in The South Bronx, have suffered far greater health impacts from the pandemic than the wealthier parts of the City. These impacts result not only from the quality and availability of local hospitals, but also from lack of access to

primary care, and from long-term inequalities and access to a healthy environment and economic opportunities.

This is why I am here today in my capacity as Land Use Chair. New York needs to move forward in a more holistic, coordinated approach to ensure that the development of an equitable 21st Century delivery system. Our city and state agencies must work together to expand access to quality primary care, ensure baseline standards of access to quality hospitals, and use all available tools to understand and address the social, environmental, and economic factors that are at the root of persistent health inequalities.

Planning for our public health must work in tandem with planning for housing, open space, economic development, and our social infrastructure.

I look forward to continuing to work with the Health and Hospitals Committees on these issues, and I thank the staff of all three committees for their ongoing work, thank you.

CHAIRPERSON SCHULMAN: Thank you, Chair Salamanca. Before we move forward, I want acknowledge that we

have been joined by Council Member Yeger and Council Member Joseph.

I want to welcome the administration today, we are joined by Rishi Sood, Executive Director of Health Care Access & Policy at New York City Department of Health and Mental Hygiene; Dr. Andrew Wallach, Ambulatory Care Chief Medical Officer for New York City Health + Hospitals; Dr. David Silvestri, Assistant Vice President, for Emergency Management at New York City Health + Hospitals, and Dr. Manuel Saez, Senior Vice President of Facilities and New York City Health + Hospitals.

Please proceed with your testimony.

COMMITTEE COUNSEL: First I have to [INAUDIBLE] the oath.

CHAIRPERSON SCHULMAN: Oh, you... Okay, sorry.

COMMITTEE COUNSEL: No, no...

CHAIRPERSON SCHULMAN: Sorry, the counsel will give the oath.

COMMITTEE COUNSEL: Will you please raise your right hands? Do you affirm to tell the truth, the whole truth, and nothing but the truth, before this committee, and to respond honestly to council member questions?

[ADMINISTRATION AFFIRMS]

COMMITTEE COUNSEL: You may begin.

DOCTOR WALLACH: Okay, good afternoon, Chairpersons Schulman, Narcisse, Salamanca, and members of The Committees on Health, Hospitals, and Land Use. I am Dr. Andrew Wallach, the Ambulatory Care Chief Medical Officer at New York City Health + Hospitals. Importantly, I am also a practicing primary care physician at Health + Hospitals Bellevue.

I am joined today by my colleagues from H+H, Dr. Dave Silvestri, Assistant Vice President of Emergency Management, and a practicing emergency medicine physician at Health + Hospitals, Lincoln; and Dr. Manny Saez, our Senior Assistant Vice President of Facilities.

Thank you for the opportunity to testify regarding the work Health + Hospitals does to promote access to healthcare for *all* New Yorkers, and ensure its preparedness for emergencies.

While Health + Hospitals is only one component of a much larger healthcare delivery system in our great city, we are very proud of what we do.

Health + Hospitals is indeed the largest municipal healthcare system in The United States. Our mission is to deliver high quality healthcare services with compassion, dignity, and respect for all regardless if insurance status or the ability to pay. We provide essential inpatient, outpatient, and homebased services to more than 1 million New Yorkers every year, in more than 70 locations across all five boroughs in New York City. More than 60% of our patients identify as either Black/African-American, Hispanic/Latinx, or Asian-American/Pacific Islander. More than 70% of our patients are insured by Medicaid or have no insurance -- including nearly 400,000 uninsured New Yorkers who otherwise would not have access to care.

Health + Hospitals offers high quality and affordable healthcare services at our 11 acute sites, five post-acute skilled nursing facilities, and through our federally qualified health centers or FQHCs known as Gotham Health.

Gotham Health has over 50 community health centers throughout all five boroughs allowing us to address the primary care needs of families of individuals in their own neighborhoods.

At both our hospital-based primary care practices and the Gotham health centers, we provide routine checkups, preventative health screenings, and immunizations for both children and adults. We perform chronic disease management including for asthma, heart care, and diabetes. We offer adolescent health services, behavioral health services, diagnostic imagining services, women's health and maternity care services, well-baby care and pediatric services, senior care and geriatric specialties. We also are helping implement lifestyle changes and other wellness goals of our patients.

Health + Hospitals offers free language service, 24 hours a day, seven days a week, 365 days of the year in over 200 languages and dialects. We translated key patient documents such as consent forms and patient education materials in to the top languages spoken by limited English proficient New Yorkers who represent an estimated 30% of our patients.

In addition to our extensive physical footprint across New York City, I am also incredibly proud of our new telehealth and mobile services, which expand

access to care and allow Health + Hospital patients to receive their care where and how they need it.

For telehealth, we have several options such as telephone appointments, video visits, and an online patient portal for patients to connect with our healthcare providers without coming in to the doctor's office or hospital. All are accessible via our MyChart system, part of our electronic medical record.

For non-emergency urgent care services, we offer Virtual Express Care. Virtual Express Care launched in 2020 to ensure convenient, one click access for patients seeking urgent care services to the most appropriate level of care, where they were safest during the first wave of COVID-19, in their home.

Virtual Express Care is available 24/7, and allows patients to receive virtual care from a Health + Hospitals provider for common physical, mental, emotional and behavioral health issues. We provide this service in over 200 languages including American Sign Language with in-screen interpretation services.

Virtual Express Care has become a nationally recognized leader for its COVID-19 treatment model that helps patients access treatment via telehealth

and offering home delivery for antiviral medications and same or next day treatment with monoclonal antibodies.

Additionally, this summer we received funding to launch and integrate and new telehealth behavioral service in to Virtual Express Care and to create a tailored version of the new tele Behavioral Healthcare service for New Yorkers experiencing homelessness.

We are also brining care directly to New Yorkers. For New Yorkers experiencing homelessness, the Street Health Outreach and Wellness or SHOW mobile units engage individuals where they are, and provide vital health and social services. These SHOW units have provided COVID-19 testing and vaccines, behavioral healthcare, and a host of other harm reduction and social services to well over a 100,000 New Yorkers.

In addition, our Mobile Test to Treat program offers COVID-19 testing and Paxlovid distribution to thousands of New Yorkers via 30 mobile vans.

To ensure deployments are reaching New Yorkers most in need, 75% of our Mobile Test to Treat locations have been established in neighborhoods, the City's Taskforce on Racial Inclusion & Equity, TRIE,

determined who are hardest hit by the COVID-19 pandemic.

Hospitals play an essential role in planning for and responding to the needs of New Yorkers during any citywide emergency. Health + Hospitals has a history of preparing for, responding to, and recovering from a myriad of emergency events including pandemics.

While Health + Hospitals has been activated in response to the COVID-19 pandemic, we have had to currently respond to multiple other emergencies including coastal storms, winter storms, mass transit shutdown, extreme heat, and most recently, the monkeypox virus outbreak.

Health + Hospitals has maintained and even expanded operations throughout each emergency event, and provided continuity of care to our patients and the communities we serve.

Health + Hospitals uses and infinite command system, ICS, to manage all disasters, emergencies, and other incidents. The ICS is a national best practice for coordinating emergency response and allows for communication, coordination, and collaboration with other agencies.

A central office incident management team, imbedded within the system's ICS is responsible for coordinating emergency response across the health system.

Once Health + Hospitals activates the ICS, internal and external notifications are made while information is gathered for situational awareness. Staff are assigned to their incident command roles, briefings are held -- providing the latest intelligence, and incident action plan is developed for the first operational period. This process repeats for each operational period throughout the activation.

Similarly, for preparation and planning of an emergency, Health + Hospitals also utilizes the ICS. Trainings and exercises take place regularly where each facility tests components of the Emergency Operations Plan to ensure operations and communication chains run smoothly.

In addition to its robust procedures to address and emergency as it unfolds, Health + Hospitals takes great efforts to ensure its preparedness well before the disaster strikes. To ensure the safety of its patients and staff, Health + Hospitals has extensive

plans in place in the event of weather, public health, or other catastrophic emergencies. Our Emergency Operations and Response Plans are developed to address all hazards -- with specific incident response annexes and guides for high probability and high impact events, which include: coastal storms, extreme temperatures, and winter and summer weather events.

Each of our sites is required to conduct training and exercises to test and evaluate their plans. Planned exercises and actual response activations are reviewed to identify gaps and areas for improvement.

Importantly, we do not work alone. Health + Hospitals works closely with The Mayor's Office and the New York City Emergency Management in all phases of emergency management including planning, mitigation, response, recovery, training, and exercises.

Each year Health + Hospitals participates in exercises with other agencies and are led by NYSUM (sp?). While the intent of these exercises is to test plans and identity gaps, real-life activations also serve this purpose and allow for real-time identification of gaps, and resolution of the issues.

In addition, Health + Hospitals partners with other hospital systems in New York City through the Greater New York Hospital Association to prepare for emergency events. We are always striving to better serve our patients and make our system even stronger and better prepared for the next emergency.

Health + Hospitals is committed to enhancing the resiliently of its facilities in order to mitigate future disasters, plan for future emergencies, and shore up our aging infrastructure.

We are learning and building resiliency from COVID-19, shoring up facilities, increasing patient capacity, safeguarding long term COVID-19 services, and supporting our staff.

We have also learned and rebuilt after major hurricanes. Sites that incurred flood damage after Hurricane Sandy, made major improvement measures including moving critical infrastructure to higher floors, flood protection for our facilities, flood resistant infrastructure, investing in generators, electrical panels, HVAC systems, and other capital projects.

In May, Health + Hospitals and the New York City Economic Development Corporation broke ground on the

new flood protection system and New York City Health + Hospitals Metropolitan in East Harlem.

In October, Health + Hospitals will open the Ruth Bader Ginsburg Hospital and New York City Health + Hospitals South Brooklyn Health Campus. This will feature a new concrete floodwall and flood resilient infrastructure for power, heating, cooling, and water systems.

Over the next 10 years, Health + Hospitals has significant infrastructure needs; however, including IT, equipment, and capital improvements. This includes work specific to the COVID-19 response, green energy upgrades across the system, and work to improve the patient experience such as individual patient rooms, improved behavioral health settings, and renovating operating rooms and emergency departments.

Infrastructure improvements are especially important to Health + Hospitals as a safety net provider. Our infrastructure is 17 years old on average, compared to an average of nine years for other New York City hospitals.

We have made significant investments to modernize our facilities and we are grateful to The Council,

the Mayor, and borough presidents, as well as our federal delegation for their crucial funding support. Hospital and healthcare infrastructure should be considered equally critical as roads and bridges, and we continue to engage on this topic and the city, state, and federal levels.

In closing, it is the mission of Health + Hospitals to deliver high quality healthcare services with compassion, dignity, and respect to all without exception. Every day, we work towards that mission, and strive to continuously improve our services and stay ready for the next challenge.

Thank you to The Committees for the opportunity to testify and for your continued support of Health + Hospitals. I look forward to our continued partnership and answering any of questions, thank you.

CHAIRPERSON SCHULMAN: Thank you. I just want to advise that everybody has about five minutes for testimony. If you could summarize, uh, because we have it in... we have the testimony in writing, which we are going to take back with is, uh, that would be great, thank you.

EXECUTIVE DIRECTOR SOOD: Good afternoon, Chairs Schulman, Narcisse, and Salamanca, and members of the committees. I am Rishi Sood, Executive Director of Health Care Access & Policy at The New York City Department of Health and Mental Hygiene. Thank you for the opportunity to testify today.

The Health Department believes access to quality health care should be available to all New Yorkers in the past two and a half years, we have seen and experienced how important and essential access to healthcare is, yet social, economic, and geographic factors can often be barriers to receiving health services -- especially for marginalized populations. Lack of access to healthcare is both a public policy issue and a moral one. We work together with other City agencies, such as Health + Hospitals, community-based organizations, and community healthcare providers to identify and respond to the barriers that prevent access to healthcare to ensure that all New Yorkers can receive the care that they need.

Over the past two and a half years, the City has worked tirelessly to ensure that equitable access to care was provided for all New Yorkers during the COVID-19 pandemic – from standing up a massive

vaccine infrastructure to supporting the existing healthcare system, and ensuring distribution of available treatments. The City pursued a broad effort to address health disparities and serve communities hardest hit by COVID-19 -- focusing on 33 Task Force on Racial Inclusion and Equity or TRIE neighborhoods. We broke down languages access barriers by bringing translators and translated materials to vaccine sites and partnering with community-based organizations to deliver critical health information to their communities in the languages that they speak. We met people where they were by deploying mobile vaccines through tents, vans, and buses to locations across the City, where people live, work, dine, commute, learn, play, and even brought them in to their homes.

More recently, the City increased capacity to ensure that New Yorkers have access to the medication needed to treat COVID-19 as soon as they test positive -- through telehealth services, same-day delivery, and treatment vans.

The collaboration between public and private partners that exists in our COVID-19 response extends to The Health Department’s work every day to address

the social and environmental factors that impact health.

Specific to our work to address healthcare access, we engage with community healthcare providers to bolster their capacity to serve their neighborhoods. Our support for these providers helps to identify and address residents' healthcare needs and reduce their health risk factors for both infections and chronic diseases to provide support for telemedicine, and to ensure providers receive adequate PPE to reduce their own risks during public health emergencies.

Our engagement with the community involves collaborating with community partners, identifying issues that lead to poor health outcomes, creating response strategies, increasing awareness of health information on infectious and chronic diseases, and ensure that residents receive resources and services that they need.

We work with trusted partners in the community -- and this is an essential part of The Health Department's work -- dispelling misinformation and promoting positive health behaviors.

In addition, The Health Department works closely with other agencies including the Mayor's Office of Immigration Affairs, Health + Hospitals, and The Department of Homeless Services to provide services to immigrant populations. We work collaboratively to provide psychological first aid, emotional support services, health insurance enrollment, and to connect individuals and families to primary care appointments.

We work closely with The Community Healthcare Association of New York State, individual community health centers, and networks, and primary providers and stakeholders across the City to ensure access to primary care services and continuity of care for all New Yorkers -- particularly those who are low income, and are uninsured.

We continue to identify ways to improve coordination of the healthcare safety net during complex public health crisis, such as monkeypox and COVID-19, as well as an ongoing basis.

New York City's healthcare safety net is always in need of more resources, but it is strong, healthy, responsive, and available to all New Yorkers, regardless of insurance or immigration status.

We recognize that health insurance provides a vital pathway to care and financial protection -- particularly for more specialized care. As such, we work through our own office of Health Insurance Services to enroll New Yorkers into coverages through the state marketplace, and we provide enrollment assistance with both paper and web-based portal applications and renewals.

Our staff are designated Certified Application Counselors [or CACs], trained to provide education, outreach, and enrollment services from our health centers across the city. CACs help all New Yorkers, with a focus on people with lower income, Black, Latino, and immigrant communities; and those who are medically vulnerable. In collaboration with other City agencies, we assist the older adult 65+ population, and certified blind, and certified disabled populations in New York City through education, outreach, and enrollment assistance for public health insurance.

Additionally, we assist with applying for the supplemental nutrition assistance [or SNAP] Program, and refer individuals to other social service organizations as needed.

It is important to note that regulation of healthcare facilities, including hospitals, is conducted by the state, specifically, The New York State Department of Health. Among other responsibilities, the State's Public Health and Health Planning Council receives and makes decisions on Certificate of Need Applications submitted by hospitals, homecare agencies, and hospice facilities when they are looking to establish facilities, transfer ownership, or make substantial changes.

In the face of this landscape, The Health Department utilizes a multi-faceted approach to support New Yorkers in accessing quality healthcare, and we will continue to provide equity and access to ensure that New Yorkers are getting the services and support they need.

Thank you again to the Chairs for holding this hearing today. I'm happy to answer any questions.

CHAIRPERSON SCHULMAN: Is there more testimony?

Okay, alright, so... So, uh, what we are going to do is, uh, so, some ground rules, and one is I am going to actually... I was... I would be the first to ask questions, but my colleague, uh, Brooks-Powers has a childcare issue, so she is going to ask some

questions. Then I will do it, and then Chair Narcisse, Chair Salamanca. Also, we are going to... Because, there so many members here today, we are going to limit members to three minutes of questions. And if we can get it go... A second go-round we will. So, uh, Council Member Brooks-Powers?

COUNCIL MEMBER BROOKS - POWERS: Thank you so much, Chair, uh, and good afternoon, everyone.

I would like to express my appreciation for the Chairs for convening today's hearing. Council Member Schulman, Council Member Narcisse, and Council Member Salamanca, and our committee staff for facilitating.

Like many communities across the City, my district, and Rockaway in particular, suffered from disproportionally poor access to quality care. Following the closure of Peninsula Hospital in Edgemere over a decade ago, Rockaway residents faced dangerously low travel times to the nearest facility, which right now is all the way in downtown Jamaica. It's about time we bring quality healthcare back to the Peninsula, which is why I have been working hard with dozens of community partners to establish a Health Access Taskforce to identify the best opportunities to close these gaps and keep Rockaway

residents safe. I look forward to engaging with Health + Hospitals and other healthcare providers across the City to identify opportunities to increase access. In light of these pressing issues that are facing communities across all five boroughs, I would like to ask a few questions.

First I would like to know how the agencies present... press... Excuse me, present today, coordinate in identifying the best locations for new healthcare facilities? For instance, is there a set of metrics DCP can provide our health agencies in terms of targeting communities most in need?

DOCTOR WALLACH: Great, thank you, Council Member, uh, for that, uh, question. I just will remind The Council, that indeed, uh, NYC Health + Hospitals does have a very extensive footprint -- right? -- in clinical spaces with over 70 locations throughout our five boroughs. In addition, we are very proud, as I mentioned, of the ability for patients to receive care through our telehealth services, uh, for both primary care and for our virtual express care services.

That said, to your point, we continue to access the community need. And, I think that is made

evident by the addition of our three recent, uh, Centers of Excellence, uh, all in neighborhoods that were underserved, uh, as part of the COVID-19 response, as well as our commitment, uh, in conjunction with our partners at EDC to build a new clinic in the Rockaways. We understand the importance of having these healthcare services in our communities. And, again, I want to emphasize that at H+H, our goal is to provide this care to all New Yorkers.

COUNCIL MEMBER BROOKS - POWERS: I'm sorry, so what are the... like, is there is set of metrics that you all look at to be able to provide these health agencies? And if so, what are they?

DOCTOR WALLACH: Yeah, so as a public safety net hospital, we, again, committed to using our resources, uh, for our patients here in the City. There is a process, uh, where we at NYC Health + Hospitals, as well as other hospitals in our City [TIMER CHIMES] as well as across the state, need to establish new services. They go through a process called, uh, this New York State Certificate of Need, uh, in order to meet that eligibility. And, I am going to ask my colleague, Dr. Manny Saez, to see if

you want to add anything to that of what the process is?

DOCTOR SAEZ: Thank you, uh, Dr. Wallach. Yeah, when Health + Hospitals, and other healthcare facilities across the state, seek to establish new services or construct or renovate new or existing facilities, we acquire a Certificate of Need that we work very closely with The New York State Department of Health. So of those considerations include the community needs, uh, finical feasibility, architectural and engineering standards, uh, current compliance, and assessment of the applicant's organizational structure.

It is a very lengthy process, but that is the process we follow along with New York State.

COUNCIL MEMBER BROOKS - POWERS: And what is the best way to be able to start a process if a community would like to have, like, a new health facility, in particular a hospital, a trauma hospital in their community? What is... Like how would, uh, you best uhm, I guess, suggest to initiate that process?

DOCTOR WALLACH: Do you want to comment on that?

DOCTOR SAEZ: Well, it is... Doing the continuing assessment of these community needs, making sure that

we can provide services to the community, that we have financial stability in the community. And, more importantly, that the distribution of services is equal and equitable for all of our New Yorkers. So, there are specific metrics that are considered. But, for the purposes here, the taking through the CON processes, the primary avenue for advocating for a new facility.

DOCTOR WALLACH: Yeah... (CROSS-TALK)

COUNCIL MEMBER BROOKS - POWERS: And this is my last question... (CROSS-TALK)

DOCTOR WALLACH: Yeah, and I... (CROSS-TALK)

COUNCIL MEMBER BROOKS - POWERS: If it's okay, just one last... Just one last question.

I just want to say, uhm, ,you know, looking at the information we were provided, Queens has the most hospitals that have been closed across the City, with only 1 point, I think, 8 beds per 1,000 residents -- which is a significant disparity. Which communities have the agencies started to prioritize as most in need of better access? And, I understand you have to, uhm, the Gotham Centers that are coming, but I am talking about actual hospitals that can handle trauma related care?

That you, Chairs.

DOCTOR WALLACH: Yeah, thank you, Council Member Brooks - Powers. Again, I can't speak to the closures of the private hospitals. But, again, we are committed to providing care, including emergency care, as you said, and trauma care, to New Yorkers. Within the borough of Queens, we do have two acute sites, Elmhurst and Queens Hospital, as well as eight Gotham sites that are part of NYC Health + Hospitals. Again, with regard to creating a new acute hospital, I would ask... defer to my colleague from The Health Department, uh, to begin what that would look like as far as the process.

CHAIRPERSON SCHULMAN: Alright, thank you. And, I am sure we are going to revisit this some more. And I also, we are going to go a little bit out of order, my colleague, Chair Salamanca, uh, needs to leave. So, he is going to ask questions before, uh, me and my colleague, Council Member Narcisse.

CHAIRPERSON SALAMANCA: Thank you, uh, Chair. Uh, I promise I will stay within my time.

So, uh, thank you, uh, Commissioners for attending today's hearing.

My question is, in the City Council in Land Use, we do many, uh, rezonings. In my district alone, the time that I have been in the Council I have approved close to 7,000 units of a 100% affordable housing. But, yet, I am not getting new services, I'm not getting more ambulances, I am not getting an increase in the fire department, the police department, my, uh, my food pantries.

What communication does HHC have with City Planning when we are building new housing throughout the City of New York to ensure that we are meeting the needs of the communities?

DOCTOR WALLACH: Yeah, and thank you for that question, Chair. I would say one of our biggest strengths, quite honestly, are our community advisory boards, uh, that we have affiliated within all five boroughs, uh, associated with our facilities. These are very much a robust group of individuals who advocate on behalf of their communities. And that information is fed directly back to us. In addition, we formally do annual community advisory assessments in each of the communities where we work. And we respond based on that information that we gain from

the assessments. And that helps with our strategic planning.

CHAIRPERSON SALAMANCA: Okay, so, you have an assessment? What action is done?

DOCTOR WALLACH: So... (CROSS-TALK)

CHAIRPERSON SALAMANCA: You're not building new hospitals. Are you building new clinics? What exactly are you doing with this assessment?

DOCTOR WALLACH: Yeah, so great... Great point. So, most of our assessments are about the clinical needs of individuals in those communities. So, for example, in The Bronx where there are what we call, uhm, food deserts? Right? We hear implementing a lifestyle medicine program, which helps with the delivery of fresh fruits and vegetables to individuals. We continue to advocate with The Health Department in order to get addition businesses and groceries to open. But, with regard to your question about building new hospital, again, I would say I cannot comment on the ability of closures of privates or beginning a process. I would defer to the state health department and to the city health department here.

CHAIRPERSON SALAMANCA: I will move on to my next question. Uhm, access to quality healthcare is one issue. But access to quality is a multifaceted issue. Since 2019, I have allocated over $7 million, myself alone, to Lincoln Hospital for a new X-RAY suite, a nurse call bell, a tumor detection system, and an ultrasound and neonatal equipment -- among other things. But the despite that, Lincoln Hospital still needs millions and millions of dollars in capital needs. What is HHC doing -- Health + Hospitals -- doing to ensure that our public hospitals that are already stretching the dollars thin, have resources needed to provide quality healthcare in a post-pandemic world?

DOCTOR WALLACH: Yeah, first and foremost, Chair Salamanca, I want to thank you for your personal commitment to H+H. Those dollars that you have committed, uh, to Lincoln have been very much appreciated, and we thank you for your ongoing advocacy for that facility.

As I mentioned, as part of the public health system here in New York City, our infrastructure is old, uh, certainly compared to the private facilities here in the City. And so, I will, uhm, ask my

colleague, Dr. Manny Saez, if you want to make additional comments specific to the Chair's question about how we are able to kind of move forward and what we're going to do?

DOCTOR SAEZ: Uh, thank you, Dr. Wallach, and thank you, Councilman. And, again, I echo the support that we have received at Lincoln Hospital, uh, very much needed in that south area of The Bronx. We have been working towards providing, uh, capital submission improvements to structure and re-structure. -- a lot of our ambulatory care suites -- and working amongst other services inside of the hospitals to help make those improvements.

CHAIRPERSON SALAMANCA: Okay. Alright, alright, I promise I'd stay within my time, thank you, Madam, Chair for allowing me to speak, yes.

CHAIRPERSON SCHULMAN: Alright, thank you very much. I just, uh, before I begin, I want to acknowledge we have been joined by Council Member Feliz, Council Member Borelli, Council Member Moya, Council Member Ariola, and Council Member Krishnan.

Alright, so, couple of things, one... One is over the past 20 years, 10 hospitals have been closed in Queens, which was why the, uh, the pandemic,

Queens of the epicenter of the epicenter, particularly Elmhurst Hospital, which I know you familiar with.

So, my first question is, uh, do you think there are enough hospitals in Queens given the pandemic we have just been through, and that we are seeing new viruses every day, and other things like monkeypox and other diseases?

DOCTOR WALLACH: Yeah, thank you very much, uh, Chair Schulman.

So, indeed, I can comment again, that New York City 3-1-1 system Health + Hospitals is a part of the healthcare system here in New York City. We do have two acute care facilities, they are perhaps two of our most robust systems. As you know, Elmhurst in particular, is an incredible facility. But, I cannot comment on the total number of acute care facilities in that borough. But, I will ask my colleague from The Department of Health if he would like to make any comments?

EXECUTIVE DIRECTOR SOOD: Thank you, Dr. Wallach, and thank you for the question, Chair.

As I mentioned in my testimony, the issue related to hospitals including regulation, is an issue for

the state health department. However, we are constantly not just working with our colleagues at Health + Hospitals, but also with the Greater New York Hospital Association, and with private hospitals across the City during emergencies and non-emergencies -- both to respond, but also to plan -- related to the health infrastructure.

CHAIRPERSON SCHULMAN: I appreciate that, it's not sort of really answering my question, but I understand that it's a little bit tricky. So, I am going to move on.

So, the next thing I want to ask is, considering that asylum seekers are stretching the City shelter system, how is that affecting hospital capacity?

DOCTOR WALLACH: Great, so I will... I will begin, uh, Chair, then again I will pass it over to my colleague from The Health Department.

So, indeed, uh, New York City has been the recipient of many asylum seekers coming from our southern states. Often times, as you know, without advanced warning, uh, these buses just arrive.

CHAIRPERSON SCHULMAN: Mm-hmm.

DOCTOR WALLACH: I have been very pleased with the City's response, with the multiple agencies coming

together to provide care, uh, housing for these individuals.

At H+H per se, to your question, we have not seen a significant number of hospitalizations, uh, from these individuals who are arriving to our City. However, there is the need for basic care. There are individuals who diabetes; the children who are coming here often times don't have their school immunizations. And so we are providing access of part of our public hospital system to have a fast track for those individuals to be able to get in to either for chronic disease management or for preventative health. Overall; however, the hospitalizations have not been significant in our system. Again, I don't know if there's anything you'd like to add from The Health Department's perspective?

EXECUTIVE DIRECTOR SOOD: No, just, thank you, Chair for asking that really important question on this topic that we are working with our partners on every day. My colleague mentioned, related to hospitalizations, I do want to just, uh, not that The Health Department is playing a key role in the City's response related to health care -- providing

psychological first aid and emotional support, health insurance enrollment, and importantly, with our Health + Hospital partners, and FQHCs across the city, direct connections to primary care providers, which as Dr. Wallach noted, is really, really important right now for everything from school immunizations to getting started on routine primary care.

CHAIRPERSON SCHULMAN: Thank you. I just want to make not, as I mentioned in my opening remarks that, you know, we are not, I mean, the COVID is still around, we have the flu season coming up, it's supposed be a very bad flu season, what you mentioned is that there are primary care issues, and with the asylum seekers to some degree that has not resulted in hospitalizations, it doesn't mean it won't in the future. And that, you know, one of the goals that I have is to make sure that the City is prepared for that.

So, the next question I want to ask, is the structural issues that place financial strain on safety net hospitals remain, and are already beginning to reemerge after the infusion of pandemic related federal aid, is there any kind of baseline

standard for access to hospitals that the City will seek to maintain moving forward?

DOCTOR WALLACH: Yeah, thank you for those... Thank you for those comments first, uh, Chair, and for your question. I could not agree, uh, any further. Indeed, I think as we prepare for the upcoming fall and winter season, which, again, we have been doing a lot of preparation for all of the items that you just mentioned, because we too are very concerned about a potential, uh, for a rough flu season on top off waning COVID here in the City.

There are things that are important to us. So, the first, the standard of care is to provide access to our primary care services within 14 days. And that is what our target is. And I am happy to report to The Council that is something that we have worked on considerably at H+H, and we can say that our current third next available, which is our metric used for access is 12 days for primary care services.

I think a big part of this, to your point though, is to be able to expand how we provide those primary care services. It is no longer just brick and mortar. It is now telehealth services, it is virtual expressed care, and most importantly, it’s about

building out care teams. As I mentioned in the beginning of my testimony, I am a primary care provider. And it used to be, when I started in the system 25 years ago, that everything fell on my shoulders to take care of my patients. And instead, more recently, we have built out care teams that include myself, a nurse, a med tech, an advanced practice provider. So, an entire healthcare team that is built around the patient in order to free up, if you will, the provider's schedule, so that I can see more patients. So, even with our existing staff, we are looking at ways to improve our capacity for the points that you made.

CHAIRPERSON SCHULMAN: What's the... Just out of curiosity, what is the hospital capacity now for H+H in general? Like, where are you... Where are you at in terms of people being admitted and...

DOCTOR WALLACH: Per our census numbers?

CHAIRPERSON SCHULMAN: Mm-hmm?

DOCTOR WALLACH: I don't have that number. We would be happy to get that back to you. But, I will say... (CROSS-TALK)

CHAIRPERSON SCHULMAN: You can get it back to us? Like is it 90%, 80%? (CROSS-TALK)

DOCTOR WALLACH: But, I... Yeah. So, I don't have the exact number, but I will tell you that we have seen, as other hospital systems in New York City have seen since the beginning of the pandemic in 2020, our hospital census has been running much higher than it was prior. And I think to your point, is that many of these patients had missed care because of the pandemic. And now we are seeing the sequelae of that missed care. And, so, indeed, we will get you the exact numbers, but we are seeing our hospitals busier than pre-COVID.

CHAIRPERSON SCHULMAN: So, has it peaked, or is it on the downswing, or is it kind of steady?

DOCTOR WALLACH: Yeah, a great question. Again, it has pretty much plateaued.

CHAIRPERSON SCHULMAN: Okay... (CROSS-TALK)

DOCTOR WALLACH: We have seen kind of, you know, in the past, we used to see seasonal peaks... (CROSS-TALK) CHAIRPERSON SCHULMAN: Mm-hmm?

DOCTOR WALLACH: You know, to our service end. We really haven't seen that. It's really been kind of a steady census over the past two years.

CHAIRPERSON SCHULMAN: Which I would argue shows the need for increased hospital capacity. But, I will move on.

The current technical manual for environmental review in New York does not require... Does not require a study of hospital or health facility capacity as part of the study of potential impacts from new development. Given the amount of new development that's going on throughout the City, including in my district, do you think that health facility capacity should be required as part of environmental review for major developments.

DOCTOR WALLACH: Yeah, uhm, so, I think that is a little bit out of my realm, and I would have to defer the response to that.

CHAIRPERSON SCHULMAN: Okay.

Uh, one second, okay, I am going to ask about hospital support. So, City's public hospital system and other safety net hospitals serve the majority of the City's uninsured and underinsured population, many of their sites are located in the communities hardest hit by the pandemic. The New York Times reported that these hospitals could have benefited

from additional resources as they were caring for some of the patients most in need during this time.

How did the administration prioritize ensuring our public hospitals and safety net hospitals receive the PPE and equipment that they needed?

DOCTOR WALLACH: Yeah, thank you again for that question. And I will just say also, uh, Chair, that in my 25 years of practice, what we have experienced over the past three years is completely unprecedented. Never in my wildest imagination would I have, uh, envisioned what we have been through and are going through at the current time.

I will say, I am very proud of my colleagues in supply chain. At New York City Health + Hospitals from the very beginning of the COVID pandemic in early 2020, they have kept our hospital system supplied, not only with medical equipment, but most importantly with the personal protective equipment for its staff as well as for patients to be able to provide masks, uh, when they come into our facilities. So, for us, again, our supply chain, I don't know how they work magic, but they do. And they have been, uh, really terrific.

Now, I am going to ask my colleague, Dr. David Silvestri, if there is anything else you want to add from the emergency management perspective?

DOCTOR SILVESTRI: Thank you, Dr. Wallach, thank you, Council Member... Actually the... All the representatives from the various communities who are here today. This is a really important conversation.

Not much to add on PPE. I would say that, in general, just to remind the council, NYC Health + Hospitals was at the, obviously at the leading edge of The United States response, and in some sense actually acted quicker and swifter than a lot of the guiding bodies at that time, you know, to put in place things like, for example, airborne protections for our healthcare workers. We have, you know, continued to see, uhm, as Dr. Wallach mentioned, robust preparedness from our supply chain colleagues, not just with regard to PPE, but ,you know, also with regard to ventilators you mentioned, as well as ,you know, vaccines etc.

CHAIRPERSON SCHULMAN: What is the, uh, what is the census also for ICUs, actually now that you mentioned that?

DOCTOR WALLACH: Yeah, so our ICUs have found and tracked similarly to overall hospital census.

CHAIRPERSON SCHULMAN: Okay.

DOCTOR WALLACH: And, again, there are ebbs and flows, but overall, I would say our ICU census has been increased again in comparison to, uh, pre-pandemic. Now, I will add one comment if I may, Chair, and that is very interesting: We are at a point now in the pandemic, uh, where the number of patients in our ICU for COVID related illness as the primary cause of their admission, is very small. In fact, last week we reviewed charts, and I think there were only two patients on our entire ICUs across the system, that were there for primary COVID. And both of those individuals were unvaccinated. So, this had been the real success, in that from a COVID perceptive we see marked improvements, uh, in critical care.

CHAIRPERSON SCHULMAN: So, then it is possible that people who weren't getting preventive and primary care during that time are now the people in the ICUs? Is that corollary correct?

DOCTOR WALLACH: Yes, I mean that could be the case. I will say, and one of the things that I joke

with Dr. Silvestri all of the time, we were very fortunate, at NYC Health + Hospitals, that pre-pandemic we had instituted our new electronic medical record system called Epic. In my perspective, that has been a game changer. And we would not have been as successful in our response to the pandemic without it.

And to your question, we use it be... in a way that we can do active outreach to our patients. So, there was a short period of time, probably in March and April of 2020, where people were scared, quite honestly, to come to primary care. They didn't want to come in to a hospital that was quote "full of COVID". And so there were definitely people that lapsed. One of the nice things about the electronic medical record system, is that we are able to have registries of patients based on their diagnosis, specifically chronic diseases like diabetes or heart disease, and we have been using that to call those patients back in to care, so that it's not just dependent on the individual deciding to access healthcare, but rather to be proactive.

CHAIRPERSON SCHULMAN: Okay, I am going to ask one more set of questions, and then I am going to turn it over to my colleague.

So, during the pandemic, when the Governor mandated capacity increases, how did H+H perform the infrastructure changes?

DOCTOR WALLACH: Yeah, thank you for that. I have to say, you know, I am an outpatient provider, and what I like to call a recovering hospitalist. I stopped my inpatient work four years ago. But, I have never been more proud of my inpatient colleagues in their response to the pandemic. It was quite horrific what we were seeing in the spring of 2020. And our facilities' colleagues in particular, worked miracles in transforming units, uhm, from med-surge in to ICU level of care. We took non-traditional, uh, clinical space and made it in to hospital beds. It really was incredible what they were able to do. The other big piece of this, again, selling the importance of our electronic medical record, is we operated as a system. So, if one particular hospital was overrun, we were able to, within our 11 hospitals, transfer patients between sites to kind of level load.

And, I am going to ask Dr. Silvestri to comment a little bit further, since he and his team were the ones who... who actually ran that.

DOCTOR SILVESTRI: Yes, I mean, it's a hugely important issue, particularly in the spring of 2020. I think as you know, obviously, you know, there were certain pockets that were disproportionately hit during that early COVID wave. There were other parts of our system that were less hit. Even if a facility was less hit in the community immediately surrounding it, we would still open up units that were not, you know, part of the active care space prior to COVID, and really flex that. We obviously have to bring staff in to you know, care for patients in those units. To Dr. Wallach's point, we would actually transfer patients. So, as a system, with 11 acute care facilities, you know, very despert regions, we are able to really, you know, offer more capacity than we would with a single standalone site. And so I think, you know, then that was a major part of our first wave response and became a staple of our subsequent wave of responses as well.

DOCTOR WALLACH: And I would use actually the analogy of building an airplane as we were flying it.

And, again, I am in awe of Manny and his teams. I woke at Bellevue as you know, and we literally, I feel like, built a new hospital within the hospital. We took space that used to be our ICUs and were decommissioned, they were being used as offices, and Manny and his team literally brought those units back to life, uh, as ICU and critical care beds. And it really was truly remarkable.

CHAIRPERSON SCHULMAN: No, you... You, uh, H+H did a lot.

Uh, my last question is -- for now, uh, a New York Times Article recently detailed how many hospitals are redesigning their facilities for more flexible layouts that can better handle future surges from pandemics or other events. Did H+H peruse this kind of physical redesign, or are you?

DOCTOR WALLACH: Yeah, thank you, Chair. That was actually a really wonderful article, uh, in the Times. I thought it was very well written and to point.

Uh, I will defer, uh, to my colleague Manny Saez in just a moment. But, what I will say is that this is something that we do at H+H. We are continuing to look forward. Right? To renovate, to build us to the

place. We know, unfortunately, COVID-19 is not the last pandemic and not the last outbreaks that we will see in our lifetime. Especially with infectious disease as our global world is becoming smaller and smaller. So, I think one of the things that the Times article really brought out was the idea of having every room being a single isolation room -- Right? -- that you can readily convert. And, so that is something as we plan for future renovations is very much on our mind.

But, Dr. Saez, do you want to comment anything further about our future planning for that?

DOCTOR SAEZ: Thank you, uh, Dr. Wallach. Uhm, yes that was a very informative article. And we always, always are on under consideration of what we can do with our spaces to help improve its flexibility -- not only from a space perspective to be able to meet capacity, but what we can do in terms of our cooling systems, our heating systems, being able to have more real-time controls, uh, being able to also stay green conscious and be much more energy efficient and reduce our carbon footprint for the City. So, we are always working towards new innovative ways to consider out builds.

CHAIRPERSON SCHULMAN: Thank you, and I think the... I speak on behalf of The Council, we're here to be of service... assistance to you if need be.

I am going to now turn it over to Chair Narcisse for questions.

DOCTOR WALLACH: Thank you.

CHAIRPERSON NARCISSE: Thank you. Uhm, you spoke eloquently about telemedicine.

DOCTOR WALLACH: Mm-hmm.

CHAIRPERSON NARCISSE: From primary care. As a nurse, preventive care is -- for me -- is cost effective, and that is the way we should be going right now for what we have been through.

So, for telemedicine, I'm so concerned about the seniors, the homebound.

DOCTOR WALLACH: Mm-hmm?

CHAIRPERSON NARCISSE: Uh, without broadband. How is the hospital dealing with that population?

DOCTOR WALLACH: Yes, that's such a great question, thank you so much, Chair Narcisse.

And, again, I just want to thank you for your opening remarks and all of your support, uh, to the H+H system. It is greatly appreciated.

You know, I have to say, uh, as a primary care doc, uh, your question was my initial concern in my practice, uh, back in March and April of 2020 as we pivoted literally overnight to telehealth -- as many patients were scared and concerned about coming to the facility. As someone who has been practicing for 25 years, my patient panel is definitely on the older end of the age range. I have a lot of patients in their 80's, uh, a couple in their 90's. And I was really worried about how I was going to provide care to these individuals, thinking they're not going to have a smart phone or they're not going to, you know, go online. I will tell you, I have been pleasantly surprised at a couple of things. Number one, a lot of my older patients have been using technology with the help of their children. So, I have been conducting telehealth visits with older individuals through the phones or a laptop computer of their adult children and sometimes their grandchildren setting it up. And so there has been the ability to do that.

Now the other thing that NYC Health + Hospitals has done, which I am really proud of, is they actually provide technical support for individuals.

I will tell you, I am somewhat of a technical Luddite myself. I use technology because I have to, but I am not the best at it. And, I felt very strongly, as we were building up a telehealth program that we needed to make sure that we have customer support for our individuals. And one of the things I am most proud about is midway through the pandemic, we actually switched vendors. We changed our platform for our video visits, because we were getting feedback from our patients. They were having difficultly connecting to the virtual visits that had video. And so we took that very seriously. We did an RFP, and we now have landed with a new vendor that is literally the press of a button. The technology is simple. And on top of that, what was very important to us, is that our new platform has the ability to have interpreter services built in, uh, to those visits, whereas, I will tell you, in March and April of 2020, I was Jerry-rigging my personal cellphone where I had the interpreter, I had the patient on the computer or a telephone. Now, it's seamless, it's all built in. And, again, technology can help us, if we know the right questions to ask and get the right equipment.

So, to answer your question, yes, uh, number one, some seniors have surprised me. Now that said, there are a number of seniors who don't have adult children with them or folks who can assist them. And so for those individuals, we have made it a priority in our geriatric clinics to make sure that we have in-person visits for those older individuals.

So, it really is a combination, and it's up to the patient what works best for them.

CHAIRPERSON NARCISSE: Thank you.

But, right now, I am trying to work on the broadband, especially around the NYCHA housing with the help of my colleagues.

So, can you elaborate a little for me on the criteria you use to determine where to place the Gotham clinics or the FQHCs clinics? Because, I just mentioned before, and I am going to keep on saying it until we get a working clinic in our community in the 46th District where we do not have any hospitals or healthcare centers.

So, can you elaborate on the specific criteria that you use to place those? Because we still have a lot of communities... (CROSS-TALK)

DOCTOR WALLACH: Yes.

CHAIRPERSON NARCISSE: That the hospitals are closed, and there is nowhere to actually go.

DOCTOR WALLACH: Yes, thank you for that question, Chair. And I will say, uh, we have heard you loud and clear. You have been an amazing advocate for your district and your constituents. I know that you and your office have been working closely with our team at H+H. And we will continue to do so, and in fact we will make sure that they follow up after today's hearing. Because, again, we agree that every New Yorker has the right to healthcare, and not only the right to healthcare, but to high quality care. And that is what we are doing and building out with our Gotham FQHCs. And I think the latest example, you know, is the new facility that we are moving forward with in the Rockaways in conjunction with our colleagues and support from the EDC.

But, again, it is a complicated process, but we are committed to working with you and others here in the City to have that move forward.

CHAIRPERSON NARCISSE: Thank you.

Culturally competent care is always, you know, as a nurse always at the top of my mind. How are we ensuring that healthcare offered in our city is

culturally competent? Can you elaborate on how we are ensuring that we are serving the unique needs of all those folks in need --disabled folks, limited English proficiency, limited digital literacy -- which we just spoke about a bit -- older adult patients -- all in to one ball.

DOCTOR WALLACH: Yes, so, thank you for that question again, uh, Chair.

I will say, one of the beauties of New York City is that we are a true melting pot. Some might say the center of the universe. And because of that, we have such a rich cultural history here in our city and amongst our patients.

At H+H, as we recruit, and we are constantly looking for new talent whether that be nurses or providers, one of the things that is really important to us is that our staff reflect the communities within which they provide care. And that is something we take very seriously. A significant number of our staff in fact are bilingual. Which is really wonderful to be able to talk to a patient in their primary language. If they're not, of course, as I mentioned before, we have language services with over 200 languages and dialects available 24/7. Very

easy to use. In addition, all of our major forms, things like consent, are all translated in to our top 13 languages. Again, so that the individuals or the patient has that in their primary language, you know, when they are being presented with those decisions and asked to sign forms.

So, it is something we take very seriously. We are very... we have cultural humility, if I may, you know, at H+H. We continue to learn from our patients, and we take their feedback whether it's formal through a community advisory board, or even if it's at the individual level. But, we are continuing to improve. All of our staff are required to go through annual in-service training on cultural humility and being able to make sure that the care we provide is of the highest quality and sensitive to the individual.

CHAIRPERSON NARCISSE: Thank you.

You know, we can ask you all kinds of questions, and say, how are you going to do things, but we know the bottom line is, like in my opening statement, it's comes with the resources.

What... Does H+H need more resources to keep up with the primary care?

DOCTOR WALLACH: Yeah, thank you for that question. You know, I would say first and foremost, The Council has been incredibly supportive to H+H with specifically regard to primary care. So, for that we thank you.

Right now one of the things that we've learned from the COVID-19 pandemic, if you will, uh, with the issuance of executive orders at the state level, is that our staff has been able to operate at the top of their licenses. Right? There have also been federal and state regulations that allowed us to use telemedicine, right, at get reimbursed, uh, at the same rates. And we are concerned that as we continue to remove ourselves from the pandemic, some of these benefits, if you will, will also go away. And, so you're ongoing advocacy and support, specifically for telemedicine, uh, and the ability of our staff to function at the top of their license, would be greatly appreciated.

Now, I know you are a former nurse, uh, and one of the things in particular, and I think you and I have spoken about this before during one of your visits to our sites, is that I believe nurses are providers. And, I am very much in favor non-patient

specific orders, whereby, nurses on their own, with their training, would be able to administer immunizations, HIV tests, and other things -- place PPDs for tuberculosis for our patients, and I want to make sure our nurses are operating, uh, at that level. I think it also helps them become a better part of the care team. Their more engaged with their patients. And it's something that we continue to work towards.

CHAIRPERSON NARCISSE: Thank you. And, to have to correct that. Once a nurse, always a nurse.

DOCTOR WALLACH: Touché.

CHAIRPERSON NARCISSE: Has the pandemic impacted access to inpatient mental health services at H+H? What about outpatient services? As of today, how many inpatient mental health beds are within Health + Hospitals? Has H+H seen an increase demand for mental health services? What about services specifically for substance use?

DOCTOR WALLACH: Yeah, excellent question, again, thank you for asking that, Chair.

Indeed, I am really proud of our system that throughout the pandemic, even in its darkest days back in 2020, we kept our doors open -- specifically

on an inpatient behavioral health units. And I am really proud of my colleagues for that work that they were able to do. We know oftentimes these patients who are struggling with these issues require face to face encounters in order to be successful with their treatment.

In addition, similar to what we have done for primary care services, kind of mid-pandemic, our behavioral health colleagues also implanted telehealth sessions. Whereby, if patients were able to or wanted to reach out, uh, virtually, we were able to do that.

Similarly, uh, within adult primary care at Bellevue, we stood up a virtual Buprenorphine clinic -- getting to your question about substance use disorder -- so that patients who were being treated would not have an interruption to their treatment, uh, because they physically could not come to the hospital system because of COVID.

Similarly, we provided, through our behavioral health services, methadone delivery to individuals, again, who traditionally would come to the facility to get their medication. We instead partnered with

DOHMH and Oasis, uh, to get that medication taken, uh, to the individual at their home.

We also provided behavioral health services at the isolation hotels that were established here in New York City. We have made behavioral health a significant part of our SHOW vans, recognizing the importance of offering those services to those individuals. And, then lastly, we have kind of hardwired behavioral health in to primary care. So, we screen patients within primary care for depression and anxiety, for substance use disorder, and throughout our Collaborative Care Program, we have behavioral social workers and psychiatrist within primary care to be able to provide those services to those individuals rather than having them go to a separate behavioral health clinic.

So, overall, I would say, as you know, provide 50% of all behavioral health beds in New York State. That's pretty significant number in our system. And I am really proud of the work that my colleagues have done to continue to make sure their patients get access to care.

CHAIRPERSON NARCISSE: Thank you, but do you have a specific number for that?

DOCTOR WALLACH: Uh, for... (CROSS-TALK)

CHAIRPERSON NARCISSE: For the beds?

DOCTOR WALLACH: The inpatient behavioral health beds? (CROSS-TALK)

CHAIRPERSON NARCISSE: Inpatient.

DOCTOR WALLACH: Yeah, I believe it 800... It's about 850 beds.

CHAIRPERSON NARCISSE: And you have seen an increase in substance abuse?

DOCTOR WALLACH: So, we have. Again, New York City is not unlike the rest of the country, and we have seen this as a trend, uh, as part of the pandemic where people took to alcohol or other illicit drugs during the pandemic.

And, again, building on the infrastructure that we had created pre-pandemic, we are in a much better position to be able to offer these services.

Again, I want to highlight the fact that we offered Buprenorphine, within our primary care services, uh, at many of our facilities. So, yes.

CHAIRPERSON NARCISSE: Thank you.

Overall, our healthcare system is shifting from inpatient services to outpatient services. H+H has

previously discussed their efforts to increase capacity for outpatient mental health services.

Can you please speak to this increase in capacity, and provide an update on available services? How does H+H ensure that there is still enough access to inpatient care despite the shift to providing care within the community?

DOCTOR WALLACH: Yeah, so, again, a really great question and a really important topic related to behavioral health.

I will say that we continue to maintain our inpatient psychiatry beds. But, as you alluded to, we also, in tandem, are continuing to grow our outpatient services. Right? And so that is under a myriad of activities. That includes our clinics; that includes our partial hospitalization programs; it includes our intensive outpatient programs -- our IOPs -- and it also includes our Assertive Community Treatment or ACT teams.

Again, we have built in behavioral health to our Virtual Express Care. The theme is we are trying to meet the demand and the need of the community to provide these services where and when the patients want it.

So, although we maintain our inpatient behavioral health beds, we continue at the same time to expand what we are doing on the ambulatory side to provide these services, and quite honestly with the goal to try to help, thwart, or prevent hospitalizations.

CHAIRPERSON NARCISSE: Thank you.

We talk a lot about mental health and telemedicine -- telehealth, is there any data on demographics of who is using telehealth the most?

DOCTOR WALLACH: Yeah, so that's a great question. We will have to get back to you on those details of who is actually accessing. But, again, I can tell you from my own practice and from colleagues, it has really been universally accepted. Uh, and we are seeing quite a wide range of [INAUDIBLE]. But, we will get back to you and your office with the specifics.

CHAIRPERSON NARCISSE: Okay, is there data on whether it is effective?

DOCTOR WALLACH: So, again, that's a great question, thank you, Chair.

One of the things that we use to look to see how we are doing as a hospital system, and specifically on the ambulatory side of the house, are outcome

measures. Right? We want to see how well our, uh, patients with diabetes are controlled. That their A1c's are less than eight, or that their blood pressures are controlled. And what we have seen, as the rest of the country, is that early in the pandemic, we saw a decrease in some of those measures -- that we've done a little bit worse. What I will tell you, thankfully, is that over the past year or so, we have seen a rebound, and in fact, our control measures are back to where they were pre-pandemic. And I think in no small part, this is combination of not just the in-person visits, but also the ability to conduct these telehealth visits.

There is a movement in medicine to do remote monitoring. Many of our patients, especially if they have high blood pressure, we have given out a prescribed home blood pressure machine. Our patients with diabetes have glucometers. And so we really are moving in to a new realm of health care delivery, uh, where we will have these tools to assist us to make those telehealth visits even more rich, uh, and beneficial to the individual.

But, I am happy to report that our measures across the board have rebounded.

CHAIRPERSON NARCISSE: Thank you.

I keep coming back to telehealth because, like you said before in your opening remarks, that this is not our last pandemic. We might open for more things, because we live in a global world, right?

How does the lack of high-speed internet or lack of smartphones or computers affect equitable access to telehealth appointments?

DOCTOR WALLACH: Yeah, again, it's a great point. And I would agree with you that even in the absence of another pandemic, which by the way, I'd appreciate if you did not schedule another one, thank you. Uh, but even in the absence of another outbreak or pandemic, telehealth is here to stay. Right? Telehealth is convenient for patients. We are learning. We are improving. It only gets better over time. And, so, it is part of our new healthcare delivery model. And just by way of example, uhm , ,you know, during winter storms when we had some snow last year, and we actually had to close clinics, in the past, those patients with appointments would have missed their appointments, and we would have had to reschedule it. But, instead we know have the flexibility, instead of cancelling those

appointments, we wholesale switched them to virtual visits. And so the patient was still able to connect with their provider. The provider may not have made it in to the clinic, they may have been at home, the patient certainly was at home, but we were able to still move forward with care. And I am really proud of that and really appreciate and recognize the importance of telehealth to do that.

Now, to your point though about broadband access and the ability of individuals to access virtual care, I want to remind The Committee that we will meet the patient where they want to be met. So, very early on, I have committed to making sure that we can conduct telehealth visits by the telephone. So, if somebody does not have access to the internet or a smart phone, we will still do a visit over the telephone. And that is something very important to us from a health equity standpoint.

CHAIRPERSON NARCISSE: Thank you.

My last question -- I will make a statement: Brooklyn Borough President -- right? -- Antonio Reynoso, had invested his entire $45 million capital budget in maternal healthcare services at three different public hospitals in Brooklyn. It is a

great step toward achieving maternal health equity and fighting against maternal morbidity inequities. Right?

What are some of the things H+H are doing to close the glaring maternal healthcare gap?

DOCTOR WALLACH: Yeah, thank you for that question, Chair.

And I would argue that some of our maternal care and morbidity that we're are experiencing here in New York and throughout our country is the next outbreak or pandemic. And this is a really important health emergency for us.

I am very proud of my colleagues in Women's Health at H+H. We have done several things. There are probably five main interventions that we have done. The first are simulation based programs at our simulation centers. We have created maternal medical homes modeled on the patient centered medical homes that we have used in primary care. We have also created integral pregnancy optimization programs where we asked patients about planning, so that if and when they get pregnant, they're on the right multivitamins and supplements to have a successful and healthy pregnancy. We have also created a

mother-baby coordinated visit program where the both the mother and the child have their followup visits together on the same day to ensure that they come. And, then lastly, H+H, uh, has taken a strong stance against Race-norming, uh, specifically in maternal health. And, so, you may be familiar with a calculator that people used to use about C-sections, uh, excuse me vaginal births after C-sections, which included race, uh, as a component to that. And we have committed to eliminate that as we move forward.

I think the biggest thing; however, is the first item that I mentioned, and that is our simulation. We have created incredible simulation labs where doctors and nurses can train together as a team in these high risks scenarios. Right? Whether that's worst case scenario -- cardiac arrest, hemorrhage, or other maternal emergencies. One of the things, interestingly, early on that our staff noted, was that the mannequins that we were using in this simulations were all white. And they did not reflect and look like our patients. And so they actually fed back to the vendor, and I am happy to report, because of that feedback, we now have mannequins that actually look like our actual patients. And I think

that is really important. And they have now made this available, you know, kind of nationwide. But, this is something we take very seriously at H+H. And again, we have a very active Women's Health Council that continues to improve and iterate these domains that I just shared.

CHAIRPERSON NARCISSE: I thank you. I know it wasn't a part of this, but I just had to bring it up, because, uh...

DOCTOR WALLACH: It's important.

CHAIRPERSON NARCISSE: It's very important.

DOCTOR WALLACH: Absolutely.

CHAIRPERSON NARCISSE: So, thank you, Chair Schulman, I appreciate your time, Chair.

CHAIRPERSON SCHULMAN: Thank you very much for those great questions, Chair Narcisse. I am actually going to now turn it over to committee counsel.

COMMITTEE COUNSEL: Thank you. We will now hear testimony from the public.

The first panel will be Andrew Title... Sorry, you may go, Administration, thank you.

CHAIRPERSON SCHULMAN: Thank you very much for your testimony and for your answers, and we are going to follow back up with you, thank you so much.

COMMITTEE COUNSEL: Our first panel will be Andrew Title, from the Greater New York Hospital Association. Please wait for the Sergeant At Arms to announce that you may begin.

SERGEANT AT ARMS: [NO AUDIO]

ANDREW TITLE: Good afternoon, I am Andrew Title, I am the Associate Vice President at Greater New York Hospital Association. And, thank you, Chair Schulman and, uh, Council Member, uh, or Chair Narcisse for the opportunity to talk to you today, I really appreciate it.

As you know, Greater New York represents every, single hospital and health system in New York City -- voluntary and public. Our members proudly take care of all New Yorkers regardless of the ability to pay, 24/7, 365 days of the year. And, in 2020, New York City hospitals, the 62 acute care hospitals in New York City, delivered 900,000 inpatient visits, 73% of those visits were covered by Medicaid and Medicare together. There is no substitute for the highly specialized care that hospitals provide. But, at the same time, hospitals are so much more than that. They have always been community providers. They run vast ambulatory care networks, and they delivered 13

million outpatient visits in 2020. This mirrors a national trend, and I know a lot of other people talking today talked about this, how we are moving to an outpatient world, and healthcare delivery is shifting to that ambulatory setting. More medical procedures can safely take place there, and we believe that this benefits patients by empowering them to seek care before they need to go to an emergency department with severe issues.

Dialogue with the community is super important during this transition. New York City Hospitals work with community partners, they hire diverse culturally competent workforce, and invest in language access for this purpose. They regularly access community health needs and implement interventions to meet those needs through those efforts.

Any discussion of healthcare today would be incomplete without addressing the ongoing COVID-19 pandemic, and that is something that people talked about today also.

When the pandemic hit, New York City hospitals led the largest mobilization of healthcare resources in US history. They rapidly increased bed capacity; they coordinated with government and their hospital

colleagues; they mobilize staff and volunteers, and we all owe a debt of gratitude to Hospitals and the heroic healthcare workers who have sacrificed so much and continue to do so today.

I also want to address something that you brought up, Council Member Schulman, about delayed care. Unfortunately that was something that was somewhat inevitable during this process, because of the historic nature and unprecedented nature of the pandemic. But, Hospitals felt the same way that you did, that it was unfortunate that certain procedures had to be delayed because of priorities, and that is why they undertook a campaign to urge people to seek care and explained the procedures that were put in place for the benefit of patients and everybody else for infection control. But, we definitely hear you on that, and I just wanted to make sure I mentioned that.

Hospitals learned from the pandemic, and they are preparing for future emergencies by maintaining a flexible infrastructure and coordinating with partners.

Partly as a result of the pandemic, Hospitals faced server challenges today -- severe financial

challenges. Inpatient volume is declining; inpatient discharges decreased 8% while outpatient visits increased 9% from 2013 to 2019. We expect this trend to continue. And, from January to May of 2022, it has accelerated. Workforce shortages make it harder to find staff, inflation is rampant, for profit insurance companies are denying care at record levels, and perhaps most critically -- and this is something that member of The Committee also talked about -- they incurred significant losses when they treat New Yorkers with public insurance. Medicaid pays 63% of what it costs to take care of a patient; Medicare pays 80%. That is a recipe for financial disaster, and it's really the animating problem that we see in the New York City Hospital world today.

In view of all of this, we believe that expanding community based care, while maintaining our 24/7 hospital infrastructure, is the best way to improve health access for New Yorkers, and we can do that in five main ways:

One, is investing in convenient outpatient options across the City, especially in underserved areas. Another is increasing inadequate Medicaid and Medicare rates and supporting safety net hospitals.

We can close the insurance coverage gap and get everyone covered; invest in the socially determined set of health, because not everything is controlled by a hospital; and we can also invest in the workforce. Part of that is the pipeline, because there is a shortage of people who are going to healthcare for various reasons, and the other is something that, uh, my colleagues at H+H have talked about before, talking about expanding scope and ensuring that health care professionals can practice at the top of their license. That is something we support very strongly.

Thank you for the opportunity to testify on this critical issue. I am happy to take any questions you might have, and I am looking forward to working together with The Council in the future.

CHAIRPERSON SCHULMAN: Thank you, uh, so, one comment is that, in terms of the elective surgery pieces, when Omicron became a variant in, uh, the beginning of this year, the governor, when she issued the -- Governor Hochul, when she issued the Executive Order excluding cancer, any change of diagnosis from being considered elective surgery. So, that is how that was... That was how that was addressed. That's

number one, but what I want to ask you was, I see where you have some suggestions on ways to achieve goals here, uh, support Medicaid all of that, uh, are you in favor of the HEAL Act, which allowed undocumented people to get... Was the HEAL Act or? The... That allowed undocumented...

COMMITTEE COUNSEL: I'm not sure.

CHAIRPERSON SCHULMAN: To get insurance?

The Governor, when they passed the budget, The Governor, there was a push by the state legislator to allow the undocumented to be able to be part of the Affordable Care Act. As you are aware, the Affordable Care Act, when it was passed, excluded them, because that was the only way that it could go... get through Congress. The Governor sort of split that a little bit and allowed people who were 65 and older to be able to do that. But, are you in favor of the undocumented, who bellow the age of 65 being able to buy insurance under the Affordable Care Act so that they could access services at your hospitals?

ANDREW TITLE: You know, I haven't seen, uh, the proposal for allowing them under the Affordable Care Act, just because in Washington I think it's not

as... as viable an option. But, we do support the bill in Albany, the Coverage for All Bill that you may have heard about... (CROSS-TALK)

CHAIRPERSON SCHULMAN: That's what I'm talking about, that's the Coverage for All. Okay... (CROSS-TALK)

ANDREW TITLE: Yeah, that's... (CROSS-TALK)

CHAIRPERSON SCHULMAN: I was just giving the genius of it, yes.

ANDREW TITLE: Okay, yes, we do [INAUDIBLE]... (CROSS-TALK)

CHAIRPERSON SCHULMAN: Okay, you do...

ANDREW TITLE: support that.

CHAIRPERSON SCHULMAN: Okay, you, so, yeah, that wasn't included in here, that's why I asked the question.

Those are the only two things for right now, thank you.

CHAIRPERSON NARCISSE: Thank you for coming to testify, it's very important to have folks coming out, and so I can ask some questions.

So, nurses' ratio has been a problem for H+H. How is it in the private hospitals?

ANDREW TITLE: I think that the answer is not going to be the same at every, single hospital. Staffing is something that the volunteering public hospitals are very concerned about in New York City, We have recently agreed to a law that was negotiated at Albany concerning staffing at hospitals. And, what that law says, and it's going in to effect soon, is basically that every, single hospital needs to have a Labor and Management Committee that talks about staffing and agrees on what the best path forward is on staffing. I think that the challenges right now that we are facing on staffing are partly that they're just are not enough providers. And, the other challenge that we are facing here is that, uh, we really need to include everybody here, not just RNs; although, RNs are extremely important in the staffing process. And that is why we like that this law, uh, considers not just RNs, but all different kinds of healthcare professionals including CNAs and Transporters, people like that.

CHAIRPERSON NARCISSE: Thank you

COMMITTEE COUNSEL: Thank you, Mr. Title, you may go.

COMMITTEE COUNSEL: At this time that concludes the end of in-person testimony unless any addition Witness Slips are received.

We will now move to the remote testimony portion. As a reminder, once your name is called, a member of our staff unmute you, and you may begin once the Sergeant At Arms sets the clock and cues you to start.

I will now call the first remote panel, this panel will consist of Jamal Westmoreland, from NYSNA; Dr. Anuj Rao, and Dr. Colleen Achong, The Committee of Interns and Residents, SEUI as well, thank you.

You may begin when the sergeant cues you.

SERGEANT AT ARMS: Starting time.

JAMAL WESTMORELAND: Good afternoon, Chairpersons, council members, my name is Jamal (sp?) Westmoreland (sp?), and I am a Registered Nurse employed at Woodhull Hospital in Brooklyn. I am also a proud member of NYSNA. Today I will be reading the testimony on behalf of Dr. Judith Cutchin.

"Good afternoon, Chairperson, council members, my name is Dr. Judith Cutchin, I am a Vice Chair of NYSNA Board of Directors, and the President of

NYCHHC Mayoral Executive Council, which represents more than 9,000 RNs who work for the Public Health + Hospitals system. I am also a Registered Nurse employed for more than 30 years at Woodhull Hospital in Brooklyn.

First, I would like to discuss the role of NYC Health + Hospitals in the New York City area in providing care to New Yorkers.

The NYCHHC systems accounts for almost one-fifths of the total hospital beds in New York City. We care for a disproportionate share of the uninsured on a citywide basis -- receiving little or no compensation. NYCHHC operates almost half of the most Advanced Level 1 Adult Trauma and Mental Health hospital services within the City. Services that are costly, labor intensive, and poorly reimbursed. Many private hospitals and other private healthcare providers, avoid caring for patients who are from underserved communities. NYCHHC assumes a huge role on the cost of providing care for a wide range of services and populations that private sector providers increasingly dump on public sector hospitals.

The COVID-19 pandemic revealed gross inequities within our healthcare system. It also revealed how short-term, profit driven thinking by private hospital systems left New Yorkers unprepared to handle the waves of patients needing treatment and lifesaving care. As we enter yet another phase of the ongoing COVID-19 pandemic, and face new variant surges -- not to mention the rise of monkeypox, polio, and other diseases -- nurses are demanding that hospitals focus on rebuilding a stronger more resilient healthcare system that will put patients first, gives frontline nurses and healthcare professionals the tools needed to provide quality care for all while centering on the community most impacted.

Nurses need improved staffing to provide high quality patient centered care, fair wages to recruit and retain nurses, along with expanding the public hospital workforce to uplift our community with well-paying jobs, and to address the needs of the communities we serve.

We urge The City Council to closely monitor the financial condition of Health + Hospitals, and increase...

[TIMER CHIMES]

SERGEANT AT ARMS: Time expired.

JAMAL WESTMORELAND: the funding to address... I have one sentence left.

And increase the funding to address healthcare inequities in the broader healthcare system while ensuring to recruit and retain nurses and healthcare professionals."

Thank you so much for you time, Council Members, for this vital [INAUDIBLE].

COMMITTEE COUNSEL: Thank you

Next we will have Dr. Anuj Rao, you may begin with the sergeant cues you.

SERGEANT AT ARMS: Starting time.

DOCTOR RAO: Good afternoon, my name is Dr. Anuj Rao. I am a third-year Internal Medicine Resident at Bellevue and NYU, and a delegate of The Committee of Interns and Residents SEIU. Thank you to the Chairs for the opportunity to testify today, and for holding this very important meeting.

When we ask CIR member across Health + Hospitals what they would like The Council to understand about access to healthcare and hospital capacity, overwhelmingly we heard stories of patients having

to board for days in the ED, long wait times for primary care appointments, high nurse to patient ratios, and severe lack of staffing. One resident when asked about hospital capacity simply said, "We are bursting at the seams."

The written testimony CIR will submit will touch further on the situation at other Health + Hospitals facilities. I wanted to paint a picture of what high patient loads and lack of staffing means on a daily basis for patients and healthcare workers at my hospital at Bellevue.

So for example, Bellevue is a tertiary care center for Health + Hospitals. We get many transfers from the other Health + Hospitals sites. One night, one of my colleagues got a patient, they were concerned about a bleed in the brain. He urgently needed a CAT scan and there were no transporters available at the time. My colleague, who was a doctor managing several patients, went herself and brought the patient down for a scan, which showed a catastrophic bleed and led to an emergency surgery that ended up saving the patient's life.

Thankfully there were no other crises that that doctor had to deal with, but because of staffing issues, there could have been challenges in getting the patient the care that he needed.

Additionally, you know, a lot of patients are transferred for heart catheterizations. I have seen patients wait for days and days to get this procedure, as emergencies come in, as the census has been very, very high. And as you can imagine, this is extremely frustrating for patients, their families, particularly for immigrant patients who are

As these two quick stories represent, we need more staffing, and we need to ensure that we are paying them a living wage so that we can actually retain them.

My colleagues and I were incredibly proud to be doctors at Health + Hospitals and to able to provide care to all New Yorkers, regardless of their insurance or immigration status, it's a privilege. Sadly, this means we also regularly witness patient dumping. For those of you not familiar with the term patient dumping, it's when a patient seeks care at one hospital in New York, a

private, nonprofit, and are deemed to their insurance status and their illness not be profitable, and they are discharged to go to the closest public hospital.

Very briefly, I see this very often with patients at a very vulnerable time when they are diagnosed with cancer. Many blood cancers involve being in the hospital... (CROSS-TALK)

SERGEANT AT ARMS: Time.

DOCTOR RAO: from... Uh, and I just... (CROSS-TALK)

CHAIRPERSON SCHULMAN: You can finish, go ahead. Go ahead... (CROSS-TALK)

DOCTOR RAO: Just to wrap very...

CHAIRPERSON SCHULMAN: No, no, go ahead, finish, I'm sorry.

DOCTOR RAO: Thank you, just a few... Few other seconds.

You know, when patients are vulnerable and diagnosed with leukemia or lymphoma, they are discharged from these hospitals and told to go to Bellevue to receive their care.

So, as The Council address access to care and capacity for hospitals, I urge you to look beyond

just census numbers, and examine this through the lens of our for-profit sick-care system that will also dump patients like the ones I just told you about.

Thank you very much for this time and for the privilege of speaking, thank you.

CHAIRPERSON SCHULMAN: Thank you, I have a couple of questions for you, Dr. Rao. Thank you very much for your testimony.

Do you think that there is enough hospital capacity for future surges or pandemics, or any other crises -- just in general?

DOCTOR RAO: Again, you know, just in my personal experience...

CHAIRPERSON SCHULMAN: Mm-hmm?

DOCTOR RAO: I think at this time, during that initial surge in March of 2020, everything was bursting at the seams. And over the past year, as the folks previously testified, the censes -- then again, I can’t give you hard numbers, but just from witnessing, they’ve been over 100%, and we definitely need more staffing and more beds. Uh, and it has been like this for over a year now. As the pandemic still goes on today, we are not seeing

as many deaths from COVID-19, but from other holes in our social safety net, from staffing at nursing homes, patients not getting their care at clinic and putting things off. You know, all of these patients end up at one place -- at one site that cannot turn them away, which is the hospital. And, again, I want to shout out to all of the providers doing an incredible job, but with the last two years, it's been extremely taxing and we need support to continue to provide a high level of care that all these patients deserved.

CHAIRPERSON SCHULMAN: What about, uh, are you familiar at all with inpatient capacity for psychiatric patients?

DOCTOR RAO: Unfortunately I'm not... (CROSS-TALK)

CHAIRPERSON SCHULMAN: Okay.

DOCTOR RAO: Uh, yeah.

CHAIRPERSON SCHULMAN: Alright, thank you very much, and I really appreciate again your testimony.

COMMITTEE COUNSEL: Thank you, Doctor.

We will now move to Dr. Colleen Achong from The Committee of Interns and Residents. Please start when the serge cues you.

SERGEANT AT ARMS: STARTING TIME.

DOCTOR ACHONG: Good day, all, my name is Dr. Colleen Achong, I am a second year Internal Medicine Resident at One Brooklyn Health and a regional VP for The Committee of Interns and Residents SEIU.

Thank you to the Chairs for the opportunity to testify today and for holding this important hearing.

Much of the discussion of access to hospital care and hospital capacity centers around census numbers. I would like to use this time to give you a picture of what it actually means, and when we have high census numbers in the hospital. For example, in January an unexpected COVID and monkeypox surge occurred in New York City. This was different from the surge that occurred in February with the Omnicom surge. These patients, many of which stayed in the ED, and had to be managed not only... as a physician I had to manage patients on the fourth floor, where I was the primary doctor there -- as well as for several patients in the ED, either be it for monkeypox of for COVID. Some of the monkeypox patients that I

was seeing were just... had just come in to New York City; they were sent from Texas, and they were living in the shelters not so far off from our hospital facility.

These high patient numbers are one aspect that impacts how we deliver care. The other aspect are our resources and staffing.

If you ask any resident or physician at a safety net hospital in New York, they will tell you that their hospital needs more nurses and more ancillary staff such as transporter, phlebotomists, EKG technicians, patient care aids, they're direly needed.

Many of the times, patients will remain in the ED and are unable to get a bed until the point that they would have to be discharged directly from the ED. This impacts patient care in the direct way that the doctor is unable to see the patient as many times as would be preferable in a patient centered care model.

Crowding and a large surge in census will impact the way that we treat patients and the type of care that they receive. I am incredibly proud to be from the community that I serve, and it's not a

secret that there are so many members of people in this community who are in need of work. They need good union jobs, and the need in our hospitals for more staff is real. We need our hospitals to hire more nurses as well as ancillary staff.

Finally, I want to draw your attention to the fact that all of the issues that patients face and have raised, which I am sure others will raise or have raised in the hearing, are only exacerbated and harder to navigate...

SERGEANT AT ARMS: Time expired.

DOCTOR ACHONG: if they are non-English speakers. Many of the patients I would point to, are some of which that were brought to New York from Texas and it is difficult -- some of which I have treated personally. And they... Not only are they diagnosed with monkeypox, sometimes they are diagnosed with a newly diagnosed HIV or sexually transmitted disease diagnosis. They should have not only proper care but also be able to understand what is going with their health.

Thank you for this opportunity to testify today, and for taking a look at this serious issue we as

residents face every day as we do all we can to provide the best care possible for our patients.

CHAIRPERSON SCHULMAN: Thank you very much.

CHAIRPERSON NARCISSE: Thank you for your services, for caring for the most who need our services in our community.

So, if you have to summarize in one sentence, what do you think can be done right now especially for the folks that you are serving right now? If you have one thing you can ask from us.

CHAIRPERSON SCHULMAN: Did someone mute her?

CHAIRPERSON NARCISSE: Is she hearing me?

DOCTOR ACHONG: I was muted, sorry.

CHAIRPERSON NARCISSE: Okay.

DOCTOR ACHONG: So, uhm, I would... I would really ask direly of hiring more ancillary staff. More than anything else, hiring the ancillary staff is very important, because it impairs the type of care that I provide to patients. Let me give a basic example:

A patient comes in with chest pain or shortness of breath, and they need an echo, and you only have one Echo Technician in the hospital. Now patients

will wait probably 10 days until they can get this test, because they don't have that ancillary staff.

If a transporter needs to be called, many times I have been... I have advocated for my patient, so I would push the patient myself to the surgical ward or to the CT scan or to the MRI, because I know that this patient does not need to stay in the hospital. It predisposes them to more infections, to more risks, so I want my patients to have the best care so that they are treated and then they are properly discharged -- so that they can be further managed in the outpatient setting at home. But if we don't have the staffing, those things cannot be done.

CHAIRPERSON NARCISSE: Thank you so much.

COMMITTEE COUNSEL: Thank you, Doctor.

I am going to call our next panel, it will be Judy Wessler from the CPHS Board; Medha Ghosh from Coalition for Asian American Children and Families; Amanda Dunker from The Community Service Society of NY, and Taras Czebiniak from the Mayor's New York City... Yes, that's the last one, thank you.

Judy Wessler, you may start when the sergeant cues you.

SERGEANT AT ARMS: Starting time.

JUDY WESSLER: Thank you for this opportunity. I'm sorry I don't have a written statement at this point, but there are just two points that I wanted to make. And, I have to say that Dr. Rao's point about patients being dumped, I would hope would be something that The Council would be interested in following up as something very key and that should not be happening.

The second I wanted to say is, uh, there seems to be a lot of ambulatory care in this city, but at least in Manhattan one of the things that's happening is that the academic medical centers in particular are opening ambulatory care sites, but they are not taking... They are opening them as, I guess, private practice, and they are therefore not obligated to take Medicaid or uninsured patients. And, so it looks like there are a lot of services for those patients, but some of it is... I am looking for a work, I guess, elusory, is the best term I can.

The other thing I wanted to say that we are part of a coalition effort that is having discussions with the state Health Department, and could... and

would certainly, and we would be happy to talk to you more about this, uh, we would be happy... about how do better distribute the indigent care pool Funds, uh, which have been, uh, misallocated or dis-allocated or whatever word works, for one. But, in addition to that, uh, there is $800 million in the state budget for this year for safety net hospitals. So, the way that that gets defined is very critical, and that is something that we hope to be working on with the state Health Department, and, again, would really appreciate The Council's support.

There is a definition in law that some of us fought very hard for -- for a number of years -- the former governor would, uh, veto it, and then we would have to go back again and it took four years, but there is a definition. And those funds should be allocated to actual safety net hospitals, which of course includes all of the public hospitals and some of the voluntary hospitals as well, that actually take care of people a lot of the same way...

SERGEANT AT ARMS: Time expired.

JUDY WESSLER: I'm sorry, I'll finish... A lot in the same way as the public hospitals do. And that would bring more resources in to the safety net hospitals so they could do a better job. And a friend who said, if you don't allow me to have the budget that I need, I am not going to be able to do the job that I am supposed to do. So, we need to work on the budget.

And, thank you for this opportunity.

COMMITTEE COUNSEL: Thank you.

Medha Ghosh, you may begin when the sergeant cues you.

SERGEANT AT ARMS: Starting time.

MEDHA GHOSH: Good afternoon, my name is Medha Ghosh, and I am the Health Policy Coordinator at CACF, the Coalition for Asian American Children and Families. Thank you very much to Chair Schulman, Narcisse, and Salamanca for holding this hearing and providing this opportunity to testify.

Founded in 1986, CACF is the nation's only pan-Asian children and families' advocacy organization and leads the fight for improved and equitable policies, systems, funding, and services to support those in need.

Nearly 19 million people reside in the New York City metropolitan area, and over 800 different languages are spoken. Because of New York's linguistic diversity, it is incredibly important to ensure language access. Language barriers are a huge obstacle faced by many folks in immigrant communities, and especially in the AAPI community. In New York City, the AAPI community has the highest rate of linguistic isolation of any group, as 46% have limited English proficiency, or as I will say LEP from here on, meaning that they speak English less than very well, according to a recent report from the New York City Department of Health and Mental Hygiene. Moreover, more than two in three Asian seniors in NYC are LEP, and approximately 49% of all immigrants in NYC are LEP.

Language barriers can prevent folks from accessing vital services like healthcare. Despite there being 76 language access policies targeting healthcare settings in New York, we have found that many LEP patients still report facing difficulties like being unable to find...

CHAIRPERSON NARCISSE: Can you slow down a little?

MEDHA GHOSH: Sorry, my apologies, uh, let me start from this paragraph.

Language barriers can prevent folks from accessing vital services like healthcare. Despite there being 76 language access policies targeting healthcare settings in New York, we have found that many LEP patients still report facing difficulties like being unable to find an interpreter that speaks their dialect or being unable to fill out paperwork because a translated version in their language does not exist. A lack of linguistically accessible services in healthcare settings can have grave consequences: 52% of adverse events that occurred to LEP patients in US hospitals were likely the result of communication errors, and nearly half of these events involved some form of physical harm.

In response to this, CACF's campaign, "Lost in Translation" aims to ensure that New Yorkers have equitable access to linguistically and culturally responsive healthcare services.

Over the past two years, CACF conducted quantitative and qualitative research to identify the key barriers that LEP New Yorkers face in healthcare settings and identify corresponding recommendations.

Our major recommendations for the LEP New Yorker community, which includes many members of the AAPI community, are as follows:

- Demand healthcare institutions collect more data on translation and interpretation services and service utilization
- Increase the number of languages for translated signage and forms, and ensure accuracy of translations by engaging community partners in a language review
- Ensuring accountability for language access complaints
- Create more opportunities to increase the number of practitioners who speak the languages of the communities they serve.

Overall, we see a need for more intentional collaboration between the City and community-based organizations to better identify language access gaps in our communities and to find solutions that will have a direct positive impact on the wellbeing of our communities.

Thank you very much for your time.

COMMITTEE COUNSEL: Thank you.

We will next have Amanda Dunker. You may start when the sergeant cues you.

SERGEANT AT ARMS: Starting time.

AMANDA DUNKER: Thank you, uh, my name is Amanda Dunker, I am Health Policy Director at The Community Service Society of NY, which has been serving low-income New Yorkers for over 175 years.

One of the things we do is suite of health programs, which help over a 130,000 people a year to enroll in health insurance and then use it to actually to access care.

We have been doing a lot of research in to medical debt, and fear of medical debt stops people from accessing care when they need it. The burden of medical debt falls disproportionately on people of color.

In a series of reports on financial consequences for hospital patients, we [INAUDIBLE] that tens of thousands of lawsuits as well as thousands of instances where liens were placed on patients' homes and their wages were garnished.

We have also found that hospital lawsuits are disproportionality filed against patients who live in low income communities or communities of color -- so

communities where the majority of the community are people of color or just disproportionately people of color.

A lot of New York's hospitals have revisited some of those aggressive collection practices in the past few years. But we think that there are a few policy changes that should also be made to create more consistency and fairness for patients across the board.

All of New York's hospitals are non-profit charities and are required by law to offer financial assistance to low and moderate income patients in the form of discounted prices. Compliance with the law as hospitals receive support from the State's indigent care pool, which Judy mentioned earlier, which distributes $1.1 billion annually. CSS has found that a lot of the patients who are sued are likely eligible for financial assistance but did not receive it. And there are significant differences in the amount of financial assistance provided by individual hospitals in the city and across the state, which are not reflected in how the indigent care pool is distributed.

Some of the solutions have to be implemented at the state level. We think there are two bills in particular that The City Council could consider expressing support for. One is S5954, which Judy mentioned, that would reallocate the State's indigent care pool funding to prioritize this category enhanced safety net hospitals. Another is S7625, which would improve how financial assistance -- the application process -- works. So, it would provide a consistent process at all hospitals and would increase the eligibility to 600% of the federal poverty level, which is consistent with the levels at which the Affordable Care Act provides assistance to patients.

The City should also consider participating in the rule making process for a State law passed last year related to the Certificate of Need process. The Health Equity Assessment Act means hospitals participating in the Certificate of Need process have to submit health equity assessments to the state which would explain how the proposed change in services would effect underserved populations.

The City should consider weighing in as the law is being implemented to make sure that those

assessments are conducted interdependently and that they result in meaningful community engagement in health planning decisions.

Finally, at the City level... (CROSS-TALK)

SERGEANT AT ARMS: Time expired.

AMANDA DUNKER: I'll wrap up

At the City level a more practical [INAUDIBLE] could be adopted in ensuring that all patients are able to access hospital financial assistance. The City does extend preferential tax treatment towards hospitals due to the nonprofit status, and given the value of this preferential tax treatment and the City's investment in Health + Hospitals, we [INAUDIBLE] have an interest in ensuring that all hospitals provide their fair share of healthcare to the City's low income and minority populations. And, that includes the private hospitals as well. So we think maybe the City could consider even just investigating how many patients are successfully able to get financial assistance and which hospitals are providing the most financial assistance.

Thank you.

COMMITTEE COUNSEL: Thank you.

We will call Taras Czebiniak -- sorry for the pronunciation -- you may begin when the sergeant cues you.

SERGEANT AT ARMS: Starting time.

TARAS CZEBINIAK: Hi, good afternoon, Chairpersons and Council Members, thank you for your time.

My name is Taras Czebiniak, I am here in my individual capacity as a concerned citizen. My testimony relates to the New York City Worker Injection Mandates.

As the committee overseeing health, you have a key function managing us through crises like COVID while preserving our human rights and holding The Mayor and his team accountable for their violations.

I would start by noting that arbitrarily firing people due to ineffective and medically dangerous COVID injection mandates throws those people in to despair; it destabilizes them and their families; it worsens their physical and mental health and that of their families, and it taxes our healthcare system in the City.

With that said, I want to get five key points on the record today:

1. Yesterday, President Joe Biden declared, "The pandemic is over." So, why hasn't The Mayor rescinded the worker mandate? We need The Council to act and fix this.

2. The New York City worker mandate remains in effect and continues to destroy lives. There seems to be some misunderstanding about whether the mandate remains in place. Both the public and private worker mandates remain in place. New Yorkers still cannot work, and people are still getting fired. Teachers, nurses, sanitation, police, and fire fighters -- the people who run in to burning buildings for us -- cannot feed their families under Mayor Adams. The prior worker mandate also remains in effect. The Mayor has said he is not enforcing the mandate, but it remains on the books and employers are still firing their workers because of it. Goldman Sachs recently lifted their COVID mandates worldwide, except for New York City and Lima, Peru. Those two cities still have private worker mandates. Just weeks ago, my personal friend here in New York had to inject herself, against her voluntary consent, on penalty of being fired.

3. Democracy can only function with proper checks and balances. The Mayor has abused his emergency powers since he moved in to Gracie Mansion. He has declared an unending COVID emergency against all facts, reality, and common sense. Betrayed by his behavior, going to crowded events every day without any masks or distancing. I personally heard his administration refuse to answer simple questions about the COVID mandates in this chamber on September 9th. We need The Council to provide checks and balances and enact laws that prevent The Mayor's abuses of power.

4. This is a heavy point, but we must recognize that The Mayor worker COVID mandates violate the Nuremberg Code. For those unfamiliar, the Nuremberg Code is a set of ethical guidelines for medical experimentation on human subjects to ensure that Nazi atrocities never happened again. I'll read the code for you.

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should be so situated to exercise free power of choice without the intervention of any element to force fraud, deceit, duress, over-reaching, or other

coercion." An ultimatum that you're fired if you don't take an unwanted COVID injection is coercion and duress; mRNA injections are a new technology with no long term safety data, and therefore by definition are experimental. A recent study published in Vaccine Journal, found a one in 800 serious adverse event rate. For a city like New York, that means 10,475 severe [INAUDIBLE]... (CROSS-TALK)

SERGEANT AT ARMS: Time expired.

TARAS M. CZEBINIAK: That is a tragedy.

My final point, we the people are frustrated and angry. Our government appears to be intentionally hurting us and violating us. We feel as though The Mayor and The Council are not listening to us. We feel helpless, hopeless, and unheard.

I would hope that this council recognizes and pushes back against The Mayor's usurpation of your power, and against this ongoing human rights violations against New Yorkers. Please pass a resolution recognizing the abuses of his power. Please pass a law that limits the use and duration of emergency powers. Please declare the pandemic over, agree with President Biden, and demand an end to the

mandates. Please let all New Yorkers get back to work. Thank you very much.

COMMITTEE COUNSEL: Thank you.

If there is anyone else present in the room or on Zoom who has not had an opportunity to testify, they can raise their hand now.

Okay, so seeing no one else, I would like to note that written testimony, which will be reviewed in full by 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 , again, that is testimony@council.nyc.gov.

Chair Schulman, we have concluded public testimony for this hearing.

CHAIRPERSON SCHULMAN: Thank you. I want to thank everyone for testifying today and answering questions. This is an important topic. We will be pursuing it further in the weeks and months to come.

And, with that, I close today's hearing.

[GAVELING OUT] [GAVEL SOUND]

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 October 2, 2022