CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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HELD AT: Committee Room – City Hall

B E F O R E: Carlina Rivera
Chairperson

COUNCIL MEMBERS: Francisco Moya
Mathieu Eugene
Alan N. Maisel
Diana Ayala
Mark Levine
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A P P E A R A N C E S (CONTINUED)

Mitchell Katz
President and Chief Executive Officer
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Matt Siegler
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[sound check] Test, test, today is March 25, 2019. This is a prerecorded test for the Committee on Hospitals. It is being recorded by Sekem Bradley and [inaudible] [pause]

CHAIRPERSON: Good afternoon. I am Council Member Carlina Rivera, chair of the City Council's Committee on Hospitals. During today's hearing we will review New York City Health and Hospitals' 998 million-dollar fiscal 2020 operating budget, the Ten-Year Capital Improvement Plan, as well as performance indicators from the fiscal 2020 preliminary Mayor's Management Report. During a time when health care is constantly being attacked by the federal government it is a relief to know that New York City understands the importance of access to affordable care, and I hope to hear in greater detail the plan for the roll-out of NYC Care. I appreciate the sentiment behind this recent announcement and the good intentions of the program. However, I do not want to cause any further confusion in an already-complex system, especially when we are looking to encourage to majority of MetroPlus enrollees who seek medical services at other institutions to encourage them to be consumers at our H&H facilities. I want

to ensure that we our best utilizing our marketing efforts and funding to upgrade our centers and streamline processes to maximize the effects we can have on all New Yorkers. It will be up to us to bring H&H facilities up to their full potential. We must focus on patient numbers and outcomes while competing for the same dollars our private institutions do, and we all know how crucial a role H&H play here in New York City, especially for our most vulnerable and marginalized citizens. So it saddens me that one major rating scale, the federal government's Hospital Compare Service, has given the majority of our H&H facilities one out of five stars. In addition, the inpatient satisfaction rate is still at 62%. With the threat of a deficit looming in fiscal year 2021, I'm looking forward to hearing of steps taken to accomplish the goals of an ambitious agenda set forward last year. As we discussed in our oversight hearing on access to specialty care, it is vital that we make inclusion a priority as we make improvements to our facilities. Capital upgrades and training of staff should certainly be a priority in the next fiscal year and in the coming months I plan to hold hearings on cultural competence, implicit

bias training, resiliency efforts, cost savings of a new electronic records-keeping system, and services for immigrant and LGBTQ communities. Given these important issue topics, I'd like to take one moment to talk specifically about our LGBTQ New Yorkers, specifically access for transgender and gender-nonconforming populations. In the Committee on Health's preliminary budget hearing, a community member had the courage to speak up on a terrible experience they faced at one of our H&H facilities in the last year, one that could have been avoided with inclusive forms and an educated staff. Since this experience I'm curious to know what H&H plans to do to ensure that all hospital forms include options and language that matches New York City's diversity and philosophies. I know how difficult it is to provide the absolute best care in a national political climate that is not inclusive in its proposals put forward and the anxiety that it causes so many of us, and I do want to thank you, Commissioner Katz, and the Health and Hospitals team for all of the great work that has been done so far and to say how much I look forward to seeing where else we can go from here. I want to thank my committee staff, policy

analyst, Emily Bulkin, finance analyst Lauren Hunts, and committee counsel Emmanuel for their support over these last few months. And I'd like to call up the team at Health and Hospitals, Dr. Mitchell Kat, Matthew Siegler, John Olberg, and Patsy Yang.

MITCHELL KATZ: Good afternoon, Chairperson.

CHAIRPERSON RIVERA: And with that we're going to swear you all in.

MITCHELL KATZ: Ah, that's right, thank you, sorry.

CHAIRPERSON RIVERA: That's OK.

CLERK: Would you all raise your right hand, please. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee and to respond honestly to council member questions?

MITCHELL KATZ: I do. Good afternoon, Chairperson River, city council members. Thank you so much for inviting us. I'm Mitch Katz, the president and chief executive officer of New York City Health and Hospitals. I'm so glad to be here to review the 2020 preliminary budget. It has been an amazing year and I thank all of you for welcoming me

back so warmly to my home town, and it's been great to take 30 years of California experience and put it to use in the place that I love the most. I think we've made a lot of progress on executing on the mayor's transformation plan. In line with that plan, we are on target to achieve 757 million in revenue-generating initiatives and 430 million in expense-reducing initiatives. Through the Quarter 2 of this year patient care revenue is up 80 million versus this time last year, and you will remember that last year we were 150 million above. So this is 80 on top of that 150 million, and this is not from patients. This is, rather, from their insurance, so that previously we were subsidizing insurance when we want that money to go for us. Driven by improved billing and better performance on our value-based contracts, we're just 10 million short to what was a very ambitious target we set for this year's budget and I actually would have been disappointed if we hit our target. I would have felt that I did not set for myself a hard-enough target, because I always feel you want to stretch yourself, and the only way you can stretch yourself is to aim for more than you can do. While we've seen a decrease in inpatient

utilization, which is a good thing, we don't want people to be in the hospital, we want people to be able to get the care they need in an outpatient setting. Hospitals should only be for people who need that level of care. Much of the decline comes from our value-based contracts, which means we get paid anyway, as we should. We're getting paid for keeping people out of the hospital for providing them with primary care. Many of the important revenue initiatives are just getting off the ground and we expect that when EPIC is fully implemented it's going to significantly improve our revenue beyond what I've reported to you. On the expense side, we're just 25 million above our budget and would say that was also intentional. We heard after the budget was set a great deal of testimony before you, and you supported on inadequate number of nurses in our facilities, preventing people from getting the care, and we've hired 340 net nurses, which were not anticipated, and so that's above its net because it allows for nurses to have retired or to move on. So we've filled all of the positions where people left and then we hired 340 new nurses. So to me that's money well spent. We also increased our investment in staff to do

billing so that we can bring in these kinds of dollars that enable our system to work well. How did we manage to do that level of investment with only being 25 million over our budget? We greatly reduced the number of temporary workers in our system. We eliminated consultants across the board, and we made a large number of managerial staff reductions. A year ago was the first time I was here. I was nervous. You were very kind to me. I appreciated that. A year later, despite all of the difficulties we have from the Trump administration, including some really awful statements about immigrants who are neighbors and our patients, despite all of that we have maintained a balanced budget and we're well positioned for stability and success by the end of 2021. We've built three new Stop Shop Community Health Centers and we chose, as I mentioned in the previous hearing, I'm very proud that while other systems when they choose where to build their centers they look at the maps and figure out where the areas that have the patients with the best insurance, I'll put my clinician there. I know many systems that do that. We did just the opposite. We took the same maps and we said where are the most uninsured

patients? Where are the most patient who are out of care? That's where we want to put our clinics, not where they have the best payment, but where people most need us. We are invested in needed repairs and improvements, including a 52 million-dollar planned capital investment at Metropolitan, and I want to thank Councilwoman Ayala for supporting that, for championing it, for getting us additional money, as well as to the mayor. Other committee members have generously supported Woodhull and I appreciate that Council Member Reynoso recently gave us money for the emergency department at Woodhull Elmhurst. Council Member Maisel, Kings, [inaudible], and many of our other facilities. I also take the chairwoman's point about there are other facilities that need infrastructure improvement. We're well aware and are working on it with OMB to make sure that all of our facilities are adequate. Building on the mayor's Get Covered initiative, which did a great job getting people insurance in the community, now we need to focus on those people who are in our hospital system and therefore didn’t realize that they were missing out on getting insurance because we had such an easy system for them that no one mentioned to them that

they could have the advantages of insurance which would work everywhere. We've increased the number of applications by our patients by 20% over 23,000 applications per month, and we anticipate that this is going to bring in 40 million dollars in additional revenue this year. I spoke about all of the work on billing insurance. We want to make sure that scare subsidy dollars are going to the uninsured, not to subsidizing insurance plans. We're on track to achieve over 200 million dollars in revenue, which I think a huge step forward, and the money has to go to patient care. To me, that's why we're here, and we have hired 40 new primary care providers, streamlined our operations, and reduced our wait time, so that today a new patient can get an appointment with a primary care provider within one to two weeks. We are working on making it easier to get specialty access through eConsult. While I think we're heading in the right direction, as the chairwoman mentioned in her overall remarks, there is a lot more to be done and I get that. I'm not here to sugar-coat anything. I think we've made together a lot of progress, but there's a lot more that needs to be done if the system is going to be as great as the

people in it. The great thing we have is amazing nurses and doctors and support staff who really want to do the right thing and who really see their daily practice as a calling, not a way of making money. We need to get EPIC completely implemented. We need to open up the retail pharmacies inside our hospitals. We need to get ExpressCare working in all our emergency departments. We need to streamline our transportation. But we've shown we can do all of these things. It's a question now of scale. We have successive concept on every one of these things. Now we just have to make sure that they're available everywhere. Of course, the federal government continues to pose risks for us. There is a potential of a large Medicaid disproportionate share hospital cut coming up in the fall. The president's budget not only maintains these cuts, but makes it much worse, with deeper cuts to Medicare and Medicaid. Fortunately, a large number of people in Congress have said that the mayor's additional cuts will not be allowed under their watch, but I appreciate how active this council is in advocating for our needs. We still await the fate of the ill Department of Homeland Security proposed public charge rule, which

we know could have a devastating effect on Health and Hospitals and even more on the health of our immigrant patients and neighbors. On the state side, the governor and the legislature are still negotiating the final details of the upcoming state bill. We're working with Greater New York and other hospitals to advocate for the dollars that we need and we will continue to work on that. I still, despite all of this, I come to work every day incredibly happy. There is no job I would rather have. I have a great group of people working with me and we think this is going to be a terrific year. We're happy and proud to play a role in the mayor's Guaranteed Care Initiative. We see it as a vehicle to build on the great work New York has already done, but really bring it to the next level, where we bring in people who are currently eligible for insurance but are not on insurance, and where we enable people who do not have insurance to really connect to a primary care doctor in a meaningful way. We launch this summer in the Bronx and I'm looking forward to hearing more from all of you as city council members and others about how we make sure that this program is a big success. I appreciate very much your

comments, Chairperson Rivera, on the program and we want to be good partners in working with you. So with that I'm going to conclude. I have my wonderful CFO with me. He's prepared to answer questions, especially of a technical nature. We have our managed growth expert on the new revenues, and our Dr. Patsy Yang, who so capably runs our Correctional Health Service, because we know there may be specific questions on that as well. So, thank you so much.

CHAIRPERSON RIVERA: Thank you. Thanks to the team for showing up today. So I wanted to ask a little bit about NYC Care, and what is the process, what's the process going to be like to determine one insurance to sign up for under NYC Care?

MATTHEW SIEGLER: So for us the important thing is to get people signed up. We don't try to specify what plan they choose. We do talk to them about the value of a public plan and public accountability, which exists in our in own MetroPlus. But ultimately people get to choose where they're going to sign up.

CHAIRPERSON RIVERA: You have projections, like an anticipated head count for how many people you think will sign up for NYC Care?

UNIDENTIFIED: As of right now we don't. I mean, currently we see about 390,000 self-pay patients a year. That's a large population of the uninsured and eligible around the city. We don't have a firm projection yet on how many people are fully disconnected to care, but we expect a substantial portion of that population to enroll in NYC Care versus just being a self-pay patient in our system. But we'll come back with more specific targets as we move closer to August.

CHAIRPERSON RIVERA: You said in your testimony you're going to start in the Bronx, right? And then there's, the roll-out should be complete by 2021? So what is the plan for the Bronx? What is the plan to, are you going to expand outpatient services and primary care services? Do you have an anticipation of how many organizations you're going to partner with who have these trusted relationships in their communities?

UNIDENTIFIED: Sure, this is very much the stuff we're working on. We started with working on how many new primary care doctors would be needed, how many new specialists would be needed, and trying to accelerate the eConsult in south Bronx. We want

to be good partners with the community agencies that have trusted relationships. We know that's especially important in the immigrant population and we will continue to work closely with them.

CHAIRPERSON RIVERA: Well, because summer is around the corner. So is there, are you going to include CBOs? I imagine you're working with the current council members in those respective neighborhoods. Do you have specific neighborhoods targeted? Are there, there's just a few details on the plan, so we could know what to expect when you roll it out in the rest of out neighborhoods?

MATT SIEGLER: Absolutely, absolutely. So I mean the care itself is based in our locations in the borough that we're targeting, right, so we're currently finishing up capacity analyses and projected targets reach those facilities for how many primary care teams, how many specific specialists in each location, which clinics in each location to prioritize eConsult in. In terms of outreach, we've started with bringing key citywide organizations and other city agencies with deep ties to groups in the neighborhood together, so MOYA, DOHMH, many citywide immigration groups have been advising us and helping

us in the process and the specific outreach and partnerships we haven't determined yet, which agencies we'll be working with or which individual CBOs on the ground. But I think the general message is that we will be reaching out to anyone and everyone who is interested and anyone who wants to spread the messages, as our materials get finalized and we have key dates where people can actually take action, we're cognizant of people's great interest in this, but we want to be careful not to say please come sign up for something when we're not yet ready to accept people. So we're staggering that growth as we go.

CHAIRPERSON RIVERA: So you're going to have every type of plan available, right? You're going to have all the information for people to kind of consume and understand and then make a choice. Correct?

MATTHEW SIEGLER: Certainly. So I think that the general process is we currently, every person who comes in who does not have insurance we screen them and try to counsel them to see what they're eligible for. If they're eligible for insurance we provide them a range of options for

which they can sign up, and if they're ineligible for insurance for whatever reason they can use our fee scale. That same general process will continue, although we'd like to use our call center and other options more to get people enrolled earlier. But instead of or in addition to enrolling with our fee scale people will have the option to enroll in the NYC Care program. So it's a program for people who are ineligible for or cannot afford traditional insurance coverage. But the general process of trying to enroll everyone in the coverage for which they're eligible will continue at our locations.

CHAIRPERSON RIVERA: Is there a plan for if people who chose to enroll in insurance that is not accepted at an H&H facility?

MATTHEW SIEGLER: Currently we, people have the choice to enroll in whatever they would like. We certainly let them know which insurance plans are in network with us. We do accept the vast majority of Medicaid and Medicare plans and many commercial plans around the city in our facilities. We don't accept everything because certain plans are not willing to offer us what we view as fair rates and terms. I would like to have everybody in, and I

would like to have everyone offer us fair rates and terms, but having that negotiating leverage and being willing to say no if someone is not contracting with us fairly is important to maximizing our revenue for managed care plans, but we certainly advise people these are the plans that are in network and for what you will receive a very low or no bill at all if you select this plan.

CHAIRPERSON RIVERA: In your testimony, Dr. Katz, you mentioned that 340 new nurses had been hired. I wanted to know if you could share a little bit about the nurse staffing model by facility.

MITCHELL KATZ: Sure. Well, we're trying to do our best to [inaudible] our model that works across all the facilities. So the easiest to follow would be in an ICU the maximum would be two patients to one nurse. That's what it should be. There should never be more than two patients to one nurse. Some patients really should be one-to-one nursing. On a floor it should never be more than six patients on a medical-surgical floor to one nurse. So as much as possible we're trying to do that throughout H&H. There are other categories, like dialysis nurse or MICU nurse, where there may be differences depending

on other staffing, but the goal is to get to that. I think in terms of staffing on paper we're actually like 95% of the way there. Where we still run into trouble is that one of the ways we staffed up rapidly, when we realized that this was an issue, was we hired a lot of nurses who were working temp for us and we thereby lost some of our temp pool and we haven't fully built back our temp pool. See, what you want is you want every day to go in with the right number of hired nurses and then use your temp pool for the person who calls in sick, so that you have a backfill. So right now we do run into situations where at the last minute someone gets sick, like it happens someone has a legitimate thing and we're not able to backfill fast enough because we don't have a large enough, flexible enough temp pool and we have some ideas about how to try to make the temp pool better. But in general, I think in 95% of the cases, we have the right model and if we would just have enough leeway now to be able to backfill I think we would be right, and in the 5% where we maybe don't have it right yet, this is an organization that never had staffing plans, so, right, like having established staffing plans is a huge step forward,

that in the 5% we're still working on places where we think that the nurse ratio is off and we're trying to fix it and hire those nurses in.

CHAIRPERSON RIVERA: The reason why I ask is because we receive, so we're all as a council trying to push people to, you know, enroll in primary care, and even go to our H&H facilities. Not everyone makes that choice, and I think there's a couple of reasons. One is we get a couple complaints about the wait time and staffing ratios, and it sounds like you're actively trying to address that. How it relates to I think the NYC Care issue is that system is so complex in term of health care provision that people I feel like are steered towards certain institutions because of the level of sophistication and services and some people actually really do trust their community-based organizations to get the information about where the best services are. And so as you're rolling out NYC Care and you are marketing H&H as not only facilities that are addressing staff-to-patient ratios, but that are also trying to address your infrastructure needs, because I also think like taking down the scaffolding at Woodhull Hospital is important for how people

actually see the facility. That's just my own personal mission that I'm on. But I want to know as you role out NYC Care how are you going to talk to people about H&H? Are you working with the community-based organizations? What is the plan and how are you reaching out and choosing who they are?

MATTHEW SIEGLER: In terms of choosing who the community-based organizations are, we're getting guidance from [crosstalk]

CHAIRPERSON RIVERA: I just want to say real quick, Matt, because these are the organizations that are working with the most vulnerable populations, and so I want to make sure that we're all working as a team here to bring that information as to you have a choice. However, you know, here's H&H, here are all the great things that they're doing, and they've been opening their doors to every single New Yorker since the beginning of time.

MATT SIEGLER: No, absolutely. I think the number one message is we would love your guidance and support on that. If there are groups that have not heard from us on NYC Care you think would be good partners for us in that, we need to know about them. You know, I think we have a robust community advisory

board process that feeds information to us and suggestions about groups we should be working with and partnering with. We have a quarterly stakeholders meeting that sees dozens and dozens of groups come in and advise us on different issues around the organization. Our partners at MOYA and DOHMH have deep ties into the community and are advising us on groups that we should partner with, but our door is certainly open and if there are suggestions and people we're missing we would like to hear about that and engage them. We want as many people out there speaking with trusted voices as possible. I think the FQHC community as well is a critical part of this and our engagement with them and assuring them that this program is not about breaking continuity with people's established primary care relationships. That's certainly a message we want to deliver, and we want other health care providers engaged with us and partnering with us on connecting people into this program if it's right for them.

CHAIRPERSON RIVERA: Oh, FQHCs will be integrated into NYC Care?

MATT SIEGLER: They will certainly be integrated into the outreach and in discussions around this, and we want to partner with people on referrals. The money itself for enhancing services at Health and Hospitals will not flow outside of Health and Hospitals, but that's -

MITCHELL KATZ: But it's [inaudible] that people gain insurance cognitive and use that insurance covering at the FQHCs, that's great. And that's additional dollars to them, and so there would not be any loss to any of the federally qualified health centers.

CHAIRPERSON RIVERA: I have a few more questions. But I do want to acknowledge all of the people that joined us. I realize I hadn't done that. Council Member Eugene was here, Maisel, Council Member Moya, Council Member Ayala, and of course Council Member Levine, and Council Member Levine has a question, a number of questions. And Council Member Reynoso was here, just the whole team.

COUNCIL MEMBER LEVINE: Thank you, Madam Chair, for your outstanding leadership of this committee and of this hearing so far, and it's wonderful to see our friends from H&H and Dr. Katz.

I want to tell you how pleased we are with your first year and that of your whole team, and I've gotten to know Matt very well. You've managed an incredible feat in containing costs and improving the financial health of the institution, while also improving patient outcomes and doing it without laying off any of our critical staff. That's not easy to do, and I know it's a work in progress, but kudos to you for big progress in your first year and to your team.

MITCHELL KATZ: Thank you.

COUNCIL MEMBER LEVINE: I am extremely excited about NYC Care. It's a vision that I share and I just want to make sure that it's implemented in the best way possible. This is our one big shot. I want to first make you aware that because the program has occasionally been described in really grandiose terms, sometimes such as New York City is guaranteeing health care for all its people for the first time for a city in America, that for groups on the ground that are enrolling people now in the exchange programs there's a communications challenge, because people sometimes think there is something out there that the city is about to offer. They're confused. They think it's something like single-

payer or a public option is better than what is available on the exchange, and we get calls into my office of people asking where they can enroll in the new single-payer health care system in New York City. I just think it's important that we describe this in accurate terms, and I haven't heard any of you do otherwise, but it is a challenge out there right now that I hear from people who are on the ground. I do think it is critical that we are focused on undocumented New Yorkers and it's imperative that we find a way for them to come in for primary care. I know you share that goal. You all have made that happen in at least two other cities already, and we need to do it here in New York City. As we have spoken about IC, our wonderful network of nonprofit FQHCs as being so critical, particularly when it comes to servicing immigrants. They're on the ground in immigrant neighborhoods. They have multilingual staff. They have cultural competency. Some of them have leadership that's drawn from the same immigrant communities and they've built up that trust, and many are now serving significant numbers of undocumented immigrants. Now, there's a lot of challenges in doing that in the Trump era and it's getting harder

and harder to bring in those patients, as you are well aware. But they nonetheless represent an important part of the broader health care system of primary care to immigrants in this city, and as I understand the way you designed these programs in Los Angeles and San Francisco and the way it was designed in New York, and the wonderful pilot of Action Health back in 2015, they were integral in really the majority of the on the ground providers, or these nonprofit FQHCs, and as I understand it they are not currently built into the plan for NYC Care. I understand that you're working with CBOs for outreach and information, which is very, very important. But in terms of actual medical services on the ground, I understand they're not part of the plan as envisioned, and I wonder if you could explain that decision and implications of it as you see it.

MITCHELL KATZ: Well, first, thanks for all your positive comments about the importance of caring for this group of people. It is true that NYC Care is not the same as Healthy San Francisco and it's not the same as the LA program. Each city is different in its characteristics, and so whatever program we do, my hope for here is not that it will

replicate Healthy San Francisco or LA Care, but it will be the right thing for New York City. And that's our focus. I think you've well characterized it that our goal is to work well with CBOs, but to date there isn't a fund of money towards CBOs for care. We do [inaudible] that outreach is a different issue, but for the care itself. Certainly, from my point of view, that doesn't disadvantage FQHCs in that currently if the person has Medicaid or some form of other insurance, they'll continue, my assumption is, they'll continue to go to that great place and I would never want to disrupt that in any way, if they are undocumented and they're currently going and that clinic is currently not receiving any reimbursement for taking care of that person. In this scenario then you're better off than you're worse off. One way I want to immediately make the patient better off that I think is a good model is part of what the money is going to is to expand the capability to do eConsult. So one thing the FQHCs can't do is specialty care. Not their fault, that's by the mandate, that the enhanced Medicaid is for primary care, and it's very challenging right now for federally qualified health centers to get specialty

care, especially for patients who are undocumented, and they can try to call around and plead with a doctor to see them, or they can send them to H&H, but there has never been an easy way to do that. So then it's turned out into sending the patient to the ED, which is clearly the wrong way to do it. So, I m mean, I think that's one concrete thing that we can do with the FQHCS.

COUNCIL MEMBER LEVINE: Right, but, I mean, first off, there is a risk to them in that they could lose some patients to NYC Care and presumably it will be marketed and maybe even one day have subway ads and other things that could draw people in, so there is something of a competition there for patients, and particularly also for staff. But as for your point about the cost, I assume that their cost of service is no higher than yours, maybe it's even lower, I don't know. But you're at capacity in your primary care clinics. So you're going to have hire new staff and you might even need more space to rent. I don't know. Why is that any more affordable than expanding the capacity at some of the FQHCs, some of which actually have slack resources. Some of them are really maxed out. But some of them could

take more patients, probably, without having to hire up.

MITCHELL KATZ: Right.

MATT SIEGLER: So that the, the theory, and this certainly came up in the discussion. Often it was posed as how could you with a hundred million dollars, you know, provide so much care, right, and the only way that the money works is if you accept that a lot of the cost of caring for the people we're talking about is already in the H&H system, just in the wrong place. It's in the emergency room, it's in the admission that lasts too long because the person waited too long because there was no way for them to get in. I mean, a hundred million dollars, if you start dividing it among, you know, visits doesn't go very far. So the idea was that if in fact we're able to provide better then the dollars would flow. If the city were to make a decision to try to, you know, more pay for visits you would need a larger sum of money.

COUNCIL MEMBER LEVINE: Absolutely there is, there is cost savings and when a patient lands in the emergency room that's the first line of defense. It's terrible for their health. You're much better

off to see them preventatively, and of course it's more expensive. But you would realize that saving anyhow, if a person gets their preventative care in an FQHC and a nonprofit and avoids an emergency room visit, you still realize a savings.

MITCHELL KATZ: But I'm not allocating money.

COUNCIL MEMBER LEVINE: But there'd be a spend and a save. But from the interest of the city it could be in that, in that [inaudible]

MITCHELL KATZ: And, again, you know, these are all good models and there are a variety of ways to do it. I think what the, what I'm thinking, and again a hundred million when it comes to delivering care is not a huge number. The way I think about it is there's going to be a savings, yes, but I'm not sending the money out. I'm keeping the money to make the existing system work at the level that I want it to work. And if I send some the money out then I'm not going to be able to make the existing system work at the level that I want it to work to be able to deliver a higher quality product. But maybe there are other ways that in working together we can effect a program.

COUNCIL MEMBER LEVINE: This is a longer discussion, which I want to continue to have. I would actually advocate, even if it costs more, to expand. Maybe that doesn't come out of H&H's budget, maybe it comes out of the city's budget more broadly, but I think it would be a wise investment to be in as many places as possible, to reach as many immigrants in the most welcoming and culturally competent environment possible. But I look forward to continuing that discussion with you.

MITCHELL KATZ: Absolutely.

COUNCIL MEMBER LEVINE: And I'm going to pass it back to the chair now, and appreciate the time.

CHAIRPERSON RIVERA: Thank you. Thank you so much. I think what we're worried about is that these FQHCs will lose patients who aren't ensured, and we want to make sure that wherever a person goes, if they enroll in this program that they're going to be access either services or programs that they have consistently depended on in the past, or if they decide to find a primary care physician or become a frequent H&H consumer that this is, the choice is theirs and that, again, there won't

be a confusion in what I feel is a very, very complex system. I think that this program was announced in very good spirits to do the right thing. It just added one more layer of nuance that I think it is going to be a little bit difficult to explain to some folks. We want to be helpful, so that's why I am kind of asking with this roll-out in the Bronx, you know, any minute now, we certainly want to make sure that people who call our offices get the right information as to what their choices are.

MITCHELL KATZ: Thank you.

CHAIRPERSON RIVERA: So I, in my opening statement I mentioned the LGBTQ community and I wanted to know based on some of the testimony that we've heard from the public, we had had a hearing, Council Member Levine and I, specifically on LGBTQ services, specifically on transgender care, nonconforming care. How many staff has actually been through an LGBTQ training, in terms of understanding that sort of cultural competency?

MITCHELL KATZ: Well, John is going to look for that number.

CHAIRPERSON RIVERA: OK.

MITCHELL KATZ: Let me just say, having worked for three systems, including San Francisco, this is the first system that ever handed me an LGBTQ T-shirt to wear with the H&H moniker on it, which I have. This is the first one that ever invited me to an LGBT evening event to celebrate the members. And it was full of both, you know, LGBT members and, you know, straight friends, you know, which I've never seen. This is the only of the three systems, all of whom have large LGBT populations where there is a clinic at Metropolitan that does gender-performing surgeries, and I myself did the training and the training was not available in LA or in San Francisco. Now, that being said, like everything else, there is room for improvement and we are a, you know, 43,000-employee organization. And I certainly, you mentioned implicit bias, right, I mean, there is still, you know, I can say as an openly gay man, I mean, I've had, you know, been called things in recent years, I mean, there still remains bias in our system. I don't, I do think that, and again, not because of things that were done before I got here that, you know, Health and Hospitals has made consistent with this city's council's leadership

really great efforts around the training. I'm sure we could do more. Do we know the number?

MATT SIEGLER: The number of unique staff trained is 16,264.

CHAIRPERSON RIVERA: OK. We also spoke a lot about having a liaison to the TGNC community. Has there been any update on that discussion at H&H?

MITCHELL KATZ: Ah, starting on Tuesday we're piloting a new LGBTQ outreach program and hiring three community outreach workers. They will be based at our Pride Health Centers and we'll work closely with our central office to do this work.

CHAIRPERSON RIVERA: Well, they're called community outreach coordinators?

MITCHELL KATZ: Community outreach workers is the general title. We could come up with a snappier title together, but I think that's, that's...

CHAIRPERSON RIVERA: I just wanted...

MITCHELL KATZ: ... a personal system, up.

CHAIRPERSON RIVERA: Yeah, it doesn't have to be snappy, just, oh, it's, as long as people understand it is where I'm come from.

MITCHELL KATZ: Sure, of course.

CHAIRPERSON RIVERA: OK, community outreach workers. And were you working with some of the activists and the groups that were in the room who had made this a platform? This is one of their major campaigns, a number of people who were here that day.

MITCHELL KATZ: Yeah, I mean, I recall I think the first hearing we were act an activist spoke about this. We immediately got her a car, put her in touch with Matilda Ramon, who is our fantastic chief diversity inclusion officer. I think we've been approached actually by national organizations to help with training around this and modeling what large systems should focus on in this work, so it's an area we're very proud of and any way we can improve I know Matilda will take the lead on with all of our support.

CHAIRPERSON RIVERA: That's great. Well, I will follow up with them and see how it's going, because I know this was a really big deal. So I appreciate that you're trying. I wanted to pivot a little bit to Correctional Health Services and also mental health services and how they're related.

Before we do that, I want to turn it over to my colleague, Council Member Moya.

COUNCIL MEMBER MOYA: Thank you, Madam Chairwoman, and thank you all for being here. Just a quick question. I know that you talked about some cuts that we're looking at in terms of full-time employees. How many of the full-time employee positions cut were HHC employees and not consultants? Is there a breakdown for that?

MITCHELL KATZ: Well, ah, John looks for that. Let me thank you for your help for Elmhurst Hospital with the financial support, including the ED. We really appreciate.

COUNCIL MEMBER MOYA: Oh, thank you, thank you for that. But they do great work there and they deserve it, so.

MATT SIEGLER: Just a breakdown on the staff reduction from our, measuring from November of '18, right, our current...

COUNCIL MEMBER MOYA: Right.

MATT SIEGLER: ... staff complement is 44,835 individuals, so we're down from November of '18 of about 4500 staff. Of those, right, 1400 are in the temp position, which is about a cut of a third

of our total temps. So that's basically where we've kind of focused the reductions over this period of time, as Dr. Katz has mentioned, was really in the areas nonclinical. There were some pretty substantial reductions there, as well as in, you know, contract staff, we don't really measure contract in terms of FTES, but we measure it in terms of...

COUNCIL MEMBER MOYA: But there's a breakdown that we can look at of how many full-time employees were cut from HHC...

MATT SIEGLER: Yes.

COUNCIL MEMBER MOYA: ... as opposed to the consultants?

MATT SIEGLER: Yes. I, I...

MITCHELL KATZ: We'd be happy to provide that. I'll give to you and your office.

COUNCIL MEMBER MOYA: Great, thank you.

MITCHELL KATZ: 230 managerial position.

COUNCIL MEMBER MOYA: OK. And you said those were through attrition and retirement, or what?

MITCHELL KATZ: Yes. Well, the temps not.

COUNCIL MEMBER MOYA: Not the temps, but the full time.

MITCHELL KATZ: Any of the full-time positions except managerial were the attrition.

COUNCIL MEMBER MOYA: Got it. And the projected savings for fiscal 2020 and beyond through scaling back staff, do we know how it equates to how many jobs are being scaled back or cut?

MATT SIEGLER: Yeah, as I said, from...

COUNCIL MEMBER MOYA: And again how many of those are, would be actual full-time employees versus contractors.

MATT SIEGLER: Yes, we have all those breakdowns, right, we have it by full-time, temp, as well as type of position, right, so we can send you a schedule of that.

COUNCIL MEMBER MOYA: If we could just get a look at it.

MATT SIEGLER: Yeah.

COUNCIL MEMBER MOYA: That would be helpful. Thank you, thank you very much. Thank you, Madam Chairman.

CHAIRPERSON RIVERA: Well, thank you. So I just want to follow up, Council Member Moya

mentioned the cuts and things that you were doing to address the deficit and increase revenue and all the things you are doing to improve the system overall fiscally. In terms of what you mentioned last year, you had mentioned, um, really looking at the space inside of the hospitals to repurpose it and everything that was under-utilized to look at it in a different way. What is, specifically you had mentioned Metropolitan Hospital. So can you give us some examples of what you're doing to look at how we can be smart in terms of our financials?

MITCHELL KATZ: Sure, well, thank you. Well, let me start, our biggest success, and I'll ask John if he has the numbers was that we are markedly decreasing our administrative space. I calculated how many administrative FTES we had, how much we had, how much space did one need for that amount of administrative staff, and I think it was a 25% reduction in our managerial square footage. So we overall 50 million-dollar savings as we're going into a new building, we're taking all of the separate offices, putting in the same building. We'll no longer have to manage a van, which is good for the environment, save us additional dollars. So that's

been our most, our greatest success, is shrinking our administrative thing. I'm looking at the space. I think that it's bad for a variety of reasons to have empty space in hospitals. It is more challenging than I might have initially thought. The rules are tighter here in New York than they are in California about reuse of buildings. We've had some nice things about land. So like we have some great collaborations with communal life in Kings, the building supportive housing on land we own, and that seems pretty easy. What's turning to be harder is what the expense of converting existing floors, so like specific to Metropolitan, and I apologize if this is too much detail you'll waive and if it seems like the, like, for example, I was looking at a ward. OK, could I make this into respite, or, which is a need, and I could do that with communal life. The basic, the rooms themselves work beautifully, two-person rooms with a bathroom is actually perfect. The problem comes in that in order to license it you have to have, and you should have some common space, right, this is not a hospital. People shouldn't have to stay in their room. You need a dining area. But the cost then of creating the dining area is huge

because of the cost of renovating in a 1920s hospital where once you open up the walls you hit every single code upgrade. So you're basically allowed to keep maintaining everything as long as you don't touch it. But if you touch it, and what seems to me to be even, you know, as a non-architecture person, small ways, it invokes every single code and so you wind up with a cost that is astronomical. So I haven't by any means given up on this, and I don't mean this to sound like excuses, but it turned out that the bigger immediate opportunity was save 50 million dollars and shrink our administrative space, and now we're more slowly going through each facility. The first one we actually did was NCB, looking at, you know, how, and the answer is in NCB you could rearrange things to have a lot of empty space for new uses, but it would be very expensive to rearrange things because they're all on different floors. So there aren't empty floors. What there are essentially is half-empty floors. And so if you want to create the empty floor for the respite for the, you know, I've thought about residential mental health treatment, to empty the floor you have to move the part that is there somewhere else and that is where the expenses start

getting great and it's complicated. So I'm going to keep at it, and I'm open to...

CHAIRPERSON RIVERA: You can, we love the vision...

MITCHELL KATZ: ... ideas.

CHAIRPERSON RIVERA: We thought the vision was smart. So you're saying that you feel a little bit, um, I guess bound or restricted by coding regulations of New York City on I guess just overall our, I don't know, obsession with real estate and how we repurpose it.

MITCHELL KATZ: I don't want to get, even that sounds more negative, you know, I'm not, I always like to look at the upside of things.

CHAIRPERSON RIVERA: And I appreciate that.

MITCHELL KATZ: I would just say that we found an opportunity that was fast and yielded a lot of money, and so I put my energy into let's get the 50 million. I think now having done that I want to work on some of these others, some of these other opportunities, and that they're harder, but I like hard things. The fact that it's harder doesn't mean that there, it just means that we have to get smarter

people and I am planning on bringing on some additional resources around capital, because I think that would make a difference.

CHAIRPERSON RIVERA: OK, and again our offer stands is that we want to be helpful with capital. I mean, I think that when it's a public system, and I say this about public housing, public health systems, and public transit, I think that we have to do our part and this is all general infrastructure. So we want to be helpful to you. I am going to ask you about the new facilities, um, that have been mentioned for in terms of correctional health and those with mental health issue. But before that I know that my colleague has another question. Council Member Levine?

COUNCIL MEMBER LEVINE: Thank you for indulging me. I do have one more question related to the nonprofit health centers, which is actually not specifically arising from the NYC Care plan, but the broader goal, which I think you share, about better integration, particularly for referrals to specialty care, which I know you're working on expanding capacity among specialties across the board, including for your own internal referrals, and I know

you've upgrade your computer systems to perhaps allow that to be more seamless and efficient, and I wonder to the extent that you hope to make progress for outside entities like community-based health centers who need to refer into the public hospitals, these are patients who can't afford the more expensive voluntaries, they're coming to you, but if a local clinic needs to refer to a specialist it can be very difficult for that clinic to know was the appointment made, did the individual show up for the appointment, is there any follow-up information. Can you talk about that challenge and what strategy you might have to help improve that?

MITCHELL KATZ: Yes, well thanks for that. So yes, that's exactly what I would like to do, and we did this in LA. So it's entirely doable. And we did it on our low-tech platform, because it has to be a low-tech platform because every clinic isn't going to have EPIC and they shouldn't have EPIC, it's not the right product if you're running a community-based center. So the idea would be that you would have on a simple ISP, internet service provider line, be able to send in a referral and have that patient be seen and assigned a number, and you

would get back sent the report, and because my doctors have no financial incentive to see more patients they would actually send the patient back, right. In some cases specialists don't want to send the patient back because they have a financial, ah, benefit from continuing to see the patient. So I think we have all of the right things, ah, and this technical solution can be done. My view is that a federally qualified health center should, their referral should go with the same way any of my referrals would go in the system, and that's how it was in LA. We had no distinction between the federally qualified health center referral for specialty care and one of our county hospital referrals. They all go through the same platform. They all get seen by need, not who you're doing it. So I think, and I think that that would then, it would so relieve the FQHCs, because imagine, you know, you take great care of someone and the woman develops a lump on her breast, right, you can examine the woman, you can do the mammogram, but then you have to find her an oncologist willing to take somebody with no form of insurance. Not something that's going to happen. So then, I mean, I think

what people wound up doing is sending them to EDs with notes, right, and that's totally wrong, right, so I think this is one of the most productive things we could do. And I think everybody would like it.

COUNCIL MEMBER LEVINE: That is great to hear. And lastly could you speak about your plans to improve the pharmacy network within H&H, because presumably for undocumented immigrants who are coming in to primary care through NYC Care they're going to rely on your pharmacies because they're not going to have insurance, they can't go to Rite-Aid. But your pharmacies are fairly limited in ours, and maybe in some other ways. Could you talk about your plans to either grow the hours or the number of pharmacies or other services in that that?

MITCHELL KATZ: I appreciate that, and you know that is one of the major enhancements. I mean, it's great to say that we take care of everybody, but what if you get an antibiotic prescription on a Friday night at 9:00 p.m. and you have no way of paying for it? I mean, just in the short time that I've been here I've seen people at Gouverneur, both I would say insured because of co-pays and uninsured who were seeing me as a drop-in

and when I'm like why are you here, they would say well I went to the ED, I got this prescription, but then I couldn't afford the sixty dollars for the inhaler, so I never paid for it. Never got the medicine. Happens all of the time, and again not just uninsured patients, right, because you have insurance but they tell you sixty dollars for the co-pay. Well, a lot of people don't have sixty dollars for the co-pay. So we have to have what, the capability to deliver prescriptions in the evening, on the weekends, and we will. I think we'll probably, either we're still working on the solution, in LA and San Francisco I did it through contracts with 24-hour pharmacies because it was just easier to say, you know, during these hours when we're open you go here and during these hours you go there. We're not going to be able to, we don't have the scale for 24-hour pharmacy for outpatient. But, yes, that's, I see that as one of the key improvements to the system.

COUNCIL MEMBER LEVINE: Thank you, and thank you, Madam Chair.

CHAIRPERSON RIVERA: Thanks. So I wanted to ask, and thank you for being here, Doctor, I know

we've been here quite a few times and we're trying to really be supportive of the correctional health services that exist, and there was a recent article in *The City* that said that CHS put out a call for what is being called therapeutic housing units, and that these locked facilities would be located in or near three to six existing city hospitals. So I wanted an update on that in terms of which hospitals would they be close to, how is that selection process going to be made?

MITCHELL KATZ: Talk about the clinical part and then let me talk about the hospital part, if that's OK.

PATSY YANG: Thank you for your support, always. Yeah, in the jails right now we have therapeutic housing units, um, Pace is an example for people with serious mental illness. We have units for people who have substance use disorders. We have units for people with complex medical conditions, like a diabetic unit. And we know that these are efficacious. Patients do better on these units. Our staff do better and are able to provide care more easily and a more continuous basis, and reduces the demand on DOC to produce patients to us. At the same

time, we realize that there was a sort of a gap in, or an area, a group of patients for whom their clinical needs, they're not sick enough to hit that clinical threshold to warrant inpatient hospitalization, but they also have frequent and sustained need for specialty or subspecialty services. And so the concept there was that we could actually improved access and quality of clinical care if these therapeutic, if we could establish therapeutic units for certain classes of patients with medical, mental health, or substance use health concerns closer to the speciality and subspecialty services that they need. We're, that is the concept. It's all about clinical care and improving quality and access. You know, we're in the very, very preliminary stages of even exploring the feasibility of whether this concept can fly, and that's what that is, and no facilities have been identified that's not state-owned. I don't think that they are actually specified that, we don't even know that this can work at this point in time.

CHAIRPERSON RIVERA: And you did, you sent it to nine preselected vendors, I imagine with

whom you have a relationship? That's what was reported.

PATSY YANG: We just put out a solicitation and responses came in Friday afternoon, close of business. There was a preliminary review and there are some questions back and forth. It goes between with a potential consultant who would do the feasibility.

MITCHELL KATZ: One of the reasons I signaled to Dr. Yang that I wanted to answer the question about the hospitals is I want to keep everybody's roles very clear. Dr. Yang and her chief medical officer, Dr. Ross McDonald, are amazing advocates for incarcerated people and that's what I want them to do. I also recognize, and it's already been bubbling around, that there may be people in New York City who are not in favor of public hospitals housing people who were previously incarcerated, and land use, being back here just fourteen months, I can see how complicated land use issues are in New York City and I want them to stay focused on what is best about patients, and I want to myself with you and the other bodies do the, you know, community work around whether or not this is, you know, acceptable to New

Yorkers, and you're much more experienced than I am to know what will work in New York and not, but I haven't, we haven't committed to any specific hospitals. Again, I would say there's no question the therapeutic model is right, that this would be a great therapeutic model that would make both the delivery of care better, it would decrease security issues on moving inmates back and forth. It would be a better therapeutic experience. But I need to, you know, know from the council, from the mayor, from others as this rolls out, you know, how people feel about these kinds of issues and what the process would be for making a decision on where one would locate these and whether that's acceptable to the surrounding community.

CHAIRPERSON RIVERA: Will they be similar to the beds that exist at Bellevue and Elmhurst?

MITCHELL KATZ: Well, the beds, they're similar depending on how you, yes, but not exact. So Bellevue and Elmhurst are people who have to be at an acute care level. There's just no way they could be managed at Riker's, you know, and so if somebody would need acute care as an outpatient then if they're in jail they should be in an acute care

facility. That's pretty simple and that's why in a sense you can't argue it, although occasionally state prisons will build acute care units in their jail. But you can't argue the level of care, it has to be that. Here we're talking about people with intense health needs. But they're not actually at the acute hospital level. But they maybe need to seeing by specialists, you know, twice a week, say, or so that in an outpatient, I mean, I have outpatients who have to come twice a week because of their serious illnesses. But you can imagine what that's like in jail, right? You'd have to go twice and transports are not easy from jail, right, they're multi-staged, they can involve long periods of time with people in essentially pens. It’s a very difficult model to deal with the people who, you know, need a lot of care. So it's similar. A lot of care, but it isn't acute level.

CHAIRPERSON RIVERA: Inside some of these facilities are you facing any barriers hiring for CHS?

PATSY YANG: For inside in the current system? No, you know, we experience the same shortages that exist at least citywide, if not

statewide, in terms of psychiatrists. There's no question that the jails are a challenging place to work, but equally on the flip side of that, particularly since Correctional Health Services came over to Health and Hospitals, it has attracted people from all over the country, the world, who want to, who are very committed to the mission, very committed to providing care to this population, which is for whom the morbidity, the level of pathology is tremendous and they really want to make a difference. So we're delighted that we have been able to recruit and retain people who want to do this work with us.

CHAIRPERSON RIVERA: So what's the vacancy rate?

PATSY YANG: I think it's about 10%, it ranges depending on what the discipline is.

MITCHELL KATZ: But you have no barriers, right? No, I haven't...

PATSY YANG: Oh, that's true.

MITCHELL KATZ: There's no like...

PATSY YANG: No.

MITCHELL KATZ: You're not under a hiring freeze...

PATSY YANG: Right.

MITCHELL KATZ: Right. Ah, Dr. Yang can hire all of her positions. But, as she says, all of us struggle around psychiatrists. There are certain positions where there's just a sheer shortage and so we struggle with hiring them.

PATSY YANG: Yes. There's not logistic or financial barrier to our filling our staff.

CHAIRPERSON RIVERA: For the population with mental health issues how is the correctional staff and the officers, how are they being trained? I realize that there's been a lot of discussion around Thrive, and I know that Thrive does not staff the city jails. But they do provide therapeutic programming and currently their claim to fame is the Mental Health First Aid and the training that is being provided to a number of people. What I read was that Thrive had successfully trained 7000 correction officers in mental health first aid. Is that accurate, and what is that training like?

PATSY YANG: What I'm aware of is that what Thrive does do is support crisis intervention training for correctional officers and our staff. So we're trained together to work as a team to do de-escalation rather than, um, letting things continue

to rise and escalate, and that ends up with pro teams coming. So we do train with DOC. Thrive does support that, to work better with patients, manage situations that are getting out of control or could get out of control and take the temperature down.

CHAIRPERSON RIVERA: So the number, it hasn't been Mental Health First Aid that's been specifically implemented inside the Correctional Health Services?

PATSY YANG: I believe the Mental Health First Aid is a different issue, um, that is on us. I don't know.

CHAIRPERSON RIVERA: OK, I'm going to check on that. That's what I read. I wanted to ask about some other initiatives that are specifically for the women in Riker's and if you have any update on some of the metrics as to the success. So how are these, the following programs going? The opioid treatment program?

PATSY YANG: That is running gangbusters. We run the largest medication-assisted treatment program in jails in the country and with the additional funding that we receive we've been able to, actually, I think, quadruple the number of

people. On any given day we have over a thousand people in MAT in the jails. It's tremendous.

CHAIRPERSON RIVERA: You have a thousand people daily in the system...

PATSY YANG: In treatment.

CHAIRPERSON RIVERA: In treatment?

PATSY YANG: Yeah.

CHAIRPERSON RIVERA: OK. What about the number of patients receiving hepatitis C treatment?

PATSY YANG: That's also going very well. We requested a five-million-dollar funding source and we have exceeded our targets. We quadrupled the number of people who are actually initiated on hep C treatment in the jails, which is a very high number, because it's an opportunity where we are able to see them, diagnosis them, and have the opportunity potentially to cure them while they're still in custody. And for those few patients who end up being released before they complete treatment we have linkages with Health and Hospitals facilities in the community for completion.

CHAIRPERSON RIVERA: So you said you exceeded your goals. What were the goals? I'm sorry.

PATSY YANG: I think it was like 90, I can get that to you.

CHAIRPERSON RIVERA: Will you find out? That would be great.

PATSY YANG: We're having, we're yeah, yeah...

CHAIRPERSON RIVERA: What about the Substance Use Re-Entry Enhancement Program?

PATSY YANG: Sure, sure. So, um, we do discharge planning for various groups of people, this for people who are actually enrolled in, choose to enroll in one of our substance use programs, those already have discharge planning for people when they are getting released to jail, from jail, to community treatment providers and SURE is really sort of the safety net that wrapped around for people who do have substance use issues but chose not to be an active program enrollee in a formal program.

CHAIRPERSON RIVERA: So you have a number of programs that, the reason why you're saying is that not only are they being utilized, you're seeing a tremendous amount of people, and I wonder about the resources, so that way you could not only meet and exceed your goals, but set even a higher, more

ambitious goal going forward. And so I wanted to go back to Thrive for a second. So I wanted to know, in terms of the role that thrives plays in providing care for mental health citywide, considering that it is Health and Hospitals that takes care of the most acute mental health patients, do you think that more of the funds around Thrive could be used in H&H in any Correctional Health Services specifically?

PATSY YANG: I think Thrive has been really helpful to us to be able to extend creative arts therapy and some substance use and mental health screening to the youth, both now at Horizons since October 1st of last year [inaudible] 17-year-olds and then the 18- to 21-year old. But, you know, we also do so much more and had done so much more, and we'll continue to grow our services.

CHAIRPERSON RIVERA: So you see that Thrive is doing the therapeutic creative arts programming. I also read that they're doing psychiatric assessments and substance use prevention for all young adults currently housed on Riker's Island.

PATSY YANG: That's correct.

CHAIRPERSON RIVERA: OK. So with all of that, what I want to make sure is that you have all the resources that you need and I know that we're going to be talking about Thrive a little bit more in depth tomorrow at the Committee on Mental Health Services. So I just wanted to get a better idea and specifically more funding for acute care, and the reason why I ask is because recently, you know, there was the Allen Pavilion of the Presbyterian Hospital that was going to close and that was an elimination of behavioral health beds, and so I, with certain hospitals actually decreasing the number of beds to serve some of our mental health, um, some of our New Yorkers with mental health issues, I want to make sure that the funding is going towards the programs that are actually working. So when you're saying, Dr. Yang, that it is like gangbusters, I want to make sure that you have every single dollar that is available by the City of New York to do what you do best.

PATSY YANG: We think we do, thank you.

CHAIRPERSON RIVERA: Oh, OK. So let me ask a little bit about the capital plan. So we are looking at, we talked a little bit about pharmacies,

we talked a little bit about urgent care, and so I wanted to know if there was a price, a plan to price out the urgent care facility that people are asking for at Gouverneur? Or in lower Manhattan?

MATT SIEGLER: I can speak to that. I don't think we have a specific business plan or capital require on that ExpressCare currently. We're certainly looking at it. We've heard from members of the CAB that it's of value. The first two places, as I think you know, we rolled out ExpressCare are Jacobi, I'm sorry, Lincoln and Elmhurst. Jacobi will be next. Those are three of our busiest emergency departments and the theory of the case there really is to make sure people who are, you know, waiting in the ED a long time or going to the ED for things they do not, or are able to go to a different location. I think Dr. Katz practices at Gouverneur, you know, they are able to see people on a outpatient basis fairly well. But if there's a demand in the community we'll certainly look at it. But I think that busy ED nexus is the first place we looked.

CHAIRPERSON RIVERA: I mean, I would ask for you all to, I mean, I know that's where you still practice, I mean, this has been an ask in the

community and I want to just make sure that we can look at that seriously. It is, you know, it is a very densely populated area. I know that, I represent lower Manhattan, so I seem a little bit biased. But when we're looking at the urgent care facility and how this transformation of health care and its provision I feel like that's probably the model that we're going to be going towards more. I mean, how is going at Elmhurst?

MITCHELL KATZ: We've had big success in both places. So, yeah, I mean, I get in, Gouverneur would be a slightly different model, right, because there's no existing ED in Gouverneur. On the other hand, I agree, Gouverneur is an incredibly vibrant center and it's helped by the fact that unlike some of our centers it's a modern building where the building facilitates the care, right, you don't have to do work-arounds, right. It looks nice. It makes people feel good. In fact, many, many people are surprised that it's a public facility, which is a sad comment, right, because our public facilities should be beautiful. But Gouverneur actually is. So I myself heard, I didn't know about the urgent care and I'd be happy to look at it as a potential model for,

you know, we could also, ah, it could be a way of getting people into primary care. All right, that's a good one. Do they have space, was there a specific spot at Gouverneur that people were thinking this would be at?

CHAIRPERSON RIVERA: You know, so when I was there someone said there's space for it right by, um, it's not, I can't think of the street, one of the side street, not Madison. I can check for you. But people have said that it would be a really great location for one and I want to be helpful. So we can talk about it.

MITCHELL KATZ: I'll look around and if you find out please tell us.

CHAIRPERSON RIVERA: I will, and again I'll echo what you said earlier. I'm not the architect here, but I'm good at implementations, so I'm going to...

MITCHELL KATZ: Good, well, that's what we need.

CHAIRPERSON RIVERA: ...take the idea and I'm going to run with it. OK. I wanted to ask a little bit about in the capital plan, specifically in the preliminary fiscal 2020 capital plan information

systems only has funding through fiscal year 2022. Is that the anticipated complete of EPIC and its rollout?

MATT SIEGLER: Yes, yeah.

CHAIRPERSON RIVERA: Yeah? OK, that's great. Also, I wanted to ask why doesn't Major Medical Equipment anticipate having any costs after fiscal year 2021?

MATT SIEGLER: I'm not exactly sure about that. I can look that up.

MITCHELL KATZ: OK, we'll have to get back to you on that.

CHAIRPERSON RIVERA: OK, and in terms of Kings County Hospital and the major reconstruction, is that all said and done, the reconstruction at Kings County Hospital?

MITCHELL KATZ: I'm sorry, is also a?

CHAIRPERSON RIVERA: Is it done?

MITCHELL KATZ: Is it done?

CHAIRPERSON RIVERA: Yeah.

MITCHELL KATZ: No, I think there's going, there's going to be ongoing work there around the emergency department and as we look at an

ExpressCare there as well there will be some construction work associated with that.

CHAIRPERSON RIVERA: You know, in Brooklyn there's been this big move in terms of funding not just the hospital there, the hospitals there, but the medical programs and services, and so I don't have any colleagues here from Brooklyn right now, but I know that it has been a very, a major, major movement to fund the health care facilities there and so I don't know if you have any specific updates on some of the capital projects there, but I would love to check in with you all about some of the capital projects that are going on in Brooklyn and how that funding is being utilized.

MITCHELL KATZ: Right, let's do that.

CHAIRPERSON RIVERA: OK, great. So I did have a question. I saw recently an article about malpractice and I wanted to know about the anticipated malpractice payout for fiscal year 2019.

MATT SIEGLER: Um, I don't have 2019, but I do have data going back from 2002 to 2018, [inaudible] precipitous decline over that period.

CHAIRPERSON RIVERA: You said 2018?

MATT SIEGLER: Yeah.

MITCHELL KATZ: Usually you have to wait a certain amount of time because of the way courts work, so.

CHAIRPERSON RIVERA: I'm sure, I'm sure, but do you have the numbers for 2018? You said precipitous decline?

MATT SIEGLER: I do, I do. So it peaked in 2003 at almost 200 million dollars and FY18 it's on a decline to about 110 million dollars. The number of cases is somewhere between about 150 cases in 2018.

CHAIRPERSON RIVERA: Are these numbers published periodically?

MATT SIEGLER: I'm not sure, but we could certainly make those available.

CHAIRPERSON RIVERA: What's the process after a wrongful death?

MITCHELL KATZ: The process, so any time anything bad happens at a hospital, any hospital, there is, the medical staff by the rules of Joint Commission has to initiate a root cause analysis, where the case is reviewed and we do the same thing. We are trying, and I think this is a very positive movement across health care in general, not just H&H,

is to do early apologies, early disclosures. The world has gotten so much better. I was, I was told that when in training you should never admit that you did anything wrong because it would result in people suing you. And then there was a major study that showed that people were less likely to sue you if you apologized to them and disclosed it and offered a settlement. So we're trying to practice that. We practice apologies. We practice, you know, making early settlements if somebody, you know, clearly we've done wrong. What's troubling is that the language around wrongful death, right, sounds so horrible, um, but that is the legal process if somebody dies. That would be the legal process for going forward. But every case is reviewed and increasingly we make early offers of settlement if we have made mistakes and we try to support our doctors in cases where we haven't made mistakes. You know, medicine is not perfect. It requires human judgment and certain times it will make the right judgment at that time, but when you know all the facts you come to a different conclusion and sometimes that results in a favorable court settlement for the person who is

bringing the suit. But every case is reviewed is bottom line.

COUNCIL MEMBER CROWLEY: All right, and I understand, I appreciate that. I only ask because, um, I understand it's a very, you know, sensitive topic and I do believe that your staff and the doctors there really do work hard, considering how many uninsured people they serve, people who speak English as a second language, the number of very poor, the number of children that you serve, and I appreciate that you're also, you know, you're trying to be the most compassionate you can be, but understanding that competency is kind of what's been hurting, you know, Health and Hospitals and specifically trying to look into coding and billing and making sure you're doing that the right way. And so one of your focuses besides the repurposing of under-utilized space inside these facilities, which I know you said bureaucracy has been a little bit of a hindrance, has been, has been coding. Have people been going to the Coding Academy?

MITCHELL KATZ: Yes, and not only that but we had, we just saw the data two weeks ago. We've had a major increase in the, what is called the

complexity score. So because historically Health and Hospitals was not good at coding, if you looked at our patients it made it seem like they were the healthiest group of patients that were ever in the hospital, because they weren't, all their conditions were never coded because a private hospital needs to code every condition in order to get dollars. But since Health and Hospitals was never focused on dollars we never did much in the way of coding. So we have found that once we, they did, ah, John is showing me, there was a 10.6% increase in the case mix index, meaning that we coded patients much more accurately. And when we did that, we had previously been saying that length of stay was too long at our hospitals. But once you correctly realize how sick they are, now it doesn't look like length of stay is too long. So it has huge revenues implications and there's still room to go. People love the Coding Academy, so much so that we're now doing a Billing Academy. We think this is a great model with our union partners. We've had DC37 and our other unions actively involved. It's a win for everybody, win for us because we get a higher level of work, win for the staff because they gain new skills, some of which are

marketable to them. Sometimes they get new certificates, and win for all of us. I came to work for county facilities. I want them to be great. I don't want to, you know, promulgate the idea of well, it's good enough for government work. Our facility should be great and it can be.

CHAIRPERSON RIVERA: How does it translate, the 10.6% increase, how does that translate into increased revenue?

MITCHELL KATZ: Well, because our payments...

CHAIRPERSON RIVERA: Yeah, and do you have a number?

MITCHELL KATZ: ... are risk-adjusted, so we get paid more, as we should, on any value basis if your patients are sicker.

CHAIRPERSON RIVERA: Do you have a number, though?

MITCHELL KATZ: Oh, a number.

MATT SIEGLER: Yeah, yes, so, um, I won't have an exact number but I can kind of explain the concept a little more.

CHAIRPERSON RIVERA: OK.

MATT SIEGLER: So basically every, every inpatient admission is relative to 1.0 and what Dr. Katz is saying with our 10.6% increase our scale was up to 1.13. It's in essence like a 13%, right, increase on the base pay amount of that we receive, and it drives real revenue. We could monetize that and provide a number, but it's one, I think, more important things, you know, that we're doing at H&H, and I'll just brag because, again, it's a little technical, but when you look at the average length of stay, you know, the expected length of stay across the industry for the type of patient we see is 5.2 days, and at H&H we're at 5.4 days. And given how, you know, the challenges we have in terms of where we discharge people and the neighborhoods they live in, I think it's really quite an accomplishment that we're so close to the industry average. So it's driving additional money and we're actually providing, you know, better care.

CHAIRPERSON RIVERA: That's great. I want just to ask a follow-up because I see some, um, some advocates in the room. Earlier in the hearing I asked about the TGNC care and the liaisons that we were asking you for to be present in Health and

Hospitals in terms of being able to be that person, to really go into the programs and services available, and you said that starting on Tuesday there was going to be three community outreach workers beginning in this very role, that we were so vocal about in that hearing. Where are these workers going to be?

MATT SIEGLER: I believe they will rotate towards our, between our facilities. I was actually mistaken. It was last Tuesday that they began.

CHAIRPERSON RIVERA: Oh, OK.

MATT SIEGLER: But they were based at our Pride centers and will move between different locations as needed. That's my understanding. But I'm happy to get you more detail on that.

MITCHELL KATZ: Let's get detail, unless you know offhand all of the names of all the Pride centers. MAT is a Pride center. Woodhull is a Pride center. So we'll provide the names of all of the Pride centers and how those staff are moving.

CHAIRPERSON RIVERA: Yeah, I just want to have an understanding, and I realize that three is just a start and that we'll be looking to expand the program, hopefully, with some time, because you did

mention that you were working with some of the allies and the advocates in the room that day. So I just wanted to make sure that I knew how many and what you are expecting it to do. So you're expecting them to pretty much float and rotate, not just in the Pride centers but throughout the entire H&H system, is that correct?

MITCHELL KATZ: Correct.

CHAIRPERSON RIVERA: OK, just want to have an understanding so we could follow up on that. And I guess my last question to you all, um, is going to be about state legislation and recently there was a proposal, which we spoke about at some length, about ICP funding and that formula and why it's important that the state implement the new plan that was proposed by this coalition of people from nonprofits and actually that you yourself endorsed. Do you have any update on how that's going and lobbying in Albany, is there any news?

MATT SIEGLER: Well, as of last night we've not heard anything specific, um, you know, the legislature and the governor are, you know, both negotiating the budget. We remain hopeful, right. We continue to think we had a very balanced, you

know, plan that not only benefitted H&H but also other, you know, safety net hospitals. So it's with the legislature and the governor now. We continue to, you know, press. We would obviously appreciate any help we can get from, you know, the council members.

CHAIRPERSON RIVERA: OK, well, you know, again, let us know how we can be helpful. I think there's a couple of things that come to mind that I feel, you know, are urgent. I think this, clearly this formula, now those dollars trickle down to our facilities. I think the closure of Riker's and the borough-based jails and how we provide correctional health services, specifically to those detained or incarcerated with mental health issues, I think the TGNC care is something that clearly we're very, very passionate about and we want to make sure it's implemented in the right way. And, of course, you know, being honest and transparent about your opening budget and deficit, and I know that you have projections and what's actual, but, you know, when I look at the years to come I am still a little bit worried about H&H and I realize there are revenue-generating initiatives and expense-reducing

initiatives, but even with the corrective actions we're still seeing some projections of a considerate, you know, 400-million-deficit. So I know that we all want to be helpful and I want to thank you for all the work and everything that you've done, and, you know, you know, we're going to continue to advocate for you. We sent the letter to Albany, to Hasty and to our senate majority leader, and we'll continue to make sure that we're working together and keeping each other honest.

MITCHELL KATZ: Good.

CHAIRPERSON RIVERA: And so with that I just want to thank you. Thank you for answering all our questions, and I look forward to working with you in the future.

MITCHELL KATZ: Us, too. Thank you so much.

CHAIRPERSON RIVERA: All right. So I'm going to call up this panel. We have Max Hadler from the New York Immigration Coalition. We have Ralph Palladino, vice president in Locals 1549, District Council 37, and Jerry Wesley from the Get Healthier Care Together, Inc. And if anyone else wants to testimony, could you fill out a slip with the

Sergeant at Arms so we can make sure that we get your testimony on the record? Who wants to start?

MAX HADLER: I've been appointed.

CHAIRPERSON RIVERA: OK, thank you.

MAX HADLER: Good afternoon. My name is Max Hadler. I'm the director of health policy at the New York Immigration Coalition. I want to thank Committee Chair Rivera for calling this hearing before the committee. I want to mainly talk about the mayor's announcing NYC Care program. But I first wanted to thank you for the letter that you actually just mentioned, supporting the Health and Hospitals community proposal on fixing long-standing inequalities in the allocation of indigent care pool and disproportionate share of hospital funding. We appreciate the letter to the leadership. We are also fighting alongside Health and Hospitals to make sure that legislation is enacted, either through the budget or outside of the budget process to ensure equity for real safety net provider. But I mainly want to talk about NYC Care. So I just want to state for the record that at the NYIC we really value the mayor for standing by immigrant communities and issuing a powerful message of inclusion and taking a

really important step to create a program that has the opportunity to better meet the needs of hundreds of thousands of uninsured New Yorkers, and there are a lot of exciting components, in our view, of this potential program, like navigation and coordination assistance through the assignment of a primary care home, a membership card, a dedicated customer service line, and a really clear welcoming message that encourages uninsured New Yorkers to seek care on an ongoing and preventive. But, as I think we heard today, there's a lot of details that have yet to be ironed out and we urge the council, as you have demonstrated today, to provide really close oversight throughout the ramp-up of this project to ensure a transparent and timely roll-out, and that really sets the tone for Health and Hospitals as the program launches this summer. In terms of the amount of funding and the fact that 25 million dollars are allocated for the upcoming fiscal year, starting in the Bronx, and then ramping up to 75 million in fiscal year 2021 and a 100 million at full scale, I think that considering Health and Hospitals serves, at most, about half of the currently uninsured population in New York City, the idea that 100

million dollars, even when it's fully ramped up, would be sufficient I think is really concerning and I appreciate Dr. Katz mentioning today that to some extent we have to appreciate that a lot of these expenses are already in the system and there's a lot of uncompensated care that is already incurred in providing care to uninsured New Yorkers. I think it's really important, though, to think not only of the services that are currently being provided to people who are accessing services, but that if NYC Care is successful, if the outreach is successful, that the whole point is to not only make existing services more effective, it's to bring more people who don't use services at all, many of whom are the communities of immigrants of all statuses, but particularly undocumented communities that we focus on at the NYIC into the system. That requires not only repurposing existing funding. It requires a really huge investment that the state and the federal government have refused to invest in our communities, and so we're really looking for the city to increase as much as possible on the 25 million this year, and even the 100 million that will eventually be hopefully in the budget by fiscal year 2022. And I

think some of that funding would need to go expanding the region of network of NYC Care, as we talked about. We really think that federally qualified health centers outside of Gotham Health are a really critical part of providing care to uninsured New Yorkers and to ensure continuity of care for people who are already services at FQHCs, but need specialty care at Health and Hospitals. Improving upon the referral networks that currently exist is really critical. And to that point, because this has already been done, I would also say that our third main point in terms of advocacy is really making sure that this happens on a more accelerated timeline than is currently proposed. This is not a brand-new concept. We actually had a very successful pilot program in New York City, Action Health NYC, that was a very rigorous evaluation. This timeline can be accelerated because we've already demonstrated that this model is successful. So we don't really need time to prove that this model works. What we really need are a full amount of resources to better implement an already-proven model. Thanks a lot.

CHAIRPERSON RIVERA: Ralph?

RALPH PALLADINO: Sorry. Good day and greetings to you, City Councilwoman and Chair, and my city council person. My name is Ralph Palladino, from Clerical Administrative Employees, Local 1549, District Council 37. We represent roughly 5000 employees of NYC H&H and also, um, the MetroPlus HMO, and as well as workers, eligibility specialists doing research for Medicaid and HRA, as well as MAGI. We're asking, first of all, that we support thoroughly the NYC Cares program that the mayor has instituted, as well as his past funding of NYC H&H, and we think that the 600,000 undocumented immigrants who will get care, as well as others who will get care because of this program, obviously need the care and have nowhere else to go but our institution. I also work in the system and I'm a patient at Bellevue Hospital. There are 3 million immigrants in the city, 775,000 undocumented, and unfortunately there are some in the city, a small minority but still vocal, that say that this is a waste of money because it's about undocumented immigrants. Like the Irish and Italians before them and other immigrants who came to this country, legally and illegally, they work to provide services, goods, and help build our

city. They are taxpayers contributing to the economic and social life of our city. City Controller Stringer has stated that, and documented, that they estimated 8 billion dollars in city and state personal income taxes to the state annually and 2 billion dollars in city property taxes. They pay taxes. They should get their services. So we support this and hope you will support it and continue to do so. We also need to have the reach out to the state by the City Council and others and everybody this week, dealing with the state budget. Medicaid financing does not meet the cost of care. Every visit that comes into, say, any of our hospitals, there is a loss in a clinic of 150 dollars per visit. That's about the money that there is lost every time. It's more than that in an emergency room. Medicaid rates really have not gone up in over in a decade in a substantial way. Ah, in terms of the state as well, a disproportionate share, DISH funding, is not fairly distributed and is ending, and has never been fairly distributed. So this money has to come in or what, how else will H&H be funded? Um, the larger hospitals with CEOs making millions of dollars in money, they're really for-profits as

opposed to, or legally not-for-profit, get the lion's share of the money, but they don't see the lion's share of the patients. Medicaid dollars should follow the Medicaid patients. Money for the uninsured should follow where the uninsured are. Very simple, but nobody in Albany apparently wants to get this. So we really need the City Council to step up, along with the unions and other advocates to deal with that. As well as the final thing is the need for improved language services, especially around now that more immigrants are going to be coming into the system and that's important because right now there are volunteers that are doing it, non-employee volunteers, sometimes employee volunteers, and our client navigators in one hospital at Bellevue get trained on medical terminology, which is important. They also can translate documents. But right now they're using phone lines and they're using temporary people, and they're using volunteers, and this is not right. So we represent the interpreter title in the city. We represent the client navigators in the system that can be doing that work, as well as provide the information on healthcare programs both in the community and in the hospital. That is where

the title [inaudible] is all about. So we ask you to support that and support any funding that they need in terms of enhancing the language issue. I have to say that in the past I have testified about issues that were very negative towards H&H, with the idea of is, of course, H&H has helped, um, when it was Health and Hospitals Corporation, I had my life saved in the emergency room, I get great care. I never had an issue with that. But the issues dealing with access from the street, phones, things like that are still problematic. They have improved some, but not enough. That needs to continue. The use of titles that are higher paid, managerial, noncompetitive sometimes, in doing clerical work still exists. That's a waste of money. That needs to end. And also the use of the private temps, which still exists in the clerical area without really dropping much, people who are getting access to patients' information because of that. That needs to end. There are ways we suggested and we're trying to work with Dr. Katz, suggested to move on those two areas, and every other area of support for the hospital system. So we're asking to both support and fund New York City H&H Cares and look at the interpreter and

client navigator titles and proactively support in Albany the Rivera Got Free legislation for expansion of the essential care health insurance statewide that mirrors New York City Care in New York, which will also, that will also help H&H. Proactively advocating with the governor and state legislature about increasing Medicaid reimbursement rates. Its important to demand more funding for the DISH program, oppose, and fair funding, I should say, oppose President Trump's wall building and restrictions on benefits for immigrants, including ridiculous work requirements, proactively oppose President Trump's proposed cuts to Medicare, Medicaid, SNAP food stamp program, which is vital for health, especially for children and elderly, and its attacks on the Affordable Care Act. And lastly, Local 1549 supports the nurses' fight in terms of fair funding and fair, I should say, well, fair funding, yes, but fair, ah, and patient ratios staffing, fair staffing. I myself have had...

CHAIRPERSON RIVERA: Safe staffing?

RALPH PALLADINO: Safe staffing.

CHAIRPERSON RIVERA: I got you.

RALPH PALLADINO: Thank you. I stand corrected. I myself have had issues where I have had to wait three hours for a blood, a, ah, a blood pressure test, maybe blood pressure is going down, I'm losing my thoughts. Ah, the, because there was only nurse on duty in the medical clinic, and another time in the emergency room I had to get an extra shot of epinephrine, which is, can be dangerous, um, and that happened because there was only one nurse in the emergency room. This has not happened this week. But I stated these things are happening and I understand thoroughly the issue about safe staffing.

CHAIRPERSON RIVERA: Thank you.

RALPH PALLADINO: Thank you.

CHAIRPERSON RIVERA: Thank you, Ralph.

JERRY WESLEY: Greetings, Committee Madam Chair and fellow committee members. Thank you for the opportunity to testimony today. I am Jerry Wesley, a transformation futurist and founder of Get Healthier Care Together, Inc., a 501(c)(3) shared service organization. We're also a New York City approved vendor, and you can see all the various areas that we are authorized to provide services to the city. I am here today seeking budgetary funding

in the amount of 1.5 million dollars to help train hospital staff in resolving underlying and systemic causes of preventable harm and wrongful deaths that are occurring at NYC H&H, either through poor care coordination, hospital-acquired conditions, misdiagnosis, wrong surgeries, surgical site infections, medication and medical errors, and hospital falls and other preventable harmful conditions. On March 9, 2019, a *New York Post* article reported that 460 wrongful, preventable deaths has occurred at NYC H&H since 2014, with more than 400 cases pending. According to the New York City Controller's Office, between 2014 and 2017 the average annual amount that was wasted on malpractice costs at NYC H&H was $113,775,000 a year. The 1.5 million dollars we are seeking to prevent or to begin to prevent this waste is about $374 per day per hospital, is less than 1.4% of this amount. Since 2008, as you can see the chart below, NYC H&H has wasted over a billion dollars in malpractice costs. The 1.5 million we are seeking will be used to implement Care Healthfully best practices for reducing and eliminating preventable harm at all NYC H&H hospitals. Our Care Healthfully intervention is

a healthifying cure for outcome health of patients and families who entrust NYC H&H with their health and lives, for helping to upgrade hospital star ratings to one star to three to five stars over a two to three year period, reducing and eliminating burnout of an overburdened and understaffed workforce, also helping to restore the fiscal health of NYC H&H, who continue to bleed healthcare dollars internally from almost every organizational organ that generates revenue. An ongoing contributing factor of preventable harm and wrongful deaths is that 10 out of 11 NYC H&H hospitals have been labeled with an unhealthy one-star rating for 11 consecutive years with no public redress. The centers of Medicaid and Medicare services five-star rating system has labeled the following hospitals with the one-star rating: Bellevue, Coney Island, Elmhurst, Harlem, Jacobi, Kings County, Lincoln, North Central Bronx, Queens, and Woodhull Medical and Mental Health Center. The only recent two-star hospital in the NYC H&H system is Metropolitan Hospital Center, located in Manhattan. The alarming factor that has been ignored for years that should concern us all is because a one-star hospital rating is synonymous with

low-value, low-quality care services, health, and outcomes that can lead to preventable harms and wrongful deaths. In this budget cycle we are asking the Committee on Hospitals to join us in using your influence and connections to secure the 1.5 million dollars we are requesting to make sure that we as a city and as a community no longer ignore the problem that preventable harm and wrongful deaths are inflicting on our community and no longer ignore the opportunity that is staring us all right in the face to begin to eliminate preventable harm and wrongful deaths now and for generations to come. Now, let me say, we are not here to disparage NYC H&H. We love and support our community hospitals. But it does none of us, it does all of us a disservice when people are dying from preventable deaths in our hospital systems. So the time is now to take more proactive steps. I heard Dr. Katz indicate that how once a death has occurred that root cause analysis is done. But part of that root cause that we continue to ignore and have ignored for 11 consecutive years that predates Dr. Katz is that we have been a one-star facility, with no strategy, without absolutely no strategy, effective strategy to adequately upgrade

the skills of our [inaudible]. Now, we have been very successful at changing healthcare leaders. We have been very successful hiring qualified people with very impressive backgrounds, who also bring in qualified people with very impressive backgrounds to help them succeed. This has been going on for decades. But we have failed miserably at upgrading the T-banks, the thinking, behaviors, attitudes, communication, knowledge, and skills of our workforce to retrofit those T-banks for 21st century healthcare, and until we do that we have not yet even begin, or begun, to transform New York City. A very wise man said culture eats strategy change for breakfast, lunch, and dinner. And it's time that we face the difficult challenge of transforming our workforce for the 21st century.

CHAIRPERSON RIVERA: Thank you.

JERRY WESLEY: So thank you for the privilege of your time and your [inaudible].

CHAIRPERSON RIVERA: Thank you so much. I guess Ralph left, Mr. Palladino left? All right. I just wanted to ask you really quickly, Mr. Hadler, when NYC Care was being rolled out were you consulted in any way? Was your organization consulted in any

way, considering your work with the communities of New York City?

MAX HADLER: Ah, I would say not on NYC Care specifically, I mean it's, that since the mayor's task force on immigrant health access convened over four years ago now and one of the recommendations coming out of that was to create a direct access program we've been advocating with many other groups that we work with regularly and with the City Council and with the mayor's office and with Health and Hospitals for something like Action Health NYC to be expanded upon and made a permanent program. We were very disappointed when the pilot was canceled after one year without any real publicly made plan to continue that, and then, so we had ongoing conversations about what that should look like with groups all over the city, but not on the establishment of NYC Care specifically.

CHAIRPERSON RIVERA: Well, I know Council Member Levine and I would love to work with you to figure out how we can make it as a successful model as Action Health and to go even beyond that. And Mr. Wesley, I didn't want to, I wanted to address your testimony. There are members of the administration

here who I'm sure have heard your proposal, so perhaps they can follow up with you on the work that you want to do with our hospital system. So with that, I just want to thank you both for your testify and just stay in touch. Look forward to working with you.

MAX HADLER: Thank you.

JERRY WESLEY: Thank you.

CHAIRPERSON RIVERA: I'm going to call the next panel. Andrea Bowen, Cecelia Gentile, Brianna Silverberg, Shay Huffman, you all want to be on the same panel? OK. Anastasia Weiss, Elaine Mendes, and Esmeralda Matos. And, again, that was like eight names, so, but I think maybe you know each other? Same handwriting?

ANDREA BOWEN: It makes a good image.

CHAIRPERSON RIVERA: You have some squeezing.

SERGEANT AT ARMS: Just sit here and wait your turn.

CHAIRPERSON RIVERA: All right.

ANDREA BOWEN: Thank you, Council Member. Um, thank you assembled staff. I'm Andrea Bowen, principal of Bowen Public Affairs Consulting. I'm a

trans woman and coordinator of the Transgender, Gender Nonconforming, and Nonbinary, or TGNCMB Solutions Coalition, which advocates for community-based economic justice and anti-violent strategies to support TGNCMB New Yorkers. Thank you so much for giving us the opportunity to speak today, a lot of us to speak today, and thank you for your continued advocacy for the community. We wouldn't be here today if it weren't for your hearing back in the fall. So I'm joined by community members to present the need to you for three major funding items that we would like to see as an initiative in the city's FY20 budget. To summarize, and there are longer explanations in a fact sheet attached to my testimony. We're seeking five TGNCMB community outreach workers at a cost of about $470,000. H&H, as was noted in the previous, in the public part of the testimony, or in the previous part of the testimony, has been hiring for three community outreach workers for the remainder of FY19 that will support our community in finding affirming care, and we want to see this program extended to FY20 and expanded to five community outreach workers for better coverage across the city. We seek TGNCMB

healthcare technical assistance funds at $59,400. Our community has spoken extensively and will speak extensively about specific failures in the healthcare system. H&H used technical assistance funding to better train providers who supplemental knowledge in working with our community and TGNCMB organizations should be paid to provide this technical associate. We know that there is training going on but really narrowing in on specific issues is vital. Finally outreach workers and TA providers will only have so much reach, so there must be funding for a media campaign at a cost of, ah, about $690,000 to advertise these services and actions to our community. Our community can't wait for action, um, TA providers, community members, and community outreach workers can pinpoint failings in the healthcare system for our community here and now, which will happen in this very panel, and make, you know, we need to be able to make sure that the system is more responsive to us. So thank you so much, Chair Rivera, and council staff and council members. And I look forward to answering any questions you have.

CECELIA GENTILE: Good afternoon, Chair Rivera and staff of the Committee of Hospitals. My name is Cecelia Gentile. I identify as a transgender woman. I am Latina, and I would like to talk about a budget proposal related to the health, um, to health that would be vital for transitioning, gender nonconforming, and nonbinary people, TGNCMB people, and I really want to thank you all for your advocacy around this issue. It is my testimony, but I [inaudible] if I say like this story as a, without reading. Last year I was feeling unwell for a couple of hours and my partner asked me to go to the hospital. I was using the bathroom like every five minorities and, you know, he started thinking like maybe you have a UTI. And so we went to the hospital, all right. This is very uncomfortable. It is painful when you have to use the bathroom all the time. So I wound up going to the hospital and when we got to the hospital in the intake form it was no way for me to express that I was trans. You know, it was just male and female. You know, all my documentation is as female, but, you know, I think it would be better if there was a way to say that I was assigned male at birth and that I identify as a

female now. That will have saved a lot of what happened after, which was very uncomfortable. And so I crossed male and female and I wrote transgender woman, so to give them a heads up since, you know, the area that I was feeling unwell involved my genitalia. Unfortunately, the triage nurse, I guess didn't understand what happened and we had like a very heated conversation about my genitals and she continued to ask for my last menstrual cycle and she couldn't really understand why I don't have one. There was a lot of people around us. It was embarrassing. It was inconvenient. While this was happening I was also in pain. I was in extreme pain. That was the last thing that I wanted to be talking, like, you know, me and my transgender experience. I just wanted to see a doctor, right? And plus all of that, it cost my insurance a lot of money and I also paid $250 co-pay for that kind of, um, humiliation. So, you know, it's like the hospital wasn't doing me a favor, I was, just, you know, I paid for it, like my insurance paid for it. At least when I go and get treatment and something that I pay for I should get something that, you know, adapts who whom I am, and health should not be a privilege of cis-gender folks.

We transgender, gender nonconforming, and nonbinary people deserve to get respectful treatment and services like everyone else. So if you look in my testimony, I really support, you know, what Andy was saying before about those three initiatives, having a community outreach worker, having a [inaudible] technical assistance that can help that triage nurse that didn't know that trans people are people, right? And they didn't know about what the situation is and, like, you know, it would have saved a lot of pain and anguish, you know, from my side and from everybody else that was waiting after me. It took a long time, precious time in the ER that everybody needs. So, and of course the media campaign would be amazing to have. Thank you. Thank you, thank you.

CHAIRPERSON RIVERA: Thank you for sharing.

ESMERALDA MATOS: Hi, my name is Esmeralda. I want to thank you for having me here and hear me. Almost two years ago I had, um, my gender affirmation surgery and I had an incident in which I blacked out and almost passed away. And I had to stay in the hospital for almost two months, had several process, ah, procedures, surgeries, for

to save my life, and, um, by then I don't spoke well the language English and it was very hard for me 'cause my native language is Spanish, and it was a big struggle to communicate with the nurses who don't understand Spanish, um, what I was feeling or, yeah, and I'm here advocating for language justice and I feel also it is important and I have something written in my phone. I want to, OK, thank you.

CHAIRPERSON RIVERA: OK, thank you, thank you for sharing your experience.

ANASTASIA WEISS: Good evening to Committee Chair Carlina Rivera, to the council members and staff from the Committee on Hospitals, and to all present tonight. My name is Anastasia Weiss. I write for the Daily Dot on LGBTQ issues under the pen names Anna Valens. I'm a 25 year old transgender woman from Brooklyn, and I'm here today because I have a first-hand experience that actually happened just last money with emergency room medical care here in New York City. And while I was outside of the public hospital system I think my experiences are relevant to what we're talking about here on this panel. So on Valentine's Day I had a near-fatal allergy attack. I'm allergic to nuts and peanuts,

and my co-working space's host called 911. An FDNY ambulance responded and took me to the Lenox Hill Greenwich Village Hospital and I was discharged several hours later. And while I do want to commend both the medical staff there and also the FDNY paramedics that helped me, there were several issues with the entire emergency room visit in both parts of that trip that I would like to address. So first during my ambulance ride one paramedic that supervised my initial onboarding made a joke about "male-female" and "female-male" transgender people. He also, this is not on the sheet you might have received, but he also made a joke about I received an adrenaline shot and he made a joke about receiving a hot flash in, ah, his words, not mine, my kootch. Now, I do not have a kootch. I am preoperative in the sense of gender reassignment surgery. So these two issues combined were already immediately stressful to a day that was particularly uncomfortable for me. And so when I arrived at the hospital, again this is not on the sheet, but also a paramedic then whispered into my year, have you had the surgery yet? Which again is not necessarily relevant to what I was being treated for, which was

an allergy attack. And so when I arrived at the hospital a receptionist received my insurance info, which had my then-legal name on it, I recently changed it, and after inputting my information immediately walked up to me, in front of all these paramedics and other people, and asked me if I was menstruating. This is impossible for me as, again, I am transgender woman and I biologically cannot menstruate, and so I had to out myself to this nurse, after she had already seen my legal name and, quite frankly, it was pretty obvious that I was transgender based on seeing such. Because the hospital registered me under my legal name, did not offer any option for me to put my preferred name or anything, and nurses would check up on me by saying my legal name on entering into the room. I also had it on my wrist band, which was obviously not very fun to look at for the whole entire time I'm trying to recover. I would have to correct them each time, letting them know my name is actually Anna, and explained I am a transgender woman, I am not male, but that legal name is incorrect. This became tiring and stressful on a day where I needed to recover from, quite frankly, a very traumatic experience. I believe these

experiences are a microcosm for greater issues that are present for transgender emergency room care patients, both inside and outside the public hospital system. If both the FDNY and hospital staff were given the proper training they need for sensitivity towards TGNCMB patients, I believe these uncomfortable moments would have been avoided. I think also having a care navigator, you know, accessible in that situation would have made it easier for me to advocate for myself. I would like to thank the Committee on Hospitals for your time and for listening to my story. I hope this provides, I hope this proves helpful in finalizing the city's budget and gives you an eyes and ears into what it is to be like as a transgender woman in the emergency room care system. Good afternoon, Chair Rivera and staff of the Committee on Hospitals.

SHAY HUFFMAN: My name is Shay Huffman. I'm a second-year social work intern at the New York City Anti-Violence Project and I'd like to begin by first saying thank you for your advocacy on behalf of the community and its healthcare needs. I, too, am here in support of the funding request by the TGNCMB Solutions Coalition, and I'd like to tell you why I

believe it is so vital. I am a proud New Yorker and I think of our city as a progressive 21st century town. But, as I testified last week before the Committee on Health, the realities of our transgender, gender nonconforming, and nonbinary community members contrast markedly with this notion. During my internship at AVP I've had the opportunity to research issues related to the community and its health care. I have also had the honor and privilege of meeting with, listening to, and sharing stories of community members around their experiences in accessing health care. And I've got to tell you, the information I've gleaned, the narratives I've heard, reveal numbers and challenges that fall far short of what one and should expect and desire from a progressive city. These experiences cover things such as seeking care at hospitals where intake forms do not even include an option for the gender identities. They have been asked if they want to check off other, for example. They have been refused medical care. They found themselves sitting in emergency rooms that give little consideration to the their needs and rights regarding privacy. They have encountered physicians who are not culturally

competent in their healthcare needs. And during an interview that I had with one community member, it was shared with me that even in a supposedly progressive hospital they had a physician who was freaked out by identity and would not even touch them. In another, the person shared how each prospective encounter became a trade-off, the mental and emotional well-being in exchange for medical care. It was just that stressful. And the term gender minority stressors is used to capture the experiences and expectations of rejection, discrimination, and non-affirmation that result from stigmatized social status. It's a stigma based on a person's gender identity only. Gender minority stress. Its impacts are real. It often causes people to delay care or forego it entirely, and of course that only further compromises overall health. It increases the likelihood of substance use and abuse, suicidal ideation, and suicide attempts. And, not surprisingly, the research indicates strong correlation between gender minority stress and anxiety and depression. And if a person is a member of more than one marginalized community, such as a woman, a person of color, an immigrant, the impacts

are compounded. So I would urge H&H to collaborate with community members and leaders in assessing needs, tracking concerns, and developing any initiatives, and Chair Rivera, committee staff, I respectfully submit that these are all strong indications of why we need the budget items in our ask. I thank you for your time.

CHAIRPERSON RIVERA: Thank you, thank you so much. So if, I know that there are two more people to testify, nice to see you. I wanted to just ask your request to expand, um, they have three outreach workers, you want to, so you support this effort, but of course to expand it to five as well as add, and I think you itemized this, Andrea, very well, ah, financially.

ANDREA BOWEN: Thanks.

CHAIRPERSON RIVERA: So you have the community outreach workers, you have the healthcare technical assistance, and the media campaign, and just expanding from three to five, and I think, just based on what you all have shared today I think that's very, that's the least we can strive to do to ensure that you can walk into a hospital or anywhere and not feel disrespected or misunderstood, and I

know that Dr. Katz is still here and as well as his team, and they are listening. So I hope to work with you all to make sure that hopefully this doesn't happen to another person again.

ANDREA BOWEN: Thank you so much and, um, I just, also just to emphasize, um, you know, ah, you know, I think at least having one per borough is really vital. I think three is not, and in collaboration with each other we were all like just three is not quite enough.

UNIDENTIFIED: Trans people are all over New York, in every borough.

CHAIRPERSON RIVERA: Oh, I know, they're in Staten Island, too.

ANDREA BOWEN: And, um, you know, we have people out there ready, I mean, Cecelia is a masterful trainer, could be doing TA, um, and, you know, while we believe that the average workers will be amazing, um, I think supplementing it with a kind of media campaign that like we've seen Prep and Pep and a lot of other things, the Unity Project, um, would really help our community know these things exist, so thank you so much.

CHAIRPERSON RIVERA: And I just also want to mention the language access piece.

ANDREA BOWEN: Absolutely.

CHAIRPERSON RIVERA: You know, you just look at Elmhurst Hospital alone. There's over a hundred languages spoken there, and so we are making sure that people can go in and have just a basic conversation, which I think is normal to just desire and need, and that's what we deserve. So thank you for sharing your story.

ANDREA BOWEN: Right, and having an outreach worker who can help facilitate that transaction be vital.

CHAIRPERSON RIVERA: Oh, yeah, oh yeah. OK, thank you. Right.

ELAINE RINA MENDEZ: Good afternoon, Councilwoman Rivera, fellow members of the committee. My name is Elaine Rina Mendez. I'm a community member of the New York City Anti-Violence Project, as well as a youth counselor at the Ali Forney Center. Both these organizations work to support the growth and success of members of the queer community, especially the trans and GNC community in the New York City area. I'm here, like the other members of

this panel, to advocate on behalf of the establishment of the heath outreach worker program for trans health. As a woman who began transition outside the New York City area, I can say that health care here is better than other states. But it is not perfect. I started my transition in small-town Pennsylvania, and I had to prove my dysphoria was real. This could be a little challenging, as you might imagine. Many physicians still require this performance, as they do not operate through the informed consent access to hormone therapy model. Currently, as well, word of mouth between community members is the best tool that many of us have to go through to find affirming providers who will approval allow us access that we need. It is not enough. When I was homeless in 2015 I was told to go to one of two clinics for my hormonal therapy. Two clinics in the New York City area. Later on when I was pursuing gender confirmation surgery I was informed that only breast and vaginal surgery were available. Insurance coverage later on allowed, insurance coverage later on allowed for facial feminization surgery to be covered, something which I am looking forward to next week. But the point of the story

isn't that I'm getting my face done. That's not the point at all. The point is that I was lucky enough to ask the right person where to find the treatment. Luck should not be involved with treatment, though. I am not the first transgender woman to suffer from facial dysphoria, nor will I be the last. If I did not ask the right person at the right time I might very well be stuck with this face for years. We don't settle for such lower standards of care for other conditions. Why is New York City resting on its laurels with regards to trans health care? What is celebrated as good and acceptable would be a scandal for the same low effort put forward for any other condition. Funding the health outreach worker program would be an important step, but that is said to elaborate on the earlier point. It is necessary for the city commits to a strong and robust awareness campaign. Without this the problem will be doomed to fail from the start. I trust that both lawmakers and members of the trans community alike would hate to see this become a failure. Thank you for your time, everyone. I trust the right decisions will be made by the council.

BRIANNA SILVERBERG: Thank you, Council Member Rivera, the rest of the committee for having us up here today. My name is Brianna Silverberg. I'm a community organizer at the NYC Anti-Violence Project. And with Andrea I'm a sitting member of the steering committee of the TGNCMB Solutions Coalition. I want to make clear to you all today how necessary and important the requests and recommendations that the Solutions Coalition has come to present are providing outreach workers, technical assistance, and a media campaign to advertise the outreach workers and the services they provide are a dire need of New York City's trans community. When I was beginning my transition a few years ago I was both overwhelmed and befuddled by the options that were ahead of me, particularly to get gender-affirming hormone replacement therapy. Community word of mouth was really the only resource available to me, and the people around me were telling me to go to Callen-Lorde, and then I would be OK. So you can imagine my bright-faced disappointment when I bravely tripped to the clinic that I thought would change my life and I was told that they were at over-capacity and that I would actually not be able to get treatment there.

They then suggested that I try to go Apicha, who did let me sign up for an orientation, which was another two months away, which after I went through that scheduled my first appointment, which was another three months down the line. All this could have been easily avoided if something like outreach workers were available to the community and if they were advertised appropriately. The over-capacity of both Callen-Lorde and Apicha, which led to some, frankly speaking, dangerous delays in my receiving care would be way less of a problem if patients actually knew that they had other options. We need to help people navigate the places that they can go to get care aside from the big-name clinics, and these recommendations that Andrea has presented could go a long way towards vastly improving this untenable status quo. I know from working with community that my story is painfully similar to those of a great many folks, most of whom only know of the two clinics that I named as options for informed consent care despite the many other sites available that could help them, and with that I thank you for your time, and I wish you all the best.

CHAIRPERSON RIVERA: Thank you so much for your advocacy. I know that we have a long way to go when it comes to healthcare provision. But I hope that just on what was accomplished thus far, I hope that you will know that you own that victory and that is because of you that we are here. I thank you for thanking me. It certainly feels good. But really you all have been my guiding star and I want to continue to support you. So thank you for sharing your experiences and being very honest. I think that's how we're going to get to where we need to go. So thank you so much.

BRIANNA SILVERBERG: Thank you so much.

UNIDENTIFIED: Thank you, Council.

CHAIRPERSON RIVERA: I have one more. Is Leon Bell still here?

LEON BELL: Yes.

CHAIRPERSON RIVERA: Oh, yeah, hi Mr. Bell, thank you for waiting.

UNIDENTIFIED: [inaudible]

LEON BELL: Ah, I happen to have some, yeah. They're in the back. I'll get them to you after I'm done. Hi, thank you for having me today. My name is Leon Bell. I'm with the New York State

Nurses Association. I'm not going to take too much time. It's been a long afternoon and I think, I'm going to try to get through this in a minute or a minute and a half. But I support fully the comments that were made by Max Hadler from the Immigration Coalition, our colleague, Mr. Palladino, from DC37, and in many ways some of the comments that were made by Dr. Katz earlier in the testimony today, and I just want to sort of talk about in terms of the ongoing problems, the fiscal problems at Health and Hospitals, which as you have noted are something that despite all the efforts are something that we continue to face, and also with respect to the mayor's NYC Care, um, proposal, which we fully support and we think this is actually potentially a great thing moving forward, I think, I want to sort of just address or leave you with three thoughts that maybe go beyond just the preliminary budget and the hearings and the implementation of the budget, but I think need to be considered as we move forward, both with, um, you know, preserving and expanding the role of the Health and Hospitals system and also implementing this exciting new program, um, and the first comment or thought is that reimbursement for

the services that H&H provides is insufficient, and at the end of the day you can do all the transformation and changes and you can cut unnecessary expenses, but at the end of the day the Health and Hospitals system and the role that it plays within our broader New York City local healthcare environment, um, it's designed to lose money, and that's something that has to be recognized, and if you don't fix the reimbursement, um, system and that ties into the support, for example, for the indigent care pool or redistribution of money, the H&H and community health plan to change the way that ICP money is distributed. But if we don't address those core issues I think that at the end of the day we have to recognize that the system will always be in financial peril. The second thing, and this is related to the first point, is that I think we also have to keep in mind the role of the private sector. When Dr. Katz, for example, helped to implement Healthy San Francisco in an earlier phase in his career. One of the problems that was addressed by that program was the issue of free riders. And that's not just free riders among employers who don't provide health coverage to their

employees. But also free riders in the private hospital sector. At the end of the day, um, H&H is increasingly left to cover those services that don't reimburse well related to my first point and, um, is left to do it in a way in which the private-sector hospitals a) don't share in the responsibility, and b) they actually steal the system's lunch money. They will poach patients that have the highest reimbursement rates or the types of procedures that pay well and they will leave the uninsured, the under-insured, and the types of procedures or services, such as psychiatric care and other similar services that don't pay well in the hands of H&H. And unless we address the role of the private-sector hospitals system and start to assert some sort of control, or at least pressure, on them, um, we will not address the system's problems in terms of Health and Hospitals, and we will not address effectively the issue of insuring the uninsured. So I think that's something that needs to be given consideration. Finally, in conclusion, I think that another issue is, and it ties into what the panel who just testified was talking about, as we go forward in terms of a) restructuring Health and Hospitals and

b)implementing this new, um, universal coverage program, I think it's also important that we give a lot more thought and emphasis to the coordination of the efforts in instituting some sort of planning, I think one of the things that came out in the testimony today is that this whole NYC Cares thing is really a sort of a by-the-seat-of-your-pants operation, and although we fully support it and we think that we, we look forward to implementing it effectively there has to be some level of coordination, both at the city level, at the industry level, ties back to my second point about bringing the private, um, hospitals and making them contribute or pay their fair share in this process and stop exploiting Health and Hospitals, but not only inclusion, but not only an important issue, but also inclusion of the communities for the health care workers, and other, you know, stakeholders, to use that often, you know, overly used term, stakeholders need to be included in the process of sort of setting the directions, setting the planning, and looking how we're going to do both, save the system and also implement this new program in an effective way, and I think that needs to be something that is also

considered going forward. Thank you for your time. I do have some copies of the testimony if the committee would like them, and thank you for your support on the ICP funding.

CHAIRPERSON RIVERA: Wait, let me ask you a quick question, Mr. Bell. So you said with the restructuring and within New York City care in that it's a little bit, ah, touch and go right now, so, you know, I think the issue is that we're calling it universal health care and it's not necessarily universal health care, so has the mayor, and I asked New York Immigration Coalition this question, was there a consultation with Labor as they decided to roll out this plan, or were you kind of alerted after the fact?

LEON BELL: Ah, not after the fact, but there was no consultation, and my sense personally, I'm not speaking organization, my sense personally is that, um, neither Health and Hospitals, nor the unions, nor the communities that are involved really had any sort of heads-up that this was coming. We knew that there was an announcement was going to be made and we found out basically at the press conference.

CHAIRPERSON RIVERA: OK, yeah, I agree. There has to be some coordination and planning. So I'm looking forward to working with you all at NYIC and thank you for testifying.

LEON BELL: Thank you.

CHAIRPERSON RIVERA: I don't think there are any more members of the public that wish to testimony today, so with that I am going to adjourn the hearing. [gavel]

C E R T I F I C A T E

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

Date April 28, 2019