CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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February 24, 2020
Start: 10:14 AM
Recess: 12:34 P.M.

HELD AT: Committee Room – City Hall

B E F O R E: CARLINA RIVERA
Chairperson

COUNCIL MEMBERS: Diana Ayala
Mathieu Eugene
Mark Levine
Alana N. Maisel
Francisco P. Moa
Antonio Reynoso

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

Dr. Eric Wei, Chief Quality Officer for NYC Health and Hospitals

Dr. David Reich, President and Chief Operating Officer, Mount Sinai Hospital

Lorraine Ryan, Senior Vice President, Greater New York Hospital Association

Teresa Davis, Advocate and Community Health Educator

Wendy Young, Physician & President & CEO of the Moral Injury of Healthcare

Jonathan Vondalast, Intern from New Alternatives.

(sound check) (pause) (gavel)

CHAIRPERSON RIVERA: Good morning. (background comments/pause) I am Council Member Carlina Rivera, Chair of the Committee on Hospitals. I would like to start off by acknowledging my team who's always here with me, and we'll be joined later on in the morning by other members of the committee So, today we'll hear from representatives of Health and Hospitals, H&H, voluntary hospitals, advocates and other stakeholders about the safety of our city's emergency departments or EDs. EDs have been described as a safety net of America's healthcare system. Out city's most vulnerable citizens utilize our EDs. However utilizers of EDs tend to be individuals with greater needs for healthcare services including individuals who are elderly, poor and/or living with chronic conditions. Given recent news coverage of severe overcrowding and other issues affecting EDs, I am concerned about the patients and ED staff in these facilities, and want to ensure that patients are being treated in a safe environment. EDs have grown increasingly strained in recent years. This is due to a number of factors including a reduction in the number of EDs and aging population;

limited access to primary care providers and specialists for those with Medicaid; shortages of hospital nurses and on-call specialists physicians in the ED; reduced in-patient capacity and an increased willingness of physicians to direct their patients to the ED for faster diagnostics. This is called multiple issues including longer wait times, patients being forced to occupy beds in the ED hallway for hours or even days before being admitted, a process known as boarding, and an increased strain on ED physicians, nurses and staff. On average patients in New York State spend nearly three hours in the ED before being sent home and wait a little over six hours before being admitted, although wait times can vary greatly from hospital to hospital. For example, Mount Sinai, Kings County, Brookdale, and Jacobi Hospitals each have an average wait time of over 12 hours before a patient from the ED is admitted. Elmhurst and New York Presbyterian are not far behind both with average wait times of between 11 and 12 hours. These statistics highlight the universality of this issue when it does not impact our public hospital system alone. While patients are waiting for an in-patient bed, they may end up being boarded

in the ED hallways. Studies have suggested that hallway care could be a threat to patients' safety with one study concluding patients initially triaged to the hallway have a higher chance of (1) returning to the ED within 30 day. (2) Re-admission to observation and (3) inpatient admission. The American College of Emergency Physicians affirmed these findings stating that the boarding of admitted patients contributes to lower quality of care, decreased patient safety, reduced timeliness of care and reduced patient satisfaction. The increased staring on EDs has a direct impact on the health and safety of patients and staff alike. More and more physicians are utilizing the phrase "moral injury" to describe their struggles on the job instead of describing it as burnout. Moral injury, a term developed to describe a condition afflicting some veterans refers to the emotional, physical and spiritual harm people feel after perpetrating, failing to prevent or bearing witness to acts that transgress deeply held moral beliefs and expectations. In short, ED staff often times need to provide care that is not of the quality they would provide under moral ideal situations—under more ideal

situations. The toll on ED staff has been devastating. In fact, four in ten physicians report feelings of burnout and the physicians suicide rate is more than double that of the general population. In addition, the rate of nurse suicide is going up as well. Nurses have struggled to achieve safe and effective ratios and in contrast to the New York State Nurses Association's recommended safe nurse to patient ratios, there have been reports that some nurses in New York City treat up to 15 patients at a time. Doctors, nurses and staff also have physical safety concerns. According to surveys by the American College of Emergency Physicians and the Emergency Nurse Association, almost half of emergency physicians report being physically assaulted at work while about 70% of emergency nurses report being hit and kicked while on the job, and 80% of emergency physicians say violence in the ED also harms patient care. As a result, EDs and staff have needed to adjust their practice to include new trainings and security measures. This is just the tip of the iceberg. Today, we plan to examine these issues in depth to better understand the state in which our EDs are operating. I look forward to listening to

hospitals, providers and advocates about their experiences and ideas for addressing these very serious issues, and I want to thank you all very much for attending today. And with that, we're going to call up our first panel. I want to recognize Council Member Diana Ayala. Natalia Cineas, Health and Hospitals; Eric Wei, Health and Hospitals, and does that say Sean—Sean Metsui—Sean? Yeah? Okay, and please, please correct me if I mispronounce your name. I know the feeling.

LEGAL COUNSEL: So, will anyone providing testimony or answering questions please raise your right hands. Do you affirm to tell the truth, the whole truth and nothing the truth in your testimony before this committee, and to respond honestly to Council Member questions?

DR. WEI: I do.

LEGAL COUNSEL: Thank you.

DR. WEI: Good morning Chairperson Rivera and Members of the Committee on Hospitals. I am Dr. Eric Wey, Chief Quality Officer for New York City Health and Hospitals. Oh.

CHAIRPERSON RIVERA: Sorry. Just make sure the red light is on.

DR. WEI: Okay.

CHAIRPERSON RIVERA: That's actually a good thing. Yes.

DR. WEI: Sure. I'll start over. Good morning Chairperson Rivera and members of the Committee of Hospitals. I am Dr. Eric Wei, Chief Quality Officer for New York City Health and Hospitals. I am joined by Dr. Natalia Cineas our Chief Nursing Executive at Health and Hospitals. Thank you for the opportunity to testify before you today on the safety of Health and Hospitals' Emergency Departments. Before I get into some of the strategies and initiatives that we have and continue to undertake to improve quality, safety and experience of care we provide in our ERs, I would like to thank the committee for taking an interest in this important topic and ensuring safety of New York City Emergency Departments. Dr. Katz our CEO of Health and Hospitals asked me to take the lead on this testimony because I (1) am an Emergency Department physician, and I have worked shifts in all 11 of our EDs. I can attest to the very real struggles and challenges that are our providers, nurses, and support staff face day and day out. They

are truly heroes. EDs serve not only as the safety net for many things broken in healthcare, but for many things broken in our society. When you can't get a doctor's appointment, you go to the Emergency Department. When you can't reach your surgeon with a post operative concern, you go to the ED. When you don't have shelter and it's negative five degrees outside, you go to the ED. When you're hungry, need legal advice, need to find a detoxification center the list goes on and on. Health and Hospitals has eleven full service emergency departments staffed by experienced mission driven and caring physicians, nurses and other health professionals. Our EDs are busy with over one million visits last year. In fact, New York City Health and Hospitals Lincoln was ranked the sixth busiest ED in the country. Health and Hospitals operates five level one trauma centers, seven adult and one child and adolescent Comprehensive Psychiatric Emergency Programs also know as CPEPs. We believe to reduce the burden on our Emergency Departments we need to reduce the number of patients going to our EDs. Improving patient flow through our EDs, and expediting the low of patients to in-patient and observation beds. In

addition to improve the safety of our patients and our staff, we are implementing a culture of safety to ensure we provide the highest quality and safest patient care with the best patient experience. First, a core component of our strategic plan is to shift from the old model of waiting until patients are so sick that they need to go o the Emergency Department often requiring admissions to the ICU followed by long hospital and rehabilitation courses to one focused on primary and preventative care. Establishing an ongoing primary care relationship to control that hypertension and diabetes can prevent patients from developing a heart attack or a stroke. We have expanded primary care across the system and implemented NYC Care in the Bronx enrolling over 13,000 patients while providing each one a primary care visit within two weeks. We launched NYC Care in Brooklyn and Staten Island last month, and are on track to implement across all five boroughs by the end of 2020. We understand that no how many primary care physicians we hire patients may still choose to go to the Emergency Department over primary care. They have learned over time that going to the ED may take a long time, but they go whenever convenient

around their work and home obligations and get everything done. A one-stop shop. Therefore, we invested in creating urgent cares called Express Care where patients with lower acuity complaints can have their immediate medical problems addressed rapidly, also connecting them with a primary care life experience with a smooth transition to ongoing primary care. We currently have six express care centers live, and plans to open two more this year. Once a patient arrives in the Emergency Department we have implemented multiple strategies to improve patient safety and flow. We know that patients come to the Emergency Department to see a doctor. Thus, we put a definitive provider in triage in many of our EDs. They see the patient right after the nurse completed triage and starts treatment and testing immediately. Another strategy is direct to bed such as in Bellevue where no patients wait in the waiting room any more. Patients are taken back to the treatment areas immediately after triage to be evaluated by the providers. One of the biggest influences on ED patient flow is hospital patient flow. When all the in-patient beds are occupied in the hospital the new admissions cannot be transported

out of the ED, which creates a traffic jam causing delays for new patients seeking care. We have implemented multiple initiatives to improve hospital patient flow and earlier discharges to match ED emission demand. Finally, one of our strategic pillars is to create a culture of safety. This involves a culture of obsession with where things may go wrong in order to fix them, and prevent harm. The safety to speak up, the continuous learning and improvement. In this strategic pillar we implementing the Helping Healers Heal or H3 Initiative. We currently have 18 H3 teams across our system. We have over 1,000 trained peer support champions who have provided over 600 one on one and group debriefs after emotionally and psychologically traumatizing events. This is to ensure that our staff are supported so they can best care for themselves, and for our patients. We are also implementing the Institute for Healthcare Improvement our joy and work framework, which connects staff back to the why in joining healthcare, joining and working in healthcare. We believe that engaged, supported, well and joyous staff will provide higher quality and safer patient care with better patient experience.

Over the past two years we have made significant strides in improving nurse staffing throughout our system including our emergency departments. We have recently reached a four-year agreement with the New York State Nurses Association to pay fair wages, ensure safe staffing, and improve recruitment and retention of our nurses. Health and Hospitals has also agreed to collaboratively address nurse to patient staffing ratios with NYSNA and we'll follow an improved staffing model. Other initiatives include implementation of a single electronic medical record at that—across the system so that providers have a full picture of their patients' care without having to unnecessarily duplicate visits and studies. EPIC also helps us with many of the Joint Commission of National Patient Goals such as using barcode scanners to ensure we have the correct patients and treatments. We will soon transition to a new electronic incident reporting system to reduce the activation energy required for staff for speak up and tell us where there are opportunities for improvement. Together with our robust quality assurance and performance improvement processes we continuously learn and improve our system. And

finally, thanks to the generous financial support of City Council, other local and state elected officials and other resources, we have been able to or plan to make significant equipment and physical space upgrades to many of our EDs including Lincoln, Elmhurst, Bellevue and Woodhull. In summary, as physicians, we took an oath to first do no harm, and as a system we share the same value where patient safety is what we uphold as a top priority everyday. We have taken many strides towards improving our Emergency Departments, but the work is never done, and we're up to the challenge. Thank you.

CHAIRPERSON RIVERA: Thank you so much for your testimony. So, you have some of the busiest Emergency Departments in the country, and you are taking steps towards improving some of those spaces, expanding them, renovating them, of course with money from the Administration, the Mayor's Office as well as City Council funds. In Fiscal Year 2020 the Council and the borough president designated $925,000 to Bellevue for renovation and upgrade of trauma slots in their Adult ED and you mentioned some of the other facilities who are going through some changes in terms of capital upgrades. So, what is the

process for H&H to determine the priority of the—of the Admin funding capital projects, and why do—why does the Council have to fund trauma slots in Bellevue? Is that not a priority?

DR. WEI: So, thank you Council Member for that—that question. It is absolutely a priority. We would like to provide the environment so that we could provide the highest quality care to anybody who comes through our doors. The process for us to prioritize physical space upgrades and the upgrades to equipment is a collaborative process with the Administration, with our facilities, with the OMB Office. The vast majority of our funding comes from the Mayor's Office. Those that come from borough presidents as well as Council—City Council are supplementary. We are very appreciative to all generous support to improve our physical space, and once we do have funding approved we take the necessary steps to make sure that we are making these improvements while not jeopardizing the ability to care for patients and the safety of the way we care for patients.

CHAIRPERSON RIVERA: I understand. I just want to—and I am happy to—to fund healthcare

services. I think it's—that's a fundamental human right is that people have access to quality care no matter which hospital they walk into. I am just trying to get. I'm trying to establish some sort to understanding of when they choose to fund what you need, and if you need trauma slots, if you need x-ray machines, I think you should be at the top of the list when it comes to the administrative funds. But I want you to know that I certainly want to be helpful and supportive of that, and I know my colleagues are—are certain—certainly want to do the same. So, let's go to kind of the—you mentioned at the end of your testimony the safe staffing ratios in your EDs. Is there a set staff ratio?

DR. WEI: So, I'm going to defer to Dr. Cineas.

NATALIA CINEAS: Thank you for the question. So with our new NYSNA contract we partnered with NYSNA to ensure that our staffing models would align with the Emergency Nurses Association, and we are confident that the staffing models that we've put in place will ensure patient safety. So, we made sure that we optimized our systems to look at how many patients come into our

Emergency Departments every hour, and we will ensure that we have enough nursing staff per hour based on the acuity of our patients to ensure safe staffing.

CHAIRPERSON RIVERA: So, do you have numbers? I recently saw I believe the contract that said it was 1 to 8 for non-critical low resource patients and then 1 to 5 otherwise. Do those numbers sound correct, and can you describe the progress you made in working with NYSNA towards implementing these numbers? Could you even share the ratio that was set forth in the contract?

NATALIA CINEAS: Sure. So, the ratios in our contract illustrate guidelines from the Emergency Severity Index. So, based on a patient's acuity at triage, which is an algorithm we will then understand how many nurses are appropriate to care for that patient. Going forward we have established staffing committees with NYSNA so that we are meeting every month, every other month strictly focused on staffing to ensure that all of our areas are staffed appropriately. So this is a partnership that is new for us in our contract and we're confident that we will meet those ratios and guidelines in our contract.

CHAIRPERSON RIVERA: And I think that's great that—I think Dr. Katz and all of you have clearly said how important it is to work with labor and, you know, whether it's NYSNA or 1199 or DC37, I just want to know whether you could let us—what are the numbers? Do you have a ratio set forth?

NATALIA CINEAS: So the guidelines are 1 to 1, 1 to 2, 1 to 5, 1 to 8, 1 to 8 that is our goal for us t get there based on the Emergency Severity Index, but it's all based on patient acuity. So, it's fluid based on what comes through the door, and so we have to be prepared at any given time, and that's just a framework for us to really guide nursing care hours, but that changes again based on the patient that comes through the door, but that's the guideline yes established in our contract.

CHAIRPERSON RIVERA: I just want to thank Council Member Eugene for joining us. Is there a sort of triage medicine practice at H&H EDs? Do you utilize the provider and triage system?

DR. WEI: Yes, um, so triage is one of the most important processes and tools that we have in our Emergency Departments to determine severity of illness, assigning that emergency severity index and

making sure that urgent patients get care immediately in our most high acuity areas. We do providers in triage, as I mentioned in the—in my testimony because we know that patients come to the Emergency Departments not to get their vitals taken, not to go through the triage process, but they want to see a doctor or a nurse practitioner physician assistant and have their care started, and so we in multiple of our emergency departments put a provider or multiple providers up in triage so they see them right away and get the right test ordered from the beginning, and started to get their pain treated right away. You get the fever treated right away, and so we believe that is a best practice that we are working towards getting in all of our emergency departments.

CHAIRPERSON RIVERA: You mentioned right away, what have you done exactly to reduce the ED wait times?

DR. WEI: So--

CHAIRPERSON RIVERA: You mentioned express care...

DR. WEI: Yes.

CHAIRPERSON RIVERA: …earlier in your testimony.

DR. WEI: yes.

CHAIRPERSON RIVERA: So, if you could just talk a little bit about how that's helped relieve some of the strain.

DR. WEI: Absolutely. Um, so, by having an alternative clinic, urgent care for patients to self-select to, if they do not have a serious medical complaint or problem like a heart attack or a stroke, um, they can self select to our Express Care, which is a little less chaotic than an emergency department, but almost like a clinic visit, and our plan is to staff these with primary care physicians that can say not only did if fix your problem today would you like to follow up in my primary care clinic in two weeks, and make that transition from showing up unannounced to the Emergency Department to Express Care and eventually to—to primary care. So, that's one of many ways that we're trying to offload the lower acuity patients from our Emergency Departments. Other things that we're working on include addressing social determinants of health. Why are they showing up to—to the ED and how do we connect them to our community based organizations,

our partners in the community to address those—those gaps in their social needs.

CHAIRPERSON RIVERA: In Kings—in Kings Hospital there is no express care clinic there yet, correct--

DR. WEI: Right.

CHAIRPERSON RIVERA: --even though it's the busiest.

DR. WEI: Correct.

CHAIRPERSON RIVERA: And that's slated to open soon?

DR. WEI: this year.

CHAIRPERSON RIVERA: When?

DR. WEI: I don't have the exact date, but that is on our list of prioritized Express Cares, and the way that we map this out was we partnered with FDNY and we did GEO mapping of where the 911 calls across the city were happening and which ones were showing up to—to H&H facilities, and so there are multiple factors that go into it, which include do we have a space that's readily available to be converted to an express care? Is there the need from our heat mapping data analytics for an express care, and are there other things, initiatives that are going on,

and so Kings County is one of our facilities that implemented provider and triage, and so that is something that's been very successful there.

CHAIRPERSON RIVERA: Have H&H patients ever mentioned being referred to H&H EDs instead of other EDs, and/or being sent to H&H after initially contacting another hospital first?

DR. WEI: Um, to my knowledge I don't know of any of those cases. There is an Emtala regulation that prevents hospitals from transferring Emergency Department to Emergency Department without doing a medical screening exam, stabilizing any emergency condition before even considering transferring. We do transfer patients from EDs to Des once stabilized when there is a need for a higher level of care. So, for example a smaller community hospital may not have the neurosurgery resources that a patient might require, and so then you would look to safely transfer to a receiving coordinating care hospital that has a neurosurgeon on call, and so we both transfer patients inside our system as well as outside depending on the case, the severity, the availability of these resources.

CHAIRPERSON RIVERA: And I ask, because you know, we hear from many patients, many consumers or constituents anecdotally, and you have such a high volume of patients in your systems, and we are very, very grateful to you because you serve such a diverse population of New Yorkers, and so do other hospitals who are here today to testify, and so you're a provider in triage system. So, it has come under pretty intense scrutiny saying that the practices increase hospital profits yet cause doctors to perform rapid medical evaluations that are not thoughtful and can be meaningless, and how do we ensure meaningful tests and not over-utilization?

DR. WEI: Yeah. So we number one are very happy to take care of all New Yorkers who come to our door. That is our mission. We treat everybody without exception. In terms of provider and triage, I think another core value of ours is that we treat patients with what they need at the right place at the right time. So, we are providers in our system. It's not incentivized to do more, to make more money, and so, I really appreciate that working as an emergency medicine physician and our system with doing the right thing and practicing what I would

consider medicine in its most noble form not being driven by financial incentives, and so forth. And so, our providers in triage are truly trying to order the correct test and given the right treatment nothing more, nothing less.

CHAIRPERSON RIVERA: Thank you. I want to make sure that my colleagues get a chance to answer or to ask some of their questions. So, first, I'm going to go to Council Member Eugene.

COUNCIL MEMBER EUGENE: (off mic) In the order. (sic) (on mic) Thank you very much, Madam Chair. Thank you. Dr. Wei and member also of the New York Emergency Department. I know that in New York City and I'm sure, I'm certainly confident that doctors or nurses of medical professionals they are equipped. They have the knowledge, the skill and to provide the best quality of healthcare to New Yorkers, and I know that they are doing the best that they can do. They're dedicated to do so, but my first question is are we equipped in New York City in the hospital to face the different epidemics that, um, we are facing almost every two years, every three years? Now, we are talking about Coronavirus. Before it was something else, and I guarantee you

after two or three years or four years there will be something else. Are we equipped? Are we ready to face those…those challenges, and if we are, I would be so happy to hear from you the answer.

DR. WEI: Thank you so much for—for that very important question. We share your concern. A few years ago it was Ebola. This year it's—now with Coronavirus we face flu season every year, and I do believe that were equipped, prepared and we trained on this. Speaking specifically to the Novel Coronavirus, COVID-19, we have a Special Pathogens Program in New York City Health and Hospitals, which bot the U.N. and the CDC have invited to come out and speak to learn from our program that is continuously working with both the CDC, the World Health Organization, Departments of Health at the state and the city level to prepare our facilities. We do disaster drills around epidemics such as the flu. Our front line teams train on a regular basis with the—the protocols of putting on protective equipment bringing patients in through the right entrances and—and getting them into the right rooms where the air flow is correct. We as a system have already done table talks about what if 50 (inaudible) Coronavirus

patients showed up to all of our EDs at the same time? What will we do as a system and as facilities, what can we pause in terms of elective surgeries, outpatient visits to bring all those resources together for a sudden surge in a special pathogens threat, and so I believe that we practice and we drill and we prepare every day just for situations like this because we know that in three years, two or three years there might be another virus or another epidemic.

COUNCIL MEMBER EUGENE: We know that many hospitals in New York City are closed. So that means we have less space available, and the population of New York City is increasing.

DR. WEI: Uh-hm.

COUNCIL MEMBER EUGENE: So, you could tell me or tells us are we are in the situation where we have a lot of people affected, and we need beds. We need space in the hospital to receive the treatment because the hospital has been closed. The population is increasing. We don’t know what’s going to come.

DR. WEI: Uh-hm.

COUNCIL MEMBER EUGENE: Number one could you tell us what are we going to do? Do we have the capacity to give the proper service or treatment to the people in case there's there's a tie here. If someone, people get affected for whatever reason--

DR. WEI: Uh-hm.

COUNCIL MEMBER EUGENE: --and number two what do you have in place as prevention because we have to be preventive also for our city. We don't have to wait. We cannot, you know, I testified what will come if all the details, but we have to have some measure of prevention, you know, in case there's a big tragedy, and we will be ready or we will be about to minimize the damage. What would be the answer to those questions, sir?

DR. WEI: Yeah. No, I—I—I share—thank you for that questions. I share your concern as well do we have a mismatch or healthcare capacity with the growing New York City population. I believe to—to make this equation work, as a healthcare system and as healthcare in general in New York City and across the United States, there needs to be more focus on preventative care, on primary care not trying to build our way out of building bigger EDs, building

bigger hospitals right to try to keep up or hard wire something that's already broken. The idea is can we improve the health of all New Yorkers so they get— don't need to be admitted to the hospital as often that they're not having as many serious debilitating medical events such as a stroke. That is how we are focused in our strategy of improving health of the entire community, and not necessarily trying to do more cardiac catherizations for heart attacks or, you know, stroke care. We still want to treat, and be centers of excellence in all of those things, but we believe that right controlling that blood pressure, controlling that diabetes, controlling that obesity decades before hand should be the priority, and that will reduce that mismatch between capacity and demand for our hospitals.

COUNCIL MEMBER EUGENE: Yeah, I think, we know that prevention in medicine is something very, very important. This is the best medicine as a matter of fact. I know that we are doing screening. We are taking several measures to make sure that people don't get sick. As a matter of fact, I'm a strong, you know, advocate for that as you may know. But my question is, you know, when have a virus, you

know, like a Coronavirus and all the, you know, epitome that we have in the—in the-before. It is not about prevention. It's come like that boom, boom, boom and so quick. So, my question is: Are we ready to end those type of situations? Prevention. We do prevention, you know. As a matter of fact I'm going to have a health fair, an annual health fair, you know, with many hospitals and medical clinics—clinics and also medical professionals to provide screening to the people. I know that's toward the year, but I'm talking about some situation like Coronavirs and all the epidemics that we had before.

DR. WEI: Yes.

COUNCIL MEMBER EUGENE: You know, it's not about screening. It's not about prevention. The capacity--

DR. WEI: Yes.

COUNCIL MEMBER EUGENE: --to limit the damages and the capacity to provide the proper treatment to those people who are going to be affected--

DR. WEI: Yes.

COUNCIL MEMBER EUGENE: --and the space--

DR. WEI: Yes.

COUNCIL MEMBER EUGENE: --to put them because we have to isolate them to mitigate also the propagation of the disease. That's what I want to hear from you.

DR. WEI: Yeah. Yes. So thank you for your clarification on that question. I do believe that if we can prevent emissions, preventable emissions beforehand, that would free up space.

COUNCIL MEMBER EUGENE: This is part of it.

DR. WEI: So, that would free up space.

COUNCIL MEMBER EUGENE: Some of the time it's not even possible.

DR. WEI: Yes, free up space for—for when we have a surge. Each of our hospitals has a disaster plan for these situations, which include potentially opening up additional units that are not open day to day due to the hospital census. Um, bring staff in from different areas of the healthcare system meaning if we're not running ambulatory care clinics can we bring those nurses and those doctors to help with the in-patient surge. Um, we, um, have different ways of expanding patient care spaces in emergencies all the way up to having tractor-trailers brought in outside

of our Emergency Departments to give additional patient exam spaces. So these are all things that we have a disaster plan on and we drill on as well.

COUNCIL MEMBER EUGENE: This is my last question because I got to turn it over to the Chair, but I keep saying that all the time after Sandy on the aftermath of Sandy, I visited—visited several hospitals, and I was shocked to see what I saw. An emergency room that is crowded with people coughing, you know, sneezing, sick people, senior citizens everybody together, and those rooms or emergency rooms they were so over-crowed the nurses and the doctors they couldn't even pass through people were so close to each other. Just imagine infection, contaminations, and I don't think that we were ready. I don't think so. As a matter of fact, Code 9 on the hospital they had to transfer all the patients to other hospitals. You know that what I'm talking about, but I'm telling you the picture was not too good. It was not too great, and I am very, very concerned about that because when there is a tragedy, you know like Sandy or other type of tragedy that could affect the health—the health system and the hospital, the system that we have in place I think we

have to do a better job. I'm not convinced that we are ready.

DR. WEI: Okay.

COUNCIL MEMBER EUGENE: There's tragedy in medicine. They couldn't make some of those come so good that quick, and my, you know, to that let me add you one thing.

DR. WEI: Uh-hm.

COUNCIL MEMBER EUGENE: Our medical professionals, nurses, doctors, did all receive the proper training that we've had them overcome the challenges or do a better job in term of emergency and repeating the infection. They don't receive the proper training because, of course, they have the training to treat people to do prevention, but I'm talking about emergency in medicine, infection, epidemic and stuff like that.

DR. WEI: Uh-hm. I believe we—we do. We have, infection prevention as epidemiologists at each of our hospitals that create protocols for each of these special pathogens threats, and I myself working with a Friday overnight in the Coney Island Emergency Department. I got pulled in to do a donning and doffing personal protective equipment drill with a

nurse playing the patient, and so I know this is happening daily, weekly, monthly in all of our hospitals. We have ongoing annual assessments and—and trainings for all of our nurses and our—our physicians being able to appropriately take an airborne droplet, contract precautions knowing how to put on and take off the protective equipment. It's all very much a part of our training and ongoing reassessment and training for our staff.

COUNCIL MEMBER EUGENE: Thank you, doctor.

DR. WEI: Thank you.

COUNCIL MEMBER EUGENE: Thank you, Madam Chair. Thank you.

CHAIRPERSON RIVERA: Thank you so much. I—I had the privilege of visiting Bellevue to talk a little bit about the Coronavirus and the preparation and trying to understand all of the training that the staff there is going through and there is a lot of fear and anxiety. So, I—I realize that when people are sick whether they're coming from a different country, they're visiting, they're undocumented, they want to ensure that they're receiving care. They're walking into your emergency departments. So, thank

you and I wanted to just turn it over to my colleague. First, let me recognize Council Member Maisel , and Ayala.

COUNCIL MEMBER AYALA: Thank you. I'm wondering going back to the—the overcrowding conditions at the Emergency Room Department, I wonder is there some hospital seeing overcrowding more than others?

DR. WEI: Thank you for that question. Somebody once described this to me as no two children are the same and no two hospitals and no two emergency departments are the same. So, absolutely it varies across our 11 Emergency Departments. Lots of factors depending on are there nearby hospitals with Emergency Departments, whether it's the health demand and need of that community around the hospital, and so we have anywhere from as I mentioned Lincoln Hospital, which is the sixth busiest ED in the country that sees over 400 patients per day on average to smaller community hospitals such as North Central Bronx does see about 125 patients per day. And so, all the other nine hospitals are a spectrum between there.

COUNCIL MEMBER AYALA: Such you mentioned—that wasn't—that wasn't my next question, because you mentioned Lincoln we've consistently received reports from staff that while it is one of the busiest emergency rooms, that they are also really seriously short staffed and this has been a consistent theme since I've been in office. I know I've spoken to the Chairwoman about this, and she's received some of our complaints. Has H&H addressed those staffing issues?

DR. WEI: Yes. We absolutely take each of those complaints very seriously. I have worked four shifts in the—the Lincoln Emergency Department. I see how busy it is. We have done staffing models based off of historical arrivals and severity to the Emergency Department. We work very closely with the CEO, CNO and CMO there to make sure that we are staffing to demand, and so I am confident with our provider and our nurse staffing models that we've already made a lot of progress and we will continue to partner with them to continue to—to make progress because it is our busiest Emergency Department. The South Bronx is one of the most health depressed zip codes in the country, and, um, and so we really

prioritize Lincoln as a place that we want to provide safe and quality healthcare to those most in need.

COUNCIL MEMBER AYALA: And Lincoln doesn't currently have an express care department does it?

DR. WEI: It does.

COUNCIL MEMBER AYALA: It does?

DR. WEI: It was our second one.

COUNCIL MEMBER AYALA: When did it open?

DR. WEI: It was in 2018. I don't remember the exact date.

COUNCIL MEMBER AYALA: Has it helped reduce the number of patients that are coming into triage through the ER?

DR. WEI: Yeah. Our Preliminary Analysis is showing a reduction in ESI 4s and 5s. So, those are what you expect for urgent care, your lowest acuity patients, and we are tracking the time to doctor, the time, the throughput numbers very closely, but the Preliminary Analysis is promising both at Elmhurst and at Lincoln, which are our first two.

COUNCIL MEMBER AYALA: So, if I'm a patient at Lincoln and I come in through the

emergency room, but I'm really not presenting with symptoms that would be considered, you know, an emergency, would that—would the nurse or whoever is doing the triaging event redirect me to urgent care? Is that how that works now?

DR. WEI: Not exactly. Um, because of Emtala regulations once a patient presents and declares themselves in the Emergency Department--

COUNCIL MEMBER AYALA: You have to take them.

DR. WEI: You have to do the medical screening exams, stabilize any emergency condition, and this needs to be done by a provider. So at that point if you've already a provider to do that exam, and it's a lower acuity, you might as well finish that visit than to stop there and then transfer a patient Express Care, but however we can to educate our communities and our patients and their families, but if you have an urgent care complaint that you could self-selected to go to Express Care, and so we have signage up within our—outside of the hospital within our main lobby making the community and our patients aware that Express Care Services are available, but we would—we can't violate the Empala

Regulation if once a patient chooses to come to the E-D, you need to—to really follow Empala.

COUNCIL MEMBER AYALA: Okay. so, if a hospital—if a hospital has seen consistent overcrowding, you know, in the last few years, at some point does that trigger a conversation with the hospital's administration within H&H to find a better approach to dealing with the overcrowding? I mean I get it in a hospital like Lincoln where you don't have—I mean I think the close hospital is several miles away. So, I can see that happening, but Metropolitan for instance we have Mount Sinai and Metropolitan in the same community--

DR. WEI: Uh-hm.

COUNCIL MEMBER AYALA—Mount Sinai is busting at the seams. Metropolitan, you know, has capacity. What, you know, what conversation is happening behind the scenes to better address the, um, the overcrowding issue?

DR. WEI: Yes. So, I don't think this is a periodic assessment or conversation. I feel like this is a continuous conversation, and each of our Emergency Department chiefs, the nursing leads, the administrative leads in the Emergency Departments,

this is what they think about all day, every day is how to do continuous performance improvement, to best provide the care for the patients that show up at the door as a system through our Office of Population Health, through our Community Care Division we're talking about how do we transition people once they've come to the E-D or come to the hospital back to the community? Can we prevent some of these what we would call potentially avoidable Emergency Department visits through better care outside the four walls of the hospital. So they don't need to—to come, and so this is something that through NYC Care, through expanding primary care through social determinates of health work. We're trying to turn the faucet down a little bit of the patients coming to the Emergency Department, but absolutely once they're in our Emergency Department, we're thinking about is there a better way we could do triage? Is there a better way we can do flow from triage to the provider, to the bed? Do they need to be in a bed? Right, if they walked in perfectly fine can they sit in a chair while they're getting their care and walk out? We don't have to make everybody into a sick person that has to lay in the bed the whole time, and

so constantly thinking about how we can improve each of the stops in that process.

COUNCIL MEMBER AYALA: And my last question. How are you—how is H&H promoting the Express Care hours? Because I think that, you know, for—for a person that has a chronic, you know, illness, you're in and out of the hospital. You're being exposed to all of this information. You may be speaking to your primary doctor who is also referring you, but most of us don't go to the doctor until we need to go to the doctor, and so how do you communicate that Express Care is an option for me if I am not within the boundaries of where the information is contained?

DR. WEI: Uh-hm. Thank you for that question. I think that's a great question. So, we work very closely with our Community Advocacy Boards our CABs. We work with our community based organization partners. We have done small kind of marketing campaigns around Express Care, put signage in the hospitals giving patients pamphlets and information about Express Care when they are seeking other care within out systems, our websites are all places that we list hours and the resources

available, but we know that patients are liking Express Care because patients are lining up for—for the clinic to open. So, they've clearly found value in it.

COUNCIL MEMBER AYALA: Thank you. Thank you.

CHAIRPERSON RIVERA: Thank you so much and I know as we are try to move patients towards primary care utilizing our Gotham Clinics and really staying out of the emergency room unless it's –unless it's critical, and with that being said, I want to make sure that we are supporting our local clinics our Gotham facilities. I know there's one in Coney Island, the Ida G. Israel Clinic, and there has been some discussion around making sure those doors stay open. So, I just want to ask that we work very, very hard to make sure that we're supporting our Gotham clinics and we certainly want to be an ally in that.

DR. WEI: And we appreciate that.

CHAIRPERSON RIVERA: And with that, thank you so much for testimony. Thank you so much for what you do.

DR. WEI: Thank you for the opportunity.

COUNCIL MEMBER AYALA: Thank you.

DR. WEI: thanks.

CHAIRPERSON RIVERA: I'm going to call the next panel. Dr. David Reich from Mount Sinai and Lorraine Ryan from Greater New York. (background comments/pause) Thank you for your patience, and you can begin.

DR. REICH: Good morning.

CHAIRPERSON RIVERA: Just really quickly, we've been joined by Council Member Reynoso. Thank you.

DR. REICH: guess, thank you. Good morning, Council Member Rivera and members of the City Council Committee on Hospitals. It's a pleasure to be here today. My name is Dr. David Reich R-e-i-c-h. I apologize for my own mispronunciation. I'm the President and Chief Operating Officer of the Mount Sinai Hospital. Just by way of background I arrived at Mount Sinai in 1984 to begin anesthesiology residency, and I have remained there throughout my career and remain a practicing cardiac anesthesiologist. I was Chairman of Anesthesiology for nine years, and most recently and for the past seven years I've been the President and Chief Operating Officer of the largest hospital in the

Mount Sinai Health System, Mount Sinai Hospital. I'm incredibly proud of the work our team performs every day to serve our patients and to keep our communities healthy. Despite our many successes, however, our hospital and many peer academic medical centers, emergency departments face complex challenges on a daily basis. As many leaders of the City Council know, we have been grappling with these issues for a long time. I'm here today to provide information, but also to advocate for a series of actionable changes to improve Emergency Department conditions in New York City. These suggestions are for your consideration and comment in the hope that collaboratively and collectively we can define better solutions. We all have the same goal to ensure that our New Yorkers receive the best quality of medical care anywhere. Some challenges are faced by all emergency departments across the five boroughs. The greatest of these is that too often patients arrive at our city's emergency departments who could be better served in non-hospital settings. These include hospital-at-home programs, multi-specialty outpatient settings, primary care practices, urgent care centers, telemedicine visits, community para

medicine programs and sobering center. I hope that we will have more opportunity to explore some of the solutions since we can and we should implement cost-effective reforms that address the underlying causes of emergency department crowding with the attendant consequences of long wait times, patient dissatisfaction and difficult working conditions that demoralize our dedicated ED staff. The council's advocacy and support is instrumental if we are to be effective in addressing the root causes of emergency department crowding. Mount Sinai is employing innovative approaches to the most vexing challenges for our Emergency Department. The entire organization including support staff, nursing, physicians and advanced care providers and senior administration work tirelessly to provide world class care for every patient we serve. The Mount Sinai Hospital Emergency Department is ranked third in the nation in national—I'm sorry. Pardon me. The Mount Sinai Emergency Department across the whole health system is ranked third in the nation in National institutes of Health Funding and is consequently staffed by some of the most brilliant physicians that innovate and implement ground breaking advances such

as the Geriatric Emergency Room and Hospital at Home. This is not theoretical ivory tower research. Rather, this is research that creates real advances for New Yorkers every day, and the metrics reflect the quality of the team. Patients who come to the Mount Sinai Hospital Emergency Department with heart attacks, severe heart failure, severe lung conditions or strokes have among the best survival rates in the nation. One reason for our excellent patient outcomes is the introduction of Split Flow in 2015. Split Flow is a national best practice that gets patients in front of a medical expert sooner. Patients see a triage nurse immediately upon arrival. Some patients with lower acuity—acuity problems receive their care in chairs while those with more severe illness receive the care they need more quickly. At Mount Sinai Hospital today, a walk-in patient is seen by the medical provider in an average of 22 minutes well below the national average. "Left without being seen" rate is just 1.8% lower than the national average of 2%. These are superb quality metrics. Yet, we are not complacent and are constantly looking to improve. We commission independent external department reviews every few

years, and we also benefit from the regulatory oversight processes of the State Department of Health, the Joint Commission and CMS. Over the past four years we've made several critical enhancements to our strategic plan that it helps streamline our ED Operations. We've expanded our ED staff by more than 130 additional employees across every category of clinical and support staff. Forty-two of them registered nurses, and I just checked 24 additional positions in 2019 alone. We have also added additional nursing leadership to help provide 24/7 on site leadership support and a float pool to bring additional nurses to the Emergency Department or a need shift as required. We are also on the cusp of initiating a $48 million renovation and expansion of our Emergency Department that will dramatically enhance operational efficiencies, increase throughput and improve patient experience and quality. Mount Sinai spent $3 million in 2019 engaging a team of experts to completely redesign our ED with meaningful input from staff, departmental leadership and the community. This effort culminated in the submission of a Certificate of Need Application to the State Department of Health on December 31, of 2019. We are

working closely with the Department of Health as they review this exciting project. The plan under review will expand the ED by 8,500 additional square feet doubling the space devoted to critically ill patients. We are increasing the number of exam spaces by 19 for a total of 72 individual treatment spaces, and the renovated Emergency Department will be able to serve more than 122,000 patients per year, which aligns with the projected volume of the hospital. This is an ED design for 21st Century needs. Pending the various regulatory approvals, we hope to begin construction in the multi—of this multi-year project in the middle of this year. A separate construction plan that is under preparation will relocate and expand our Observation Unit from 20 to 30 beds. While construction will be transformative over the next several years, Mount Sanai is also using innovative solutions currently to decant our busy ED. To address the needs of patients who do not require hospital admission we opened an Express Care facility on this same block as our ED in 2018. This unit accepts all insurance. This winter we've expanded Express Care to weekend hours and are seeing approximately 250 to 300 patients per week

depending upon the needs. We have also expanded access and officer hours for our community in a wide range of ambulatory hospital initiatives that address the population health needs of our community. For those patients who need admission we added 16 medical surgical beds this past Autumn and these beds are dedicate dot ED patients, and medically appropriate patients and with their consent we transferred approximately 1,000 admitted patients directly from the Mount Sinai Hospital Emergency Department to available in-patient beds elsewhere in the Mount Sinai Health System in 2019. The majority of these went to the newly renamed Mount Sinai Morningside previously known as Mount Sinai Saint Luke's. Transferred patients arrive in a hospital bed an average of eight hours sooner. Our Hospital at Home Program continues to enroll patients with excellent outcomes, and we implement our Surge Plan as needed to move patients…to move some patients to hallways on patient units. The additional case mangers, social workers, and volunteers serve the complex needs of our population by addressing placement issues, safe discharge planning and facilitating meaningful discussion about the goals of care. In conclusion,

Mount Sinai ahs made major investments that are already moving the needle for the emergency and urgent care needs of hundreds of thousands of our neighbors. In advance of the complete renovation an expansion of our Emergency Department. We are constantly innovating using science, clinical expertise and compassion to better serve our community. I think the Council again for the opportunity to testify today, and I'm happy to answer your questions.

CHAIRPERSON RIVERA: Thank you.

LORRAINE RYAN: Good morning Chair Rivera and members of the Committee on Hospitals. My name is Lorraine Ryan. Thank you for welcoming me back. I'm the Senior Vice President at the Greater New York Hospital Association. As I think you know, Greater New York represents all the hospitals in New York City and proudly, I may say that. Both not for profit and public hospitals. We also have hospitals throughout New York State, New Jersey, Connecticut and Rhode Island. I appreciate the opportunity to testify today about New York City Emergency Department Care. My understanding of this care—of care delivery in the ED comes through my clinical

training as a nurse, my experience as a hospital administrator in New York City, and my responsibilities as Director of Quality Improvement in Patient Safety at Greater New York, and I appreciated Dr. Wei's comments on how seriously we take our obligation for continuous quality improvement and development of the culture of safety across our hospitals. We also have a significant focus on infection prevention, which is one of the Council person's concerns most timely brought up because of the current virus that we're dealing with or potentially could deal—be dealing with. I can proudly say that our members hospitals believer healthcare believe healthcare is a human right, and providing life serving—saving emergency care to all New Yorkers regardless of immigration status or ability to pay is part of that core principle. The 53 EDs across the five boroughs of New York City provided over $4 million—4,000 ED visits in 2018. Obviously EDs are a critical part of New York's world class healthcare infrastructure. As Dr. Reich just mentioned, the regulatory compliance that hospitals submit to both at the state level and the federal level and in some small way at the city level as

well. And again, these obligations are taken very seriously. Secondary to financial strains we are facing a perilous time in healthcare. New York City Hospitals are open 24/7 365 days a year and committed to treating all who walk through their doors. Our hospitals both public and voluntary surge huge—sever huge number of Medicaid patients and provide the same quality of care to all. EDs as you've heard already from the physicians and Ms. Cineas exists in her design to treat patients with acute emergent and often life threatening medical conditions. Here delivered in EDs is quite different from what might be delivered in non-emergency or primary care settings. You've heard about the Triage process to determine who needs immediate treatment. Patients who come in after trauma, hemorrhage, suffering from the symptoms of a hear attack versus those who are dealing with chronic illnesses. Patients who present with these less acute conditions are assessed, diagnosed and typically discharged to their primary care provider, if known, or to a clinic for ongoing management of their conditions, and it is management of the chronic conditions, which is essential to getting us to solutions with regard to the ED

overcrowding. It's really a problem that we face today. Many patients do come to the ED with non-emergency conditions that could be treated more effectively in a primary care setting where they would have ongoing follow-up and continuity of care, which is not necessarily—not essentially-you're not able to provide that through an ED visit, if you will. According to the New York State Department of Health, around 70% of hospital based ED visits are either non-emergent and/or could have been treated in a primary care setting. There are many reasons patients come to the ED: They have no insurance coverage or under-insured. They don't have primary care providers available to them because of their—their work hours, their childcare situation, and just generally their social determinants of health that make everything more problematic. The distance to travel is too great or not affordable or accessible. The lack of awareness of the nature of their medical problems is something that we need to deal with in terms of health over the city. (sic) However, we've heard some very positive signs and efforts today both at H&H and at Mount Sinai for opening up what we can an express clinic. It's an urgent care center as an

alternative to presenting to an emergency department. We've also seen some improvement through the federal, state sponsored DISRUPT program and there's been a 2% reduction in preventally—potentially preventable visits to emergency departments over the last four years, but we still have a problem. We need to ensure that patients are getting comprehensive, efficient quality care, and to do—and in doing so, we can decrease the stress on emergency departments. We must listen to our patients, under the facts that's shaping their decisions. What is bringing them to the ED? We need to make it as easy as possible for them to seek care in the most appropriate setting, and direct them to the alternative for what has already been mentioned this morning. With regard to coverage, about 95% of New Yorkers now have health insurance because of Affordable Care Act, Medicaid Expansion and New York's essential plan. However, the remaining 5% over 600,000 in New York City alone tend to disproportionately seek care in the Emergency Department. We must give these patients the opportunity for good community based care. Hospitals have invested huge resources into building and maintaining major ambulatory networks with care

management and care navigation resources that patients with—without a clear understanding of their chronic illnesses so desperately need. In 2017, New York State Hospitals provide over 8.t million clinic and ambulatory care services to Medicaid and uninsured patients. As we've already touched on, hospitals are building urgent and express care clinics near or close to EDs enabling patients to avoid the Emergency Department. There's a federal model that we have-we think has some promise of federal emergency triage treat and transport model, which would actually reimburse emergency services providers in the community for taking the patient something less than an emergency department to a behavioral health clinic, to medical clinic when it is clear that the patient is not in need of emergency services. While policymakers and providers need to help patients get care in the community settings, which we believe is the best long-term strategy to relieve pressure on EDs and reduce wait times. We must also make sure EDs function as well as they can and are ready for actual emergencies. Hospitals, as you've heard from Dr. Reich, are seeking to renovate, improve and expand as necessary their EDs, but this

is difficult especially for hospitals struggling to make ends meet with limited access to capital. There are operational strategies. You've heard about Split Flow. We need to harness and—and better the technology available to us through Telehealth, which could enable a patient to remain in their home and have their medical condition in the moment assessed and then be directed to the proper level of care. Greater New York has the greatest respect for its workforce. You've heard me speak in the past to the respect that we hold our nurses, physicians and administrative staff to. We do believe more staffing is needed. We do not believe it should come in the form of a fixed mandated ratio, as you've heard me say in the past, and is a testament to hospitals have recently negotiated contracts with NYSNA. All are seeking to hire more registered nurses increasing their ability to deploy nurses where they are needed most, but not in a fixed ratio manner. Scope of practice is also very important to be looking at. We strongly support modification to the Scope of Practice Rules that are commensurate with professional training and education. One promising area is expanding the use of non-patient specific

orders in the ED specifically enabling nurses to perform tasks without waiting for a physician's order. These are low risk, non-invasive tests such as an EKG for patients that present with appearing to be having a heart attack. As referred to every issue social determinants of health have a major effect on ED utilization. You must invest in the social safety net, pursue policies that promote social justice, combat structural racism and improve access to critical services. In conclusion, while expanding and improving EDs are critical, we cannot build our way out of this problem. We can't ignore the root causes of ED overcrowding. We need to expand access to care and coverage options. Our hospitals are committed to finding innovative solutions to improve ED care with the ultimate goals of helping people get the care they need when they need it in the most appropriate care setting. That is the mission. It's non-profit hospitals and it's public institutions and as body of caregivers. Thank you.

CHAIRPERSON RIVERA: Thank you very much for your testimony. I want to ask you, Dr. Reich, I have to thank you because you brought testimony that has numbers and statistics and is more than just buzz

words. So I want to thank you because clearly you being here shows you want to work with the city and, of course, the City Council to make sure that we're all doing the right thing. So, thank you for being here. In your testimony you mention a few things I just want to ask you about. You mentioned some of the underlying causes of Emergency Department crowding. You know the consequences of the long wait times, the patient dissatisfaction, difficult working conditions that demoralize dedicated ED staff. Yet, is the issue the ED capacity or lack of in-patient beds in some of your facilities?

DR. REICH: Well, I would add a third piece to that, Councilman, and that is—I'm sorry, Council Member. The, um, challenge also is that too many people arrive at the EDs who don't need to be there. We work very hard to decant the busy EDs through the various mechanisms I talked about. We added 16 beds this year that were dedicated over the cold and flu season specifically to ED patients, and they Transfer Program where we take admitted patients in the very busy Mount Sinai Hospital ED and transfer them elsewhere within our health system with patient consent. In addition there is a surge plan, which we

activate where we can take selected patients up to patient floors and they wait in the hallway upstairs pending the availability of a bed. So the downstream effect in terms of what we can do with admitted patients is we're addressing to the best of our ability. But in the first place, some the crowing occurs because maybe 80…maybe 85% of so of the patients at Mount Sinai Hospital's ED this year will never be admitted. They will be treated, and released, and so in order to address that, we opened Express Care up the block, and last week there were 254 patients that were seen there. It was a holiday week.

CHAIRPERSON RIVERA: You said it was up the block?

DR. REICH: Yeah, it's—it's—it's—it's about what? About 250 feet south of the Emergency Department entrance, but in the same campus of Mount Sinai Hospital. So, it actually is a—Express Care is technically a—and outpatient facility, which is not the same as an urgent care in that we bill the patients in the same fashion we would if they were just coming to a visit for a physician office visit, which is advantageous for our patients for their

financial benefit, and so, in the busiest week, which was two weeks ago, we saw 307 patients, and those patients self-select as Dr. Wei described before, and we've worked out processes where we can educate people through signage in the neighborhood and through educating our own physicians that instead of sending the patient to the Emergency Department that we have Express Care, and in addition, we'd like to emphasize that there are possibilities to change the way we—we approach Emergency Department transportation in New York City. Now these are—there are some state and federal issues that are involved, but working with the City Council we believe the advocacy could be extremely helpful, and that relates to taking patients not necessarily to an Emergency Department, but being able for example to take them instead to a outpatient facility or to an express care/urgent care practice, a primary care practice and let's also focus on really that this is 21st Century and we can do telemedicine sometimes very effectively, but in order to really get community power medicine to the next level we will have to advocate with the state for some scope of practice

changes so that we can have Paramedics in New York operating at the top of their license.

CHAIRPERSON RIVERA: You said 85% likely won't be admitted. How many would be under observation?

DR. REICH: Well, the Observation Unit is a—is a separate process, and we have currently 20 observation beds. So, a certain percentage of patients in our Emergency Department will go there. I don't have that number off the top of my head, but I could look it up, but it's a much smaller number than will be admitted to the hospital, and a much smaller number than those who will be treated and released. And some of the patients in observation, the majority, you know, over 90% will go home in approximately 16 to 24 hours, and approximately 5 to 10% of those patients will continue with their medical illness and will be admitted to a hospital.

CHAIRPERSON RIVERA: And so in your testimony you mentioned that patients who come to the Emergency Department with heart attacks and severe heart failure, severe lung conditions or strokes have the best survival rates in the nation, which is great. What about less acuity patients?

DR. REICH: Well, we believe that the left without being seen showing a very low percentage and that the other metrics of time for provider being 22 minutes reflect and overall good nature of care and I would say excellent to superb. In terms of what's publicly reported and measured, I pick things that are actually publicly reported CMS because I could point to those statistics with certainty. But I don't believe we have any concern that people with less severe conditions are not getting the same high level of care.

CHAIRPERSON RIVERA: And you mention also are left without being seen rate is now just 1.8%, which is lower than the national average, and a lot of these changes and these improvements by what you've described happened since 2015 more or less, correct?

DR. REICH: Correct. Yes.

CHAIRPERSON RIVERA: So, what happened— what were the numbers like before that implementation, and then now that you have this—I guess this new average, which is better than—than the national average, how is the quality? What do

doctors say about the quality of care that they're delivering?

DR. REICH: Well, this all came about with the implementation of Split Flow, and just to give a minor elaboration in Split Flow, a provider sees a patient much more rapidly. There is actually a nurse at the triage desk. So you see a nurse at the same time that you're being registered for the Emergency Department, and because off that, there's an immediate triage process, which brings people out of waiting rooms. So, our waiting room is very, very empty, which is a good thing—into the back where people are either in an intake area, which is designed for people who are very likely to be treated and released, and to an acute area for those who have more severe illness where it's unclear if they will be treated and released? And so, that creates a situation where people get to doctors and nurses more quickly. I believe that—I don't have an exact statistic on it, but everyone is, you know, feels that that's the national standard, and that's the way we should all go, but I don't know if I can answer the question more specifically, Council Member.

CHAIRPERSON RIVERA: Well, if you could— if you could look into it and let us know compared to before the Split Flow and then, of course, just the quality of care I guess as you speak to the nurse, the doctors, the people that are in your facilities. You know, things are happening quicker, the averages are better, but is it the same quality of care?

DR. REICH: And I will get back to you. Thank you so much.

CHAIRPERSON RIVERA: And then you also mentioned you've added additional nursing leadership to help provide 24/7 on-site leadership, and then the float pool to bring additional nurses to the ED during each shift. Do you have ratios?

DR. REICH: Um, we work in a model where we focus on the members of the team, and address through our collective bargaining agreements with the professional practice committees how we provide the staffing. I will defer to my colleagues of Greater New York to speak about staffing ratios, but I will say that I believe we have an excellent labor management partnership at the hospital, and although people will have different opinions about how things should occur, that we work collaboratively, and I

believe that in the spirt of working with everyone trying to operate at the top of their license, that the model that we have is a very safe and effective one.

CHAIRPERSON RIVERA: Thank you.

DR. REICH: Thank you.

LORRAINE RYAN: With regard to the sort of shared governance that's taking place in healthcare today, and nursing staffing, almost all of our hospitals have something either called professional practice committee of akin to that with a different title on it. All of our NYSNA contracted hospitals have increased their incremental staffing, as I mentioned earlier. So, nursing leadership can staff to the acuity level of the patients that present whether they're in the Emergency Department or in a hospital bed as an in-patient, and it enables them to deploy their staff where they're needed to really assess the environment of care, what's happening where, the Emergency Department being a hot bed of activity. It's usually one of those areas where either members of the permanent flow pool or nurses as part of the incremental staffing pool would be deployed. We hear very positive things from

nurses at the unit level with regard to the Professional Practice Committee opportunity to weigh in. These are unit level nurses that attend these meetings and raise the concerns that they may have. So, nursing leadership and hospital administration is hearing directly from those who are providing care at the point—at the bedside.

CHAIRPERSON RIVERA: So, I understand you're doing your best to make sure that there are multiple stakeholders at the table. I know you're asking on--of people's experiences, but I'm sorry if I missed the number or has the—has the State Department of Health approached you about these safe staffing numbers? Do you have an actual set staff ratio for providers and nurses?

LORRAINE RYAN: Two points to make on that issue. In our State Code now, and it's been there for a while, Part 405 requires nursing leaders to be staffed to the appropriate numbers and type of staff necessary to ensure safe, high quality patient care. They abide by that. They are surveyed on that, as determined by their surveyors whether or not they are in compliance and that it can be raised in a statement of deficiency. A year and a half ago the

Governor discharged the responsibility for the State Department of Health to do a study on staffing enhancements. It did not just purely look at ratios, and did not just purely looking at nursing care. The state has—is working with a research university to understand what the supply and the demand would look like in the future of the population's projection and use of in-patient services, and what we see is a decrease in in-patient services between now and 2030 and 2040, an increase in outpatient services. So, to get involved in a ratio law that would force hospitals to pull nurses into the—into the inpatient setting and take them out of settings of care where they might be most needed in the future is a concern, and today, we see some very high level services especially with the oncology community of patients being provided in and out patient setting or in their homes to protect these patients from—who are immunosuppressed from being exposed to pathogens in a hospital ED, in a hospital outpatient clinic or in an inpatient bed. So, would be sort of going in reverse in terms of where medicine is going if we deployed all of our nursing resources in the in-patient

setting. We await the state's study, which should be coming any day now, and--

CHAIRPERSON RIVERA: Have they approached you? Have they—they've clearly talked to you and--

LORRAINE RYAN: Oh, yeah.

CHAIRPERSON RIVERA: --asked for your opinion.

LORRAINE RYAN: The Department of Health held hearings last September, and Greater New York among all—as well as all of the advocates, individuals from the Center for Health Workforce studies who studies the supply and demand in New York State, said that they cannot attest to the ability of hospitals to meet those staffing ratios with the current graduation rates. We see from nursing colleges and other programs if the staffing ratios were to become law. So, yes, they very much dialogues with us around this issue.

CHAIRPERSON RIVERA: And I realize that every hospital is different. I think they were compared to children earlier, which is cute. (laughter) But I—I just, you know, I still—it's very difficult getting numbers from you, I have to say. Just trying to figure out how we can set a standard

for New York City. Our hospitals are—are crowded, and I have to ask you Dr. Reich, specifically about your Emergency Department conditions and a story that was in the New York Post in December 2019.

DR. REICH: UH-HM.

CHAIRPERSON RIVERA: So, they broke a story about Mount Sinai's War Zone of an ED quoting former and current staff who say that the environment is extremely dangerous for patients and staff. And over three years ago the hospital had three out of state medical experts come and review their ED and their subsequent report detailed conditions that were among the worst they had ever seen. The report detailed poor staffing ratios, infection control and safety as well as patient boarding and other conditions, and as a result of the article the—the New York City Department of Health announced an investigation into Mount Sinai Hospital and Mount Sinai issued a statement noting the improvements made to their ED since the release of the port—the report as well as their commitment to the safety of their patients. What is the status of the Department of Health's investigation?

DR. REICH: Well, Council Member, I am very pleased to report that the State Department of Health arrived two days after the New York Post article was published and spent four business days at Mount Sinai Hospital, and left and issued a report that found nothing. No findings, and Mount Sinai was completely cleared of the allegations that were raised in the article, and so I'd like to go on record as saying that I'm extremely pleased that the staff of Mount Sinai Hospital again demonstrated to the Department of Health acting on behalf of CMS in a full Title 18 Survey that we care passionately about patients in our community, and that we are looking forward to further improving the state of that Emergency Department, which, of course, does have crowding, and that the certificate of need that we've submitted and the construction that will result from it should make for a dramatically improved patient experience. There are many claims in that article that we categorically deny, and I think that that's probably a fair statement of my response to the Post article.

CHAIRPERSON RIVERA: So, how do you respond to current staff allegations that these

issues persist today and what have you done to improve the situation there since that report?

DR. REICH: I think that some of the issues I—I specifically put into the testimony address that, but I'll reiterate them for the committee and that is that the addition of the 16 surgical beds, medical surgical beds upstairs that are caring for our patients from the Emergency Department in this cold and flu season had dramatically decreased the number of boarding patients in the ED this season, which has been a tremendous help. I would also add that we have continued to expand the Transfer Program, and note that a patient that's transferred—an admitted patient that's transferred from the Mount Sinai Hospital Emergency Department to one of our other Health System hospitals, the vast majority to Mount Sinai Morningside arrive in a hospital bed eight hours sooner than a patient on average who is waiting for a bed at the Mount Sinai Hospital. Despite all of the efforts and the extra 16 beds, it still is a great benefit to us, and then, of course, we have a Hospital At Home Program, which is a grant funded program where we actually sent staff into the

patient's home and provide hospital level care in the home and the outcomes from that program in terms of curing disease and survival have been—have been remarkable, and then further we have a team in the Emergency Department beyond nurses and doctors that include case management workers, and social workers, and volunteers, and even a part time person from the Palliative Care Medicine Department such that we are looking to address the social and society needs of our patients and work very hard with them. So, I believe that there will always be staff in a place as large and complex as Mount Sinai that are dissatisfied with what administration is doing, but I would like to go on record as saying that I believe that we have made more than good faith effort. I believe that the institution is fully committed. We love our nursing staff, we love our support staff, and we want everyone to have a healthy and—and supportive work environment, and to that end we continue to just work together. I make rounds in the Emergency Department at least twice a month, 7:00 a.m. and 7:00 p.m. with those nurses, and I hear exactly what they have to say, and I try to address their concerns.

CHAIRPERSON RIVERA: Some of the—the allegations, the current staff allegations is that the ratio can be as high as 15 to 1. Can you speak to that?

DR. REICH: I believe that those numbers are incorrect. We work very hard to keep the ratio under 1 to 10, but the problem with any emergency department as Dr. Wei can attest behind me is that you never know what's going to happen in the next hour. You could have a dramatic influx of patients from ambulances or walk-ins, and so we try to remain flexible, and bring that additional staff. We have staff scheduled to come in every few hours as the day sort of ramps up between the morning and the afternoon, and with the float pool and with the addition of frankly a physician's assistant to manage the patients who are boarding in the Emergency Department and floating staff down from the floors, I believe we're addressing it to the best of our ability at this time.

CHAIRPERSON RIVERA: So, do you think that the nurses and staff are overburdened and do you have any programs or benefits in place to improve the staff mental health in the Emergency Department? ?

DR. REICH: Well, we've worked very hard to listen and to respond. We for example more than doubled the number of security officers approximately a year and a half, two years ago, and engaged NYD off duty officers to be at the entrance to our Emergency Department to improve the staff perception of-of their own safety, and we still work on that every day because of the increase of workplace violence in the nation as a whole, but that is one area where we've worked very specifically to help the staff. We have an Employee Assistance Program. We have a Star Simulation Center, and I'm not exactly sure what those four letters stand for in Star, but it's basically a simulation center where we work with our nurses and physicians to simulate critical scenarios, and—and frankly I believe that having one of the leading academic departments, emergency departments in the nation is something that brings the staff a feeling of great satisfaction in that they work with people who are at the cutting edge, but there's always more that we can do, of course.

LORRAINE RYAN: Can I just add that there are several other hospitals throughout the city that have added security personnel to their Emergency

Departments, and indeed those security personnel do accompany the hospital security on rounds throughout the hospital to ensure the safety of the patients and the staff, and it—it is very critical that staff feel comfortable and secure in their work environment. I think the other issue that we tackle each and every day more and more is recognizing the level of burnout, recognizing the level of stress among healthcare providers in general. This is not a problem unique to New York, but I think like everything else it always seems more acute in New York because of the volumes of patients and staff that-that we are working with and dealing with. So, it does not go unnoticed by any means, and, you know, as a hospital association we can only do so much, but we do bring our hospitals together almost monthly to deal with these issues to share best practices, to understand what's working in your institution at Mount Sinai, could that work in another institution dealing with a similar type of population, and a similar type of volume. So, um, we are—we're not immune to understanding and recognizing that it's a difficult environment for healthcare providers, but it's also one that offers a lot of rewards, and

unfortunately we don't get to talk a lot about that or hear a lot about that because it's just accepted as the norm, but we very much take these issues seriously, and as a nurse myself I understand what these nurses go through. As a patient recently in Ortho, I asked the nurse how many patients she was taking care of, and what the workflow was like and what of the 12-hour shift is like on a family, a young family, but they do it. They seem--for the most part I'd say they do it gladly and with a mission driven attitude, but we need to do more as those who are there to protect the workforce.

CHAIRPERSON RIVERA: And some residents can spend over 100 hours in the ED in a given week. That's—that's what we hear some of the—the work that they are putting in. So, that-that mental health piece why I'm asking about it for you to kind of highlight what you're doing is because we do know the nurses and the doctors are incredibly dedicated and they're motivated to do the best thing for their patients. So, we want to make sure that we're highlighting some of that work. I do want to just ask you Dr. Reich about the—the oversight of ED staff, and as a result of a case that we saw and was

highlighted in an extensive investigative report issued by the news outlet that cut detailing a sexual assault of Aja Newman perpetuated by one of Mount Sinai's staff. And so how has the oversight of ED staff changed as a result of the case?

DR. REICH: I'd like to say that the case of the—Aja Newman assault that was featured in New York Magazine is—is something that was very upsetting for Mount Sinai. The situation was horrific and abhorrent, and in no way reflective of what happens at Mount Sinai. Mr. Newman is a sick and depraved individual, and we are so sorry that Ms. Newman was the victim of the horrible criminal—criminal act that she experienced. No one should have to ever experience what she did and this is a legal matter and I'm no aware of and cannot discuss the specifics, but as soon as the incident was brought to light David Newman was immediately suspended. We launched a comprehensive internal investigation, and worked closely with the District Attorney's Office to bring David Newman to justice. He's been sentenced to jail for good reason. We're a world class institution with top doctors from around the globe and we hold our entire community to Mount Sinai's high core

values of treating each patient with the utmost dignity and respect with zero tolerance for any inappropriate or illegal behavior towards anyone especially women. But as with any medical system anywhere especially one of our size, 40,000 employees, the size of a small city, and as one of the largest employers in New York, there may be extremely rare isolated cases like this one where individuals do not hold themselves to Mount Sinai's high core values, basic medical ethics or the law, which is why we have the industry's leading safeguards and systems in place to immediately address any kind of inappropriate actions for any of our staff or doctors. And so the staffing at Mount Sinai Hospital at the time of this particular incident was actually really quite good. So, I just want to put everyone's mind to rest that staffing was not the cause. David Newman was sick and depraved individual who deserved to go to jail and he did.

CHAIRPERSON RIVERA: So, how has your oversight of the staff changed?

DR. REICH: The oversight is something which is constantly under review. We recruited a new leader for the Emergency Department who began his

tenure February 1st. I have a bi-weekly meeting with Emergency Department leadership, and that includes by the way not just the physician leadership, nursing leadership, the advanced practice providers specifically the Chief Physician's Assistant, the Chief Residents and in addition the head of the—we call it the Designated Institutional Officer, but basically the physician who is head of all residency programs for the whole institution, and the Chief Medical Officer, and I probably left out one or two. And when we sit around every two weeks we talk about the issues. So, I believe that the between that forum and in addition the bi-monthly rounds that I do with the Chief Nursing Officer and also with the leadership of the department and with the involvement every day of the leadership of the Emergency Department and the Environment, Safety and Quality huddles that we have every single work day at 8:00 A.M. that we have tremendous oversight of the Emergency Department and the—if you looked at 2015 and 2020, you would see two very, very different sets of circumstances. And so I hope that answers that question adequately, Council Member, because I believe that Mount Sinai has invested tremendously. I

personally feel very responsible for every patient in our Emergency Department, and worry every day that we're providing the best care that we can.

CHAIRPERSON RIVERA: Thank you and in terms of your leadership what are the demographics? You know in the article in the investigation there were comments as to speaking of the ward and some of your best making sure that you—that there was diversity and equity in terms of pathways to advancement, promotions and leadership opportunities?

DR. REICH: Well, we have worked very hard as an institution to address that. I have some statistics that I could read if you'll give me one second to look that up, but the—I think that the main issue is that we have worked very hard as an institution to, you know, to try to improve diversity. One second. I had some nice little comments already to go. Just give me one second, and what I'll do is I'll just—I'll—I'll take it as just without—without the multiple pages in front of me. We have received awards related to our approach to gender diversity and diversity in general as an employer. We work very hard to make certain that we will not as an academic institution host a meeting,

which has all men on the panels. We work as institution to improve gender diversity such that we've actually named a Dean for Gender Diversity at Mount Sinai, and we look very carefully in all of our recruitments to see that whenever we have a senior recruitment that women and people under-represented in medicine are interviewed for every position of leadership in the institution. So with my apologies for not having all my notes right in front of me, I think I hit both the major points.

CHAIRPERSON RIVERA: And if you do find the numbers in there--

DR. REICH: Yes.

CHAIRPERSON RIVERA: --and I understand the paper situation, please do let us know. Of course, we're very interested in knowing how that—how that culture has changed to be more welcoming to women and others and, you know, there is a lot of stigma and a lot of talk on—on culture and I want to ask on the terms—in terms of accepting patients who are coming into your facilities and not—not just Mount Sinai, but all of these facilities public versus private insurance and patient flow, how do you

respond to reports of private pay patients getting care quicker compared to publicly insured patients?

DR. REICH: For a Mount Sinai hospital that is a categorically false statement. We look very carefully at the statistics. We look for example at the patients who are transferred from Mount Sinai Hospital's Emergency Room to other hospitals and we saw that the ethnicity and the gender distribution was identical to the patients that were admitted to Mount Sinai Hospital. We look very carefully to see that essentially every patient receives the same care. When we receive any calls to expedite a patient's care, it doesn't matter where that call comes from, a concerned family member, from an faculty person, from even elected officials. That no matter what the circumstances we always try to expedite the care for every patient regardless of their socio-economic status, the insurance status or their ability to pay. Mount Sinai is a mission driven organization that's committed and it cares passionately about our community.

CHAIRPERSON RIVERA: Thank you, and Ms. Ryan, I want to ask you the same questions: Would the individuals with public health insurance wait

longer to be admitted than those with private health insurance?

LORRAINE RYAN: I can say without reservation that that is not true, and that all of our patients as Dr. Reich just mentioned and as you heard earlier from those from H&H all patients are treated equally. They're treated on the basis of the acuity of their condition, not on their status as an insured or employed or unemployed. It's all about how sick they are, and what services do they need and how fast can we treat them and expeditiously move them through the system. Patient flow is—is equally arduous for any type of patient that walks in the Emergency Department.

CHAIRPERSON RIVERA: And do you have the—the data to back up these claims because we do hear from staff inside the hospital and even consumers and patients that they feel very differently , and they feel actually the opposite of what you're claiming now, that they do wait longer, and they are treated differently.

LORRAINE RYAN: I don't have that with me, but I am happy to provide that to you because categorically whether they get modest insurance

status it is not a barrier to getting the appropriate care.

CHAIRPERSON RIVERA: And, you know, because that's has to do with—with bias. So, I guess I want to ask also what trainings around health equity and medical bias do ED physicians, nurses, and other staff receive?

LORRAINE RYAN: Did you want me to answer first?

CHAIRPERSON RIVERA: Either bot of you or one.

LORRAINE RYAN: I was going to comment earlier as doc—when Dr. Reich finished about the diversity situation at Mount Sinai. They have one of the most impressive Diversity Officers that I've ever encountered in the Human Resources Department and we've looked to this individual to help us design implicit bias training programs throughout the Greater New York membership, and maybe even further throughout the state because Governor Cuomo has dedicated a certain amount of resources as part of Maternal Mortality and Disparities in Treatment Initiative to ensure that staff throughout the state are trained implicit bias. That has not begun to the

best of my knowledge, but it certainly on individual hospital's radars and many are moving forward on their own.

DR. REICH: If I could add that Mount Sinai has for several years now performed unconscious bias training for its leaders, and various departments. I do not know specifically about the Emergency Department, but as an institution we are committed to unconscious bias training, and basically to move in a direction where everyone understands that we're all on a journey, and that journey means that we have to learn and teach ourselves exactly how we make mistakes, and unconscious bias is a factor in our society. It involves, you know—let's put it this way: To improve it requires constant vigilance on our part.

CHAIRPERSON RIVERA: Thank you. I—I—I agree about the unconscious bias, and if it's for all staff then I imagine it would be for the Emergency Department staff as well.

DR. REICH: : Well, I'm just saying that-

CHAIRPERSON RIVERA: Who's in charge of the—

DR. REICH: Yes.

CHAIRPERSON RIVERA: I guess at your facility at Mount Sinai who leads the bias training? What—what dean.

DR. REICH: We have a Dean for Diversity that is Dr. Gary Butts, and the—he heads the Center for Multicultural Affairs on the school side and the Office for Diversity and Inclusion on the health system side and orchestrates with the rest of the leadership an Executive Diversity Leadership Board that meets on a regular basis several times per year, and coordinates with the Departments for Unconscious Bias and other trainings in areas where, you know, it's—Specifically we feel it's more needed because, you know, with such a large organization we have to prioritize.

CHAIRPERSON RIVERA: Absolutely. I just want to mention we—we were joined by Council Member Moya and we are joined by Council Member Levine. And so just to—to clear up realizing there is this training that is going on because of the bias whether conscious or unconscious, are there different facilities, floors, rooms based on one's method of payment?

DR. REICH: Mount Sinai does have some private rooms, which require a supplement, but often put patients who cannot afford that supplement in those rooms whether it's for infection and prevention purposes, they might need an isolation room because they have an infection or want to prevent infections such as a cancer patient who is in protective isolation. There is one private floor, but once again, if those rooms are empty we're not going to keep people waiting elsewhere in the hospital so we often, you know, put patients in those rooms depending upon need.

CHAIRPERSON RIVERA: Are the ratios the same on like the private—on the private floor versus the—another floor? Are—are—are the ratios the same? Is the care the same?

DR. REICH: Yes. In fact, there's only—there's only one—there's only one private floor. It's a relatively small unit of 19 beds. The rest of the hospital has a combination of semi-private and private beds and the ratios are identical, the care is identical, and, um, you know, in an ideal world I could all new buildings with all private rooms, but I—I live in a complex health system with dramatically

high capital needs. So, that's not something I can—I can accomplish in the near future.

CHAIRPERSON RIVERA: Thank you. So, and I just want to go back to the burnout question and making sure that the providers know what is available. You mentioned a couple of programs. Is there—is there ongoing—are there ongoing check-ins? Are you continuing your outreach whether they're residents or long-term staff or they're nurses or—or whatever it is, how are you making sure that you are relaying that information to your—to your staff to faculty there to—to avoid burnout?

DR. REICH: Well, in—in such a large organization, many departments have different processes, but I would highlight that the Emergency Department has been a leader in staff engagement. They have regular town halls. They have regular conferences. There are staff huddles every single day, and I mentioned already that we have the—the Star Unit, which is a full environment simulation facility, and when I make my rounds at 7:00 A.M. and 7:00 P.M. twice a month there is unhealthy food in the way of pizza or donuts or whatever is appropriate thereafter the rounds people can feel a little bit of

you know, a little comfort food to—to help them through the day. But I think the other things I would talk about are the Tea Cart Program, which is actually designed by our social—our Department of Spiritual Care. They go around cart that has Teas and candles and soft music and we bring this into the lounges, and we serve people tea. Apparently, you have to wear a saffron scarf to make it work as I've been told, but I—even without the saffron scarf I was able to do that announcement at Queens and we also have the I Care Program, which is a staff support program where if there is for example let's say a patient expires in the Emergency Department and the staff are upset, we can call confidentially and other staff members who are in a similar sort of job class can—can work together and talk to that individual, and, of course, if necessary we refer those individuals to our employee assistance program where formal counseling is provided.

CHAIRPERSON RIVERA: Okay. It must be some tea.

DR. REICH: It's very good.

LORRAINE RYAN: Can I just add a couple of comments to what was just said, the answer to that question.

CHAIRPERSON RIVERA: Sure.

LORRAINE RYAN: I don't think you can underscore the effectiveness of what's been mentioned a couple of times today which are huddles, or safety huddles as they were initially titled. These are daily and sometimes twice daily huddles where the staff on the unit includes all levels of staff, physicians, nurses, transporters, environmental services workers who can identify what they're worried about the most for their shift. What's going to go on that could possibly be—go awry that would impact them or impact a patient? They're very transparent in open discussions. Executive leadership are often part of these huddles and if they're not they—they sort of make their secret shopper visits so that they understand exactly what their workforce is concerned about, and they often voice concerns about their own welfare, and it might be about a patient, the capacity to take care of those—the type of patients that they may not be the most familiar with the, diagnosis or a complicated

cancer treatment that they haven't dealt with before. Staff are encouraged to speak up at all levels. All people are equal in these huddles, and I can't say enough about how it rally given the staff a sense that they are cared about, that they do trust their administrators, they do trust the executives that are leading these institutions, and they're very impressive. If you—if you attend one, you want to attend more because every hospital does them slightly differently I recently attended one at Mount Sinai affiliate where the CMO has a whiteboard and he practically—he—he basically knew about every patient that they had—that anyone in that room had a concern about in that institution whether it's getting our urinary cap, or we're getting someone off a ventilator, concerns about discharge to home because the home environment wasn't safe. I was floored with the level of detail that these people knew about the patients in their hospital. So, I think goes a long way to ensuring safety, and very quickly on the I-Care, a program that Dr. Reich mentioned, H&H also ahs the Helping the Heroes Heal Program. These are programs that focus only the staff, which are often the second victims in the healthcare environment

either because of morbidity—mortality that was unexpected or something that was planed, and procedure an unexpected complication what have you. This is totally about ensuring that the wellbeing of that staff member who might have been involved with a particular patient care issue is taken care of, and more and more of our hospitals are emulating these programs, and again, it's another way to not only demonstrate support, but to really provide that needed emotional support.

CHAIRPERSON RIVERA: Thank you, and my last question and-and thank you very much for staying and answering everything I've asked you thus far. Is—Doctor—Council Member Eugene was here earlier, and he asked Health and Hospitals about what they were doing to prepare for the Coronavirus for a potential—a potentially significant impact on the capacity of the Emergency Departments. How are you facilities preparing?

DR. REICH: I'll note that at Mount Sinai Hospital we constructed a—a—a room just off the Triage desk where people walk in and to the ambulatory entrance to the Emergency Department where patients who are—everyone has a travel screen and

every patient is asked those particular questions and if anyone screens positive on the travel screen, fever, cough, foreign travel for example, they're immediately handed a mask and they're walked into that room, and the door I closed so that they can have further evaluation. This type of system dam about during the Ebola crisis in 2014, and although I am an anesthesiologist not an infection prevention specialist I am very impressed just in general how the state, how Greater New York Hospital Association coordinating among the hospitals and the individuals health systems have all thought carefully about what their processes will be for caring for patients. That being said, so many people are dying of the flu in our community, and it is a preventable illness in many cases because many individuals do not get their flu shots, and so I think it's important that even as we talk about COVIT 19 or Coronavirus preparations that we emphasize that as leaders in the city, that I would hope that also we can get strong advocacy from the City Council to help overcome the fear of vaccination, which is rampant in our society, and many—we can't predict the future, buy many—tens of thousands of patients die in the United States from

flu every season and although COVIT 19 now for Coronavirus is a severe threat to the world. We have frankly a more curable disease at home that we failed to treat adequately.

CHAIRPERSON RIVERA: So, and thank you for saying that because I agree. I thin many forget the—the flu season and how it has, it's killed so many Americans already and that we have a potentially severe season among us right now. So, I guess in short that your health system does feel ready. You're ready, willing and able to assist with any potential cases really making sure that they support the Health and Hospitals system, which has been really incredible on this, and that your Emergency Department is ready capacity wise.

DR. REICH: And Emergency Department and, in fact, the entire health system has contingency plans in place in terms of how to treat and to safely care for patients with any disease including the now Coronavirus Covit 19, and we are emphasizing FEMA fit testing for all of our staff emphasizing to our staff please don't steal masks, that we need them for the hospital environment. So, I think that managing the public's perception and our staff's perception and

making everyone feel safe is our job as hospital leaders and I know we all take that job very seriously.

CHAIRPERSON RIVERA: And we will certainly try to assist with managing this kind of public perception and what people are reading and how New York City is actually very ready, and thank you for answering all of my questions about the public perception on some of your institutions and facilities, and I appreciate your testimony today. Thank you.

DR. REICH: Thank you. Thank you, Council Member

CHAIRPERSON RIVERA: And with that I'm going to call the nest panel. Wendy Bean, Theresa Davis, and Jonathan Varslares

JONANTHAN VARSLARES: Jonathan (inaudible)

CHAIRPERSON RIVERA: Can you say that again?

JONANTHAN VARSLARES: Jonathan (inaudible)

CHAIRPERSON RIVERA: Alright, I'm going to ask you to say that to the microphone. I'm sorry.

(background comments) You're from New Alternatives, right.

JONANTHAN VARSLARES: That's right.

CHAIRPERSON RIVERA: Okay.

(background comments/pause)

CHAIRPERSON RIVERA: Okay, who would like to begin. I—I do encourage everyone who is here to testify to please stay and listen to our advocates and additional individuals here to testify, and I want to thank you all for your patience in waiting as we heard from some of our health institutions. Sure go ahead.

WENDY YOUNG: Okay. so thank you. I'm Wendy Young. I'm physician and I'm the President and CEO of the Moral Injury of Healthcare, and I'd like to thank you Chairperson Rivera and Council Members for the opportunity to testify on the safety of New York City Emergency Rooms, and also I would to thank you for taking an interest in the challenges facing ED clinicians. The Moral Injury of Healthcare is a 501(C)(3) non-profit that's dedicated to addressing clinician distress thorough research, advocacy, education and training. Chairperson Rivera, as you mentioned in your opening remarks, moral injury is

increasingly recognized as a problem in healthcare. Since publishing an article: *Reframing Clinicians' Distress to Moral Injury in July* of 2018, we've heard from hundreds of clinicians that it is increasingly difficult to deliver good care where they work. Many of them are—have been Emergency Room clinicians. As you accurately described, moral injury is perpetrating, bearing witness to—or bearing witness to acts that transgress deeply held moral beliefs. In healthcare those deeply held moral beliefs are the oaths that we take to put our patients as a priority. That is deeply engrained in clinicians from the day they first start training. Patients come before we eat or sleep, before our children's birthdays and our own anniversary dinners. Clinicians are incredibly dedicated as—as previously mentioned in several testimonies, but dedication alone is often not enough. The main thing we've heard from clinicians around the country is that staff are doing to much with too little for too long, and they worry they no longer provide the quality of care they expect as a standard. This situation is not unique to New York City, but that does not excuse inaction. Increasingly the business framework of healthcare:

volume expectations, direction staff, tracking door-to-doctor times, decisions to discharge times, prior authorization requirements and leakage constraints requires that clinicians consider and often choose something other than our patients as a priority. Routinely—routinely doing this increases our risk for moral injury. When the Emergency Room is routinely short-staffed, clinicians have less time with each patient. They rush histories and physicals and writing orders and providing treatments. They may rely on one, lab tests or imaging, which are easy to order generate laudable revenue, but which may also inflate the patient's bill and provide an incomplete picture of the condition. Rushing makes errors more likely, alienates patients and breaks down the unspoken alliance between clinician and patient. It makes civility a little less likely. When the Emergency Room is overcrowded with boarders, clinicians are distracted by the increased workload. They're frustrated that patients lack the privacy and dignity they deserve. Clinicians are afraid that in their—that in these conditions they will hurt patients and that hurts them. All of this impacts patient safety with respect to medical errors, but it

also impacts clinician safety because patients and families less—feel less inclined to be civil when someone who—with someone who's rushing them, and dismissing their concerns. They may feel the need to be more strident to be heard, and over the long term, moral injury being un—and being unable to give patients the care they need. When unacknowledged and unattended, they lead to burnout and contribute to unacceptably high rates of physician suicide, which is twice that of the general public. (bell) We believe the business framework of care was not put in place with nefarious intent, but that the divergence of business practices and clinical practices is at the root of the problem. Administrators and clinicians are less attuned to the challenges and incentives of the other. But nefarious intent or not, the dysfunctional framework is kept in place by a culture that is deeply—that is not deeply curious about the conditions impacting the wellbeing of its employees. Unmasking misaligned incentives is critical. The challenge then is to realign incentives for all stakeholders to ensure patients get the best care and clinicians can work in a sustainable way. Thank you for your leadership in

addressing this concern, and again for the opportunity to provide this testimony.

CHAIRPERSON RIVERA: Thank you so much.

TERESA DAVIS: Okay, thank you. Good day. My name is Teresa Davis. I am an advocate and a community health educator and I'm also an adult living with an inherited disorder. So, I have been on both sides as an Allied Health Professional working in the hospitals particularly on first the funded grants to provide non-medical coordination of care for pediatric patients with hematological disorders. I can attest to what the doctor was saying their being understaffed, overworked people on the floors. I have great admiration for the medical professionals that I work with, but also as a person who was seen in the hospitals as a patient, I've seen some very egregious things. I myself don't always experience them because when I go in people recognize me or everything I'm actually an employee of the hospital so they kind of tiptoe around things, but the last time that I had to access an emergency room it was unusually crowded that evening. I came in in distress, and because I wasn't the caricature that most health professionals think when they see someone

with my diagnosis coming in. I was, you know, calm. I was having problems breathing, and I was basically told well, you know, it's busy here tonight. I don't know when the doctor is going to see you, and we don't have any beds so you're going to have to sit and wait. My condition actually is considered something that is an emergency. It's on the same level as a cardiac arrest, but I was not treated in that fashion. I did happen to see one gurney behind a nurse who was telling me that there were no more beds, and I told her I can't—what I'm experiencing right now I can't sit here, and wait to be triaged nor can I sit here and wait to take my treatment, which may take two to three hours. I actually told her to take my name off the list, and I walked out, and I waited until the next morning to call my physician and my daughter to help me to another hospital, which when they saw me within a short period of time they immediate—immediately admitted me. The situation that occurred the night before was because the Emergency Room was understaffed, and could not really provide the level and quality of care that I needed because of an assumption I was not treated as an emergency case, which also is another

problem because the National Institute for—I'm going to get this right—Heart, Lung, Blood Institute, okay and HLBI has a protocol of care that in some instances I've had Emergency Room staff ask: Is this evidenced based. And I'm like: Are you serious? You're asking if an MIH Protocol is evidence based? If those things were in place and as Dr. Reich said earlier, if people were given the option and given more access to programs that were outside of the ER. You would not have this overcrowded and people rushing to go to the ER to be seen. Many a times for the people that I represent most of who are living with inherited blood disorders do not go to the hospital as soon as they know that they need medical attention because they don't want to deal with what's happening in the Emergency Room. We don't want to be made to wait. We don't want to have attitudes because yes I have seen people's faces change the moment you say what your diagnosis is. It's a shame that bias is inherent. It is present. Usually if the staff knows you, you don't get that, but if they don't know you and you come in and say I have a rare disease. I have Hemophelia, I have Sickle cell disease, you do see a powerful in the persons

attitude towards you. From the community based side we've been working diligently to try to change that when somebody comes in and says I need help that they are taken seriously We actually have two physicians, both who are living with the same condition that I have, who visit ED directors in hospitals throughout the city to try to speak with them, and get them to understand that there is a protocol that the hospital should be looking at this as part of their policy and adopt it so that when people come into to be cared that things are taken care of relatively quickly. For the last nine years the Coalition of—was it New York State Coalition of Inherited Blood Disorders, have been lobbying for monies for comprehensive treatment protocol centers throughout the state, and as a of this year again we have been denied the opportunity to be funded to get those programs, which would alleviate a lot of people going into the Emergency Room to receive their care. And one more thing. As an advocate as an individual with a rare disease, what we need help from the City Council with is having these protocols of care established in both public and private hospitals that when we walk we in, staff immediately knows this is what needs to be done

especially when we're telling people as soon as you know you're going that help, go right away to the doctor because not everyone has a private physician. Not every private physician has the set up to—to actually provide treatment in their offices for their patients particularly when it comes to having to dispense narcotics. You know, they have to have certain set-ups to have those things there. So, the first thing a doctor will tell you is go to the Emergency Room, and when you incur a situation where the Emergency Room is particularly over-crowded, there has been instances where people have been in the Emergency Room after were brought in for six hours and no one came to see them in that cubicle. You know, it's—it's difficult because I do sympathize with the professionals and what they are going through. I have seen people being verbally abused. I have not—I've heard the stories, I have not actually seen staff be physically assaulted, but I know that these kind of things do happen, and then I've also been, you know, witness to on the receiving of just malicious attitudes would kind of escalate, the kind of negative interactions between a professional and a patient. That should never happen, but I can say,

you know, my last hospital admission was absolutely wonderful. We had, you know a few (laughs) issues and are working with the administration for them to fix, but for the most part I think that we may have to legislate certain things to make sure that not only are people giving—given more information to access alternative means for treatment like what Dr. Reich said earlier about receiving treatment at home at the level of the hospital. That's the first time that I'm hearing that, and I've been advocating and—and—and going to D.C. going to Albany speaking with physicians. I have never been told, you know, that hospitals can offer treatment at home at the same level that you would get it in the hospital because there are a lot of people who would opt to do that as opposed to going into an Emergency Room and creating, you know, further crowding, taking up space, and also increasing cost for care, and that's something else that we are also trying as from the community base trying to alleviate the tremendous cost to Medicare and Medicaid for Emergency Room treatment.

CHAIRPERSON RIVERA: Well, thank you. Thank you so much and I'm going to ask you a question. I just want to make sure that we hear from

Jonathan. Jonathan is going to be very gracious and tell me how to pronounce his last name.

JONATHAN VONDALAST: So, I'm a—hello Councilor. I'm a Belgian intern. It's my third week in New York. I'm an intern from New Alternatives so excuse my English because it--when sometimes it's not that good but I'm trying (background comments) Yes. So, New Alternatives is a alliance for homeless LGBT youth and in my first week of my internship I met a client at the ER. He was calling us because he had a lot a lot of pain and he was crying. So, I went over there and it's—he was already in the ER for six days. They transferred him from ER to ER. There were no rooms upstairs, and when he called for a doctor they didn't—they didn't came. It was mess there actually. It was so crowded I was struck—shocked because I never saw actually a hospital like—lie this before. There were no—no beds. People were shouting. There was—everybody was scared. My client was scared because there were like people who had drug problems, smoking and people who—Yeah, it was just chaotic. So that's why he called. He didn't feel safe. I didn't feel safe. I—I—I'm—I mean myself I get sick after three days I think because of—I don't know if nobody

wear masks there. I can't explain. I never saw something like this before I saw it. Um, but then he got a room. No. so they wanted to discharge him, and I asked the—and I asked to a nurse like: Look at him. He's crying when he's got to pee because he got the infection at Synomia. He's crying when he had to pee, and he has a lot of pain and they wanted to discharge him and I—I think I stayed there for two or three hours. I keep asking the doctors like you can't discharge him, and then suddenly they came to me like oh, maybe we shouldn't discharge him. So, I was thinking like what if I wasn't there, are they—wouldn't they have him discharged while he was still—while he was still sick? So then he came—then he also had high (inaudible) H-I-V meds but they took it away from him 'cause I didn't know it's just like a roll that you can take outside medications to—to the hospitals. So, he didn't take his meds for seven days and then he—when he finally got his room 'cause my—Gay Barnhard my supervisor called the ground. So, she called something to get the room fixed, and when he finally gets a room he still didn't get his HIV meds. I finally talked like, oh, now the guy is going to get better but he didn't get better because

the had like a button to call the—the doctors and he called the doctor for like four times, but till no doctor came. Like I—I visit him for four days in the—when he gets an upper bed, a bed at the upper floor. I visit him for four days. I think I spent 15 hours with him calling for doctors, calling for a nurses, and yeah, they just didn't came. I didn't—I can't understand just like they just can't come when you call a doctor, and then finally then he was like freaking out because he didn't get the care that he wanted, and then suddenly, of course, like the other person called and the securities came. So, that's maybe why they have to hire more extras because people can't hold it any more. But the securities came. He was following him trying to calm him down, but I was like just get a doctor here and then finally a doctor came and he didn't still get his meds because he was saying like he needs to get tested again because it's a long he took his HIV meds. So he needed to be tested again before we can give it to him. And I was like okay then test him, and he was like oh you can't 'cause, you know, insurance and stuff like that all the things that I don't understand. So, then when he felt better, when

the Synomia was over, he gets the shots but still didn't have to follow up for his HIV meds, and then we made an appointment with doctor, and the doctor said to he couldn't see him because the Medicaid insurance didn't cover—cover his plan. So, I think there are lot of problems about the healthcare system. It's—it's, yeah, and I—I feel like the doctors were saying something like all the CEOs, I don't know what they were, but they are saying some nice words, and I feel it's a lie. It's like just some business talk for me. Okay. Thank you.

CHAIRPERSON RIVERA: Thank you. Yes. we are having this hearing because of the function of our healthcare system currently, and how underserves so many. So, I have just a couple of questions and I guess they are for all of you or one of you depending on kind of your experience and your research and I guess your title as a medical professional as an advocate. Do you think—do you have an ideal staffing ratio for the Emergency Department based on what you've heard and what you've seen?

JONATHAN VONDALAST: So, to—to say something, I went to a nurse and she told me she had 50 patients. So I heard it that she had 50 patients

for one nurse. So, the numbers—the numbers aren't true.

CHAIRPERSON RIVERA: Do you want to share which hospital you were at.

JONATHAN VONDALAST: I think to—it's Mount—Mount Sinai.

CHAIRPERSON RIVERA: I'm sorry.

JONATHAN VONDALAST: Mount Sinai.

TERESA DAVIS: Mount Sinai.

CHAIRPERSON RIVERA: Mount Sinai. Okay.

JONATHAN VONDALAST: Yeah.

CHAIRPERSON RIVERA: Thank you.

TERSA DAVIS: The staff to patient ratio is always low.

CHAIRPERSON RIVERA: Let me—let just. Let me add something for you because you mentioned something about bias and how people are seen and treated once they enter the system, and what more do you think hospitals could do to address the kind of health equity concerns that—that you've brought Up.

TERESA DAVIS: There is some kind of a disconnect between understanding the physiological manifestation of these disorders, what it's actually doing in the body and what people think the disease

is. Actually Navartis made a very good simulation that shows what's happened. They show just conformance going down the vein in the plasma and then what happens for instance with Sickle Cell Disease when the cell starts to sickle and how it rubs up against it in the field and lining of the vein and damages it and then not only the red but the white blood cells and everything else starts to clump together. Inflammation ensues and that inflammation is the pain. So, when I come in saying that I'm in pain, the first though is: Drug seeker. You know you're coming for drugs. This disease is predicated. It is everything about this disease starts with the pain, but the pain is basically a signal saying there is something wrong, something seriously wrong. I've had people—I've seen people discharged who have been admitted. I've been in emergency while I was doing rounds, you know, as a care coordinator who comes back after being sent home and died in the ER because they didn't get the care that they needed when they came in the first time. You don't send somebody with a respiratory complaint who has a weakened immune system home with a prescription for antibiotics when you should have admitted them and started intravenous

antibiotics, you know, specifically after taking a gram saying the same what are they going to respond best to? Even if they started with a broad spectrum at some point, if it was an infection that could be identified and something more specific could help then do that, but that's not what's happening. People are being sent home. People are coming in with a complication called acute chest, which is—can be terminal if not diagnosed and treated properly and people have been sent home in acute chest and when they come back have to rushed to ICU for treatment, which includes a partial blood exchange. Things don't have to progress to that point. If you're following a protocol, and know when this person comes in and they're explaining what their particular complaint is, you can do the testing to substantiate or rule out stuff, but get the person into the care that they need, and that's not happening across the board. Also, it—it doesn't help when patients aren't very well educated, don't really under stand and can't really relate to the physician certain complaints for them to kind of figure out okay maybe we need to look at this, we need to look at that. People do get caught up in the fact that they are in

pain and may not understand that that pain maybe coming from a complication that's serious and possibly even life threatening.

CHAIRPERSON RIVERA: So, you're—you say—I guess I'm summarizing in that there's the patient education piece. There's the education and training component that the doctors so desperately need. There's a clear cultural competency that's not translating, and more so that people want to see themselves reflected in their caregivers, which is something that I tried to ask the Institutions in terms of demographics and how we're promoting through leadership. So, I—I want to ask also you Dr. Dean you had a couple of recommendations as well that were very similar. You mention adequate staffing, sufficient inpatient beds to minimize boarding, and the physicians and nurses who just have sufficient time and focus.

DR. DEAN: Correct. So, I think one of the challenges that—that clinicians face across healthcare, but especially in the Emergency Department is that they feel under pressure from multiple perspectives, and so they feel under pressure to make sure the patients are safe, that

they're throughput is right, that they're generating enough revenue and the reality is if they were—this is my bias—but if they were shown more compassion and better supported by their institution they would be better able to support their patients and show compassion for them. What that looks like is a variety of things. It may mean listening to them regarding what they need for staffing. It may be trouble shooting where the real pain points are in care that might be unexpected and what that—what that looks like is administrators and clinicians coming together to really ferret out where are the roadblocks in healthcare and working together to fix them.

CHAIRPERSON RIVERA: Well, I just—I just want to thank you. I—and I want to just tell you Jonathan—I'm just going to call you Jonathan, thank you for sharing I guess what you witnessed that was the experience of someone else, which sounds completely unacceptable and horrible, and I'm sorry that that was kind of your—I don't want to say your welcome into our healthcare system because certainly you've been doing work with is what it sounds like, but we're certainly hopeful that we can make

improvements together along with advocates and medical professionals. So, I just want to thank you all for your testimony. I want to thank you all for being here, for all that you do, for everyone that you serve and your commitment to improving health outcomes for every single person regardless of their status, their background, how much money they have, what they look like, who they love, and just thank you so much for your testimony today.

DR. DEAN: Thank you. Thank you Chair Woman.

CHAIRPERSON RIVERA: And with that, I will adjourn this hearing. Thank you so much to everyone who was here. [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 February 28, 2020