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NEW YORK CITY COUNCIL

COMMITTEE ON HEALTH

OVERSIGHT HEARING:

HHC RESTRUCTURING –

AN UPDATE ON THE ROAD AHEAD

ALAN D. AVILES, PRESIDENT

NEW YORK CITY

HEALTH AND HOSPITALS CORPORATION

February 24th, 2014

Good afternoon Chairperson Johnson and members of the Health Committee. I am Alan Aviles, President of the New York City Health and Hospitals Corporation (HHC). I am joined this afternoon by Antonio Martin, HHC Executive Vice President and Chief Operating Officer, Thank you for the opportunity to provide an update on HHC's (2010 – 2013) restructuring plan: The Road Ahead.

Before providing a summary of the initiatives and their status, I would like to provide some context for why we needed to undertake significant restructuring, cost containment and revenue optimization efforts over the last several years.

The safety-net role of our public hospital system has made HHC especially vulnerable to deep cuts to Medicaid, the cost of serving a rising tide of uninsured patients, and the erosion of federal funding. Our system served nearly 1.4 million patients last year, and almost 500,000 of these patients had no health insurance coverage. In total, approximately 80% of HHC's patients are either Medicaid or Medicaid Managed Care beneficiaries or are uninsured.

HHC provides much of the care received by uninsured New Yorkers. In 2012 HHC provided 70% of the clinic visits received by uninsured patients in all hospitals in New York City; 43% of the emergency visits; and 34% of the inpatient care.

Since 2008, repeated cuts to Medicaid reimbursement rates have slashed HHC's revenue base by more than $540 million a year. In addition, HHC has had to absorb astronomical increases in pension and employee health insurance costs—from Fiscal Year 2002 through Fiscal Year 2010 up $500 million, from Fiscal Year 2010 through Fiscal Year 2013 up another $180 million. In FY10, facing a projected $1.2 billion budget gap for FY13, we put together a gap closing plan, "The Road

Ahead", that called for $600 million in cost containment and restructuring actions and $600 million in additional revenue ($300 City/ $300 Federal). Achieving the $600 million in revenue required New York State to enact legislation that directed $300 million in supplemental Medicaid payments to HHC, and the City putting up the entire non-Federal match.

The Road Ahead included a wide ranging set of cost-containment and revenue initiatives that yielded the other $600 million in gap closing and we believe better positioned HHC to adapt to unprecedented changes in the healthcare delivery system.

Despite achieving our $1.2 billion gap-closing plan, the challenges ahead are daunting. HHC is projecting continued out-year deficits that grow from $430 million in Fiscal Year 2015 to nearly $1.4 billion in Fiscal Year 2018. This partly reflects that Super Storm Sandy made a bad situation worse. HHC lost $142 million net of federal reimbursements in FY13 from the storm. Also, due to further cuts to Medicaid reimbursement and reduced utilization, HHC lost another $150 million in revenue in FY13.

I will now briefly review the Road Ahead initiatives and the principles that guided us in their implementation. I will close with a very brief overview of the difficult financial landscape still before us, which will demand more tough choices to ensure the viability of our public healthcare system and protect our mission to care for all New Yorkers.

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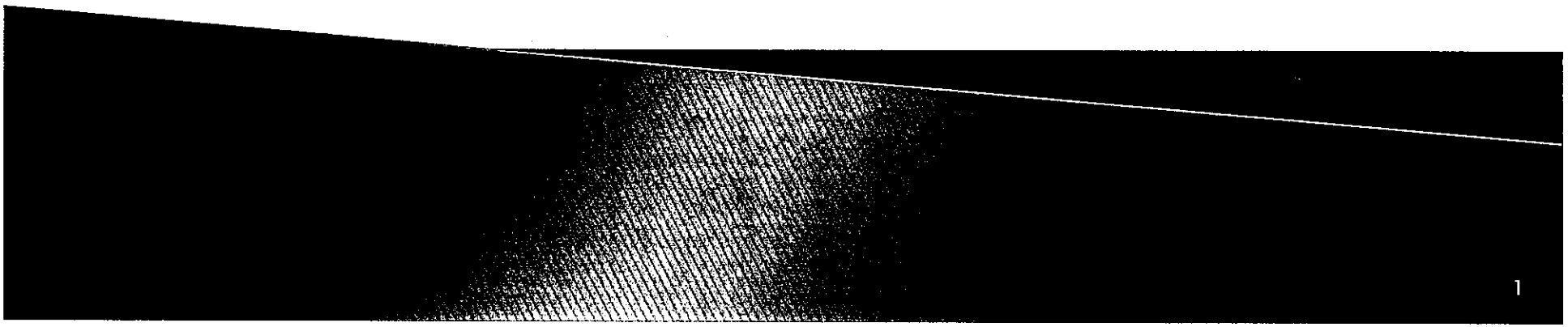
RESTRUCTURING HHC:
An Update on the Road Ahead
And the Challenges Going Forward

Alan D. Aviles, President
New York City Health & Hospitals Corporation

New York City Council Health Committee
February 24, 2014



Restructuring Principles

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- Stay true to the HHC Mission
- Focus on patient and community needs
- Maintain the quality and safety of care delivered
- Leverage our vast integrated delivery system
- Engage our workforce in change efforts

Restructuring Principles

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- Confront constructively the economic downturn and healthcare reform
- Streamline operations, especially in ancillary and support service areas
- Deploy the most cost efficient models of care and service delivery
- Leverage technology to increase effectiveness and efficiency

Areas of Focus

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- 5 Broad Categories with 39 Initiatives:

  1. Administrative/Shared Services
  2. Long Term Care
  3. Affiliation/Physician Services
  4. Acute Care
  5. Ambulatory Care

- Estimated savings or new revenue of $300 million annually when fully implemented.

Administrative/Shared Services

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- Achieve greater efficiencies through targeted cost-effective shared services operations
  - Materials Management and Supply Chain
  - Plant Maintenance
  - Environmental Services
  - Laundry and Linen Services

✓Status: Major objectives have been achieved. Work continues in some areas.

Administrative/Shared Services

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- Reduce Central Office operating costs
  - Status: Completed
- Reduce Information Technology contract staff
  - Status: HHC has In-Sourced 140 IT Jobs
- Reduce skilled trades staff levels to match HHC's reduced capital program
  - Status: Completed
- Implement laboratory services standardizations and efficiencies
  - Status: Work proceeding on a joint laboratory venture

Long Term Care

- Reduce HHC's Long Term Care bed capacity consistent with State & Federal policies
  - Status: Reduced LTACH beds by 426 and SNF beds by 410
- Work with housing providers to create appropriate housing options for SNF residents who no longer require SNF care
  - Status: More than 200 SNF residents discharged to community housing

Long Term Care

- Consolidate select administrative, support and underused therapy services
  - Status: Completed
- Optimize reimbursement opportunities (Billing, Coding, Pharmacy)
  - Status: Completed
- Rebalance Long Term Care Staffing Mix
  - Status: Completed

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Affiliation/Physician Services

- Reduce cost of affiliation contracts and rate of increase
- Align physician staffing to community need
  - Status: Costs have been lowered and work continues with affiliate partners

Acute Care

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- Reduce one-day stays/preventable readmissions thru care management model
  - Status: only one of HHC's hospitals' readmission rates is worse than the national average
- Grow Inpatient capacity in select services to address HHC patients' needs
  - Bariatric Surgery – access for more than 1,000 patients this year
  - Cancer Care – Growth at Kings County Hospital and Queens Hospital
  - NICU Babies – Increased retention within HHC at Bellevue Hospital and Jacobi Medical Center

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Ambulatory Care

- Closed six satellite clinics with low patient volume
  - Factors considered included: proximity to other clinics, utilization, physical plant
  - Status: Completed
- Seek Federally-Qualified Health Center (FQHC) status for six Diagnostic and Treatment Centers
  - Status: Pending Federal approval
- Transition Inpatient & Outpatient Dialysis Services to Joint Venture Model
  - HHC doctors retain oversight of quality and care delivery
  - Access to care is guaranteed and capacity will expand
    - Status: inpatient complete; outpatient pending

Achievements to Date

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- Achieved Road Ahead $300 million target and $300 million from other cost containment/revenue optimization
- Reduced workforce by 3,700 FTEs, mainly through attrition
- Maintained most of service capacity
- Quality of services has been maintained or improved

FCNY

ALFRED P. SLOAN FOUNDATION

SLOAN PUBLIC SERVICE AWARD WINNER

BEST REGIONAL HOSPITALS

U.S.News & WORLD REPORT RANKINGS

THE LEAPFROG GROUP

"A" Rating: Hospital Safety

Five-Star Quality Rated

by Centers for Medicare and Medicaid Services

Eisenberg Award for Quality and Patient Safety

HIMSS Davies Award

NICHOLAS E. DAVIES

Awarding IT: Improving Healthcare

ASPIRE to Excellence

carf

ACCREDITED

Commission on Accreditation of Rehabilitation Facilities

Pinnacle Award

for Quality and Patient Safety

NQF

NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS

NAP

Est. 2008

AMERICAN COLLEGE OF RADIOLOGY

ACR

American Hospital Association–McKesson

Quest for Quality Prize®

Hospitals in Pursuit of Excellence

Finalist

The Joint Commission

2/24/2014

Preparing For Delivery System Reform Imperatives

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- Achieve patient-centered medical home model
  - Status: Received NCQA designation at highest level
- Expand primary care access and reduce wait times
  - Status: Up to 25% improvements gained at many sites
- Use technology to create capacity and be more responsive to our patients
  - Status: Investment made in new EMR and improved appointment scheduling system
- Develop the care coordination/management capabilities of an Accountable Care Organization
  - Status: Achieved ACO designation from CMS and Health Home designation from SDOH

Despite Our Progress, Future Budget Deficits Loom

- Our financial plan reflects large and growing projected budget gaps
  - $430 million in FY2015 to nearly $1.4 billion in FY2018
- Hurricane Sandy: lost revenue, repair and mitigation costs
- Other threats likely to deepen projected deficits further
  - Outstanding labor agreements
  - Ongoing federal budget cuts

City Council Hearing Testimony from Adaline Walker Santiago
Bronx Community Board 7 Chair
status and review of HHC's Road Ahead
Feb 24, 2014 at City Hall Chambers

My name is Adaline Walker Santiago, I am the Chair of Community Board Seven in the Bronx. I am here to testify because to this day, labor and delivery services and the midwifery program at North Central Bronx Hospital, remain closed. Our Health and Hospitals Committee of our Board has held several meetings with the Health and Hospitals Corporation (HHC) and the administration of North Central Bronx Hospital. They have committed to re-open the services by April 30th, and now they are saying that they need more time to re-open the services. HHC's reasoning for both the re-opening and closing the unit has been due to challenges in hiring senior staff.

The unions indicated that the closing of the Labor and Delivery unit could have been prevented. The decision was made rather abruptly without any involvement of the community. Now, the NYS Department of Health says they are going to force the removal of the maternity beds, which will make the service even harder to bring back. The Board is very concerned about the negative impact on the community by keeping the services closed. Although the hearing is about "HHC's Road Ahead", please give some time and consideration for this serious matter, regarding the unexpected closing and delay of re-opening such a vital health service, that serves a documented need in our community.

New York State NURSES ASSOCIATION Advocating for patients. Advancing the profession.

February 12, 2014

To Members of the PHHPC
Members of the Committee on Establishment and Project Review
New York State Department of Health

Re: CON Application No. 132178E
Big Apple Dialysis Management, LLC

New York State Nurses Association
Memorandum in Opposition

The New York State Nurses Association (NYSNA) represents 37,000 registered nurses for collective bargaining in New York State, including the 8,000 registered nurses employed by the New York City Health and Hospitals Corporation (HHC). As a union representing registered nurses, NYSNA is also an advocate for the healthcare needs of patients, as required by applicable ethical and legal canons related to the practice of nursing. We are actively engaged in protecting and improving the quality of care, of expanding access to care as a human right, and of maintaining nursing standards of practice.

This submission is being filed in opposition to the above referenced CON application by Big Apple Dialysis Management wherein it seeks approval to acquire the license and operations of four out-patient chronic dialysis clinics currently owned and operated by HHC.

It is NYSNA's position that the pending CON application is improper and should be denied and/or withdrawn from consideration for approval by the PHHPC. Our opposition is based on the following factors:

1. The Applicant's quality of care and patient outcomes is Worse than HHC
A review of the record of quality of care provided to patients at other dialysis clinics owned or operated by the applicant's principals indicates a significantly lower level of care and patient outcomes in comparison to the level of care and patient outcomes provided by HHC. The applicant's related facilities have higher adjusted patient mortality rates, higher hospitalization rates, and poorer quality records than the current operator.

2. Drastic Reductions in Staffing for Patient Care In Order to Generate High Profits

The staffing model proposed by the applicant will significantly reduce the quantity and quality of patient care, with drastic reductions in total staffing, reduced RN hours per patient, a lower skill mix for patient care, and reduced total patient care hours per patient. The drastic slashing of patient care staffing is the foundation for the applicant to generate high annual profits, at the direct expense of patient care and outcomes.

3. Inadequate Patient Care Staffing To Properly Treat Chronic and Acute Patients

The applicant has provided a staffing model for the chronic dialysis clinics that are the subject of this CON but has not disclosed that this staff, already inadequate to provide a level of care equal to that provided by HHC currently, will also be diverted to provide dialysis treatment to HHC acute care patients. The staffing model for the clinics is not adequate to provide such acute patient treatments.

4. The Applicant Has Not Disclosed That Hours of Operation Will Be Reduced

The hours of operation of the chronic out-patient clinics that are the subject of the application will be sharply curtailed in comparison to the current operations by HHC. The reduction in operating hours will (a) tend to limit the ability of the new operator to provide optimal prescribed dialysis treatment time to patients, resulting in a decrease in the quality of care and patient outcomes, and (b) reduce the availability of and access to services by patients.

5. The Applicant Will Be Eliminating the Availability of After-Hours Shifts for Working Patients

The applicant will be eliminating patient care shifts beginning after 5:00 pm in the three HHC clinics (Harlem, Lincoln and Kings County) that currently provide such services. Those clinics currently operate from 6:00 AM to 11:00 PM (or longer). The new hours of operation appear to be limited to about 13 ½ hours per day (6:00 AM to 7:30 PM). The compression of hours of operation cuts labor costs further (given that the same three patient shifts will be treated in 4-5 fewer hours). The applicant failed to divulge this change in the application.

6. Approval of the Application Is Inconsistent With Each Element of the "Triple Aim"

The public policy of the State of New York, as embodied in the principles of the "Triple Aim" is to improve the quality of healthcare in the state, to improve health outcomes, and to reduce the costs of per capita patient care. Approval of this application will violate each prong of this policy. If this operator is given approval, the level of care of patients will be worse than that currently provided by HHC, the health outcomes for these patients will be worsened, and there will be no reductions in the cost of care per patient. The reimbursement rates for patient dialysis treatment will remain fixed at their current levels, and the savings in the form of reduced staffing and quality of care will inure solely to the benefit of the applicant/

7. Department of Health Failed to Properly Review the CON Application

The Department of Health staff review of the CON application failed to investigate or analyze the quality indicators of the dialysis facilities owned or operated by the principals of the applicant and to compare them to those of the current operator. The recommendation of approval of the CON application by the DOH was thus improper and in violation of its statutory and regulatory obligations to oversee quality of care and protect the health of patients and the public.

8. The Applicant Filed Incomplete, Inaccurate and Misleading Information
The applicant provided incomplete, misleading or false information in the application, in violation of applicable law and regulation, regarding associated/related dialysis clinic operations, quality indicators in associated facilities, changes hours of operation, elimination of after-hours patient shifts, and other necessary or relevant information that was specifically required on the CON application.

9. Pending Article 78 Proceeding Could Reverse Underlying Sale/Lease Transaction
The underlying transaction between the applicant and HHC to transfer/sell the license and assets and establish a service agreement for HHC patients is the subject of a lawsuit by NYSNA challenging the validity of (a) the sale and lease agreements between the current operator (HHC) and the principals of the applicant (Atlantic Dialysis Management Services) in the absence of City Council review and approval, and (b) the legality of the privatization of core patient care services pursuant to the requirements of the HHC enabling statute. The DOH did not analyze or consider these issues prior to issuing its recommendation for approval. Moreover, this lawsuit could void the underlying transaction. Accordingly, approval of the application is premature and could result in disruptions of patient care and significant costs to both the applicant and HHC.

BACKGRIUND

This CON application involves an agreement between the New York City Health and Hospitals Corporation (HHC) and Big Apple Dialysis Management (Big Apple) to privatize the chronic out-patient dialysis clinics and acute care dialysis services throughout the HHC system. HHC consists of 11 acute care hospitals and numerous long-term care, DTC and outpatient facilities.

Starting in 2010-2011 HHC determined that it wished to explore privatization of its dialysis services and in October of 2011 it released a "negotiated acquisition" document (similar to an RFP) outlining the parameters for proposals by interested bidders.

The general terms of the RFP set forth the required parameters of the services and patient care to be provided by the private vendor. According to the specific provisions of the RFP, "the objective of this NA [negotiated acquisition] is to ensure patient safety and quality outcomes by **improving the Corporation's dialysis services**, reduce overall costs, implement cost control methods and programs uniformly throughout the Corporation's dialysis operations, restructure the dialysis operations throughout each of the Corporation's facility **for the purpose of increasing access**, efficiency, productivity, and to reduce the costs of the services" (RFP, Introduction, page 2, emphasis added).

Other provisions in the RFP require that the vendor will provide staff "...as required by all regulations and customary conditions...to provide on-site acute and chronic renal dialysis and off-site dialysis services where medically appropriate" (RFP, pages 12-13). The RFP does not state specifically what levels of staffing and patient care are required to meet these standards, but it does state repeatedly a general requirement that the vendor will provide "adequate" or "sufficient" patient care staffing to meet the general terms of the RFP. The Proposal Evaluation Procedures in the RFP requires a "commitment to quality care and patient safety" as one of the five criteria for selection of a vendor (RFP, page 20).

In addition, throughout the process of the privatization, HHC officials repeatedly stated in public forums that the underlying premise of the privatization dialysis services was not merely to cut costs to HHC, but also that the level of services provided would by "equal to or better" than that provided by HHC. For example, in response to questions about the level and quality of patient care under the proposed privatization at a labor-management meeting held on March of 2012, for example,

HHC management representatives unequivocally stated that there would be no reductions in the level or quality of care provided by any private vendor. Dr. Ross Wilson, for example, defended the decision to privatize dialysis at the July 2012 HHC Board meeting at which the CEO was authorized to negotiate a contract with Big Apple, stating that "the highest possible standard of care" would be maintained under any agreement. Similar statements have been made by the CEO, Alan Aviles, and the Director of Nursing and senior Vice Presidents. See HHC BOD Minutes, July 26, 2012 and Strategic Planning Committee Minutes, July 12, 2012, available on HHC web site.

The agreement between HHC and Big Apple, which is a company affiliated with Atlantic Dialysis Management Service, was finally negotiated and executed in February of 2013. The agreement involved three separate elements: a) the sale and transfer to Big Apple of the licenses and assets of the four HHC clinics located at Harlem Hospital, Kings County Hospital, Metropolitan Hospital and Lincoln Hospital; b) a "license agreement" for the lease and occupancy of the space in which the clinics are located: and c) an operational agreement describing the terms under which Big Apple would provide dialysis services (acute and outpatient) to HHC patients and the rates of payment for such treatments.

Following the execution of the agreement in February, HHC commenced a phased introduction of Big Apple as a provider of acute in-patient dialysis services. The chronic clinics continue to be operated by HHC pending the approval of this CON.

Finally, it should be noted that the privatization of dialysis services has not involved any layoffs of HHC employees. All employees of the dialysis units have been or will be transferred to other units within HHC and absorbed. No NYSNA or other union employees will lose their jobs. This point is noted to avoid any suspicions that our opposition to this CON is motivated by a desire to preserve jobs for our members. Our concern is solely related to the questions of quality and access to care.

We have raised our concerns regarding the threats to patient care, patient health outcomes and access to these critical services before the HHC Board and now wish to make our opposition clear to the DOH and PHHPC.

1. QUALITY OF CARE

The sale should be rejected on the basis of quality of care and critical outcome data. Big Apple Dialysis, LLC, and its sister company, Atlantic Dialysis Management Services, LLC, have an inferior record to that of the four HHC dialysis units under consideration by a wide margin.

HHC's rep, Lauren Johnston, at the January 30, 2014 meeting of the Committee on Establishment and Project Review, provided unambiguous assurances to the Committee on Establishment and Project Review that "outcomes" were "as good or better" at Big Apple as those of four facilities operated by HHC. Her comments came on the heels of testimony, followed by question and answer, on the link between for-profit chronic dialysis and higher death rates in the U.S. The Committee, in effect, asked Johnston to provide evidence as to how Big Apple bucks this trend.

Ms. Johnston's claim that the quality of care provided by the applicants in their related facilities is as good as the record of HHC is wrong by 24%.

ESRD patients at the four chronic units at the HHC hospitals in question here are receiving care that is 17% better than average, according to the latest U.S. government data on mortality in this setting. The ten chronic facilities operated by Big Apple/Atlantic in the greater NYC area provide care that is 4% worse than average.

BIG APPLE *IS* ATLANTIC DIALYSIS MANAGEMENT

Two physicians own and operate Big Apple Dialysis. They went into the dialysis services business by founding a company called Atlantic Dialysis Management Services, LLC. In fact, Jodumutt G. Bhat, M.D., and Nirmal Mattoo, M.D., the first of whom sits on this Committee, informed DOH that Big Apple will manage the four facilities through Atlantic, not just billing and collection services, but to "advise and assist utilization reviews and quality assurance/control reviews." (Executive Summary to Committee, p. 9) So the activities of the two are entwined as a matter of operation and ownership.

Atlantic Dialysis Management has operated the following clinics (in an ownership capacity or through a management services agreement):

1. East End Dialysis Management, LLC
2. Central Brooklyn Dialysis Center, LLC
3, New Hyde Park Dialysis Center, LLC
4. Newtown Dialysis Center, Inc.
5. New York Renal Associates, Inc.
6. Ridgewood Dialysis Center, Inc.
7. Elmhurst Hospital Center (Broadway Dialysis Center)*
8. Astoria Dialysis Center
9. Springfield Dialysis Center
10. West Nassau Dialysis Center, Inc.

*a former HHC facility

STANDARDIZED MORTALITY RATIO (SMR)

This measurement is the standard for dialysis care in this country. It is drawn from data required by to be submitted to the federal government by all ESRD clinics. SMR is defined as follows:

> "This measure takes a facility's expected patient death ratio and compares it to the actual patient death ratio. The expected death ratio is the ratio at which patients with certain demographic characteristics are expected to die in a facility. This depends on the patients' age, race, sex, diabetes, and years on dialysis and whether they had other health problems when they started dialysis. It also depends on patient characteristics such as other diseases or conditions (comorbidities) and body size of the patients at the facility. Facilities with older patients or more patients with diabetes would have a higher expected patient death ratio. The actual death ratio is the ratio at which patients in a facility died during the period indicated on the table. The SMR is the observed death ratio divided by the expected death ratio.
>
> See www.medicare.gov/DialysisFacilityCompare/Data/Hospitalizations-and-Deaths.html

An SMR rating of 1.0 is average. Above average (e.g., "1.35") is deficient (by 35%); inversely, below average (e.g., ".65") is effective (by 35%).

The SMR for the four HHC facilities at issue here averaged **0.83** for the four most recent years available (2009-2012):

The SMR for the 10 Big Apple/Atlantic facilities for the same years is **1.03.**

That is a 20 point difference, or 24% higher than the HHC operated clinics.

In non-SMR adjusted actual deaths, for the last year available, the difference is even greater: the four HHC facilities cared for 246 patients and 16 died. That is a mortality rate of **6.5%** of patients. At the ten Big Apple/Atlantic facilities 1,856 patients were dialyzed and 228 died. That indicates a mortality rate of **12.2%**. This constitutes an **87%** difference in actual deaths for the most recent year reported.

In terms of days spent in hospital, another measure of ESRD patient outcomes, the difference between the Big Apple/Atlantic and HHC records is more than **10%**.

STANDARDIZED MORTALITY RATIO (SMR)
ADMS' annual average SMR is 24% higher than HHC's units.

HHC FACILITIES

HHC UNITS	4 YEAR (2009-2012) ANNUAL AVERAGE[1]
Kings County Hospital Center	1.03
Metropolitan Hospital	.61
Harlem Hospital	.72
Lincoln Hospital	.96
Annual Average	***.83***

ATLANTIC DIALYSIS MANAGEMENT SERVICE (ADMS) OWNED/OPERATED

ADMS UNITS	4 YEAR (2009-2012) ANNUAL AVERAGE
East End Dialysis Management, LLC	1.17
Central Brooklyn Dialysis Center, LLC	1.28
New Hyde Park Dialysis Center, LLC	.86
Newtown Dialysis Center, Inc.	1.08
New York Renal Associates, Inc.	1.30
Ridgewood Dialysis Center, Inc.	1.25
Broadway Dialysis Center at Elmhurst Hospital	.77
Astoria Dialysis Center	.82
Springfield Dialysis Center	.99
West Nassau Dialysis Center, Inc.	.85
Annual Average	***1.03***

[1] Centers for Medicaid and Medicare Services (CMS). 2011. Official Dialysis Facility Compare Data.

ACTUAL DEATHS
ADMS has an 87% higher average rate of patient death than HHC's units.

HHC FACILITIES

HHC UNITS	2011 DEATHS/PATIENTS[2]
Kings County Hospital Center	6/82
Metropolitan Hospital	1/44
Harlem Hospital	5/76
Lincoln Hospital	4/44
Average Percentage of Patient Deaths	***6.5%***

ATLANTIC DIALYSIS MANAGEMENT SERVICE (ADMS) OWNED/MANAGED FACILITIES

ADMS UNITS	2011 DEATHS/PATIENTS
East End Dialysis Management, LLC	18/106
Central Brooklyn Dialysis Center, LLC	31/262
New Hyde Park Dialysis Center, LLC	21/196
Newtown Dialysis Center, Inc.	25/138
New York Renal Associates, Inc.	38/259
Ridgewood Dialysis Center, Inc.	45/363
Broadway Dialysis Center at Elmhurst Hospital	4/113
Astoria Dialysis Center	10/116
Springfield Dialysis Center	14/136
West Nassau Dialysis Center, Inc.	22/167
Average Percentage of Patient Deaths	***12.2%***

[2] Centers for Medicaid and Medicare Services (CMS). 2011. Official Dialysis Facility Compare Data.

STANDARDIZED HOSPITALIZATION RATIO (SHR)[3]
ADMS dialysis patients spent 10.7% more days in the hospital than HHC patients

HHC FACILITIES

HHC UNITS	4 YEAR (2008-2011) RATIO[4]
Kings County Hospital Center	1.67
Metropolitan Hospital	1.29
Harlem Hospital	.98
Lincoln Hospital	1.04
Annual Average	***1.24***

ATLANTIC DIALYSIS MANAGEMENT SERVICE (ADMS) OWNED/MANAGED FACILITIES

ADMS UNITS	4 YEAR (2009-2012) ANNUAL AVERAGE
East End Dialysis Management, LLC	1.12
Central Brooklyn Dialysis Center, LLC	1.64
New Hyde Park Dialysis Center, LLC	1.32
Newtown Dialysis Center, Inc.	1.56
New York Renal Associates, Inc.	1.60
Ridgewood Dialysis Center, Inc.	1.50
Broadway Dialysis Center at Elmhurst Hospital	.93
Astoria Dialysis Center	1.28
Springfield Dialysis Center	1.24
West Nassau Dialysis Center, Inc.	1.33
Annual Average	***1.35***

QUALITY OF CARE SUBMISSION TO DOH IS LACKING

It is important to note that nowhere in any of material submitted by Big Apple to DOH is there any discussion of mortality, or any other quality of care or access to care issues, except for a staffing grid without any comparisons to that which exists at the four HHC clinics today.

When asked to provide quality measures in the CON, Schedule 17, the applicant invoked "Does Not Apply" in their answers. Nothing regarding applicant's track record, quality of care, outcomes or other assessments of the company's record of care were supplied to DOH.

Big Apple Dialysis proposes to buy all gear, equipment and supplies at the four HHC chronic dialysis units and to operate with its own staff. This constitutes both a sale and the establishment of a new dialysis services business, both as a *de facto* and *de jure* matter. Yet none of the information called for in the "Community Need" portion of the CON applicant, including the all-important question about the company's "track record" was supplied by Big Apple.

[3] Days in hospital

[4] Centers for Medicaid and Medicare Services (CMS). 2011. Official Dialysis Facility Compare Data.

It strains credulity that the introduction of a new provider into the lives of hundreds of dialysis patients currently receiving chronic care at the four HHC facilities would not be accompanied by a record of outcomes and quality assessments of other dialysis companies that have been in operation New York City for many years.

What possible explanation would suffice to allow the total absence of this record for the process of review of sale carried out by DOH as a matter of law?

NO INFORMATION ABOUT THE PERFORMANCE OF BROADWAY DIALYSIS, LLC, A FORMER ELMHURST HOSPITAL (HHC) CHRONIC FACILITY, WAS PROVIDED

Nor was Big Apple/Atlantic's performance at Broadway Dialysis, LLC, formerly an HHC chronic facility, provided to DOH. A thorough review and investigation, where appropriate, of quality of care and outcomes at Broadway Dialysis is highly relevant to this proposed sale.

Possible issues that have been identified at Broadway Dialysis include:

- High rates of catheter infection
- High rates of congestive heart failure
- High rates of peritonitis
- Long intervals between visits by nephrologists to the clinic
- Patient intimidation
- Poor machine calibration
- High rates of emergencies resulting in ER visits
- "Cherry picking" of patients for insurance and low acuity
- "Holding back" reportage on patient status

These allegations are serious and call for DOH investigation, especially given that Broadway Dialysis is being held up by HHC as a "model" of care within the Big Apple/Atlantic chain.

2. GROSS REDUCTIONS IN STAFFING FOR PATIENT CARE

The staffing model proposed by the applicant will significantly reduce the quantity and quality of patient care. A comparison of the staffing models employed by the current operator with those proposed by Big Apple reveals reductions in patient care staffing that will necessarily have a negative effect on patients. As was shown in the preceding section, HHC has significantly lower adjusted mortality rates than those of the ten facilities operated by Atlantic Dialysis Management Services, the related/parent company of the applicant.

The applicant's staffing model, in comparison to that of HHC, will result in reductions in total staff ranging from 30% to 60% in the four HHC facilities.

Registered nurse hours per patient during dialysis treatments will be reduced by 70% at Harlem and Lincoln Hospitals, 78% at Metropolitan and 52% at Kings County.

The cuts in RN staffing will only be partially compensated by increased use of LPNs or Techs. Thus, the overall cuts in direct patient care hours per patient (including RN, LPN and Tech time) will range from 16% to 60%. Cuts in patient care of that magnitude will necessarily lead to worse patient outcomes for HHC patients in those facilities.

The cuts to patient care staff being proposed are almost directly correlated to the projected surplus revenues from operations that are projected in the CON application. According to the data provided by the applicant it is expected that the four clinics that will be acquired by Big Apple will generate more than $20,052,000 in gross profits over five years, or an average of more than $1 million annually for each of the four facilities to be acquired. If the average cost of a full-time RN is about $100,000 in salary and benefits, the planned elimination of more than 48 registered nurses positions provides the bulk of the projected profits.

The facility-by-facility analysis of the comparative staffing models and the magnitude of the proposed cuts to direct patient care is based on the information received from Ann Rozakis, a Senior Vice-President for Labor Relations at HHC (2012), a staffing model for Kings County submitted by the applicant to HHC and received from Ms. Rozakis (2012), and the staffing projections provided by Big Apple in Attachment 13-B-1 of the CON application. Copies of the information can be provided upon request.

Harlem Hospital Dialysis: 11 Dialysis Stations

- 51% Reduction In Total Unit Staff
- 70% Reduction in RN Hours per Patient
- 40% Reduction in Total Direct Care Hours per Patient (RN, LPN and PCT)

Harlem Hospital Patient Care Staffing – HHC and Big Apple Dialysis FTEs

Category	HHC FTEs	Big Apple FTEs	Difference	Percentage Change
Nursing Director	0	1.0	+1	
Head Nurse	4.0	0	-4	
Staff Nurse	13.0	2.72	-10.28	
LPN	0.0	2.72	+2.72	
PCT	2.0	2.72	+0.72	
Total	19.0	9.26	-9.84	-51.79%

Harlem Hospital – HHC Patient Care Staffing Model – Based on 5:30 am to 1:00 am, Mon-Sat Operation

	RN	RN Hours	LPN/PCT	LPN/PCT Hours	Total Daily Hours
5:30am - 12:30pm	4	28	2	14	
12:30pm - 6:00pm	6	33	2	11	
6pm - 1:00am	2	14	1	7	
Total Hours per Day		75		32	107

Harlem Hospital - Big Apple Dialysis Patient Care Staffing Model – 6:00 am to 7:30 pm, Mon-Sat

	Big Apple FTEs	Effective Staff*	Weekly Hours	Daily Hours
RNs	2.72	2.3936	89.76	14.96
LPNs	2.72	2.3936	89.76	14.96
PCT	2.72	2.3936	89.76	14.96
Total	8.26			44.88
Effective Daily Staffing		Patients		
RNs	1.20	11		
LPNs/PCTs	2.39	11		
Total	3.59	11		

*Assuming that staff are on paid leave (vacation, holidays, sick time, personal time, etc.) for 6 weeks per year and the standard RN industry workweek of 37.5 hours. This means that each FTE is provides 88% of 37.5 hours of time worked per week or 33 hours per week of time worked. As a result, one FTE working a 37.5 hour schedule will only cover an average of 33 hours per week over the course of a year.

Comparative Staffing – HHC and Big Apple at Harlem Hospital – Per 4 Hour Dialysis Treatment Cycle

	HHC	Big Apple	Difference	Percentage
Number of RNs	4	1.20	-2.8	-70.00%
RN Hours/4 hour PT treatment cycle	16	4.787	-11.213	-70.08%
RN Hours per Patient	1.45	0.435	-1.015	-70.00%
Number of LPN/PCT	2	2.394	0.394	19.70%
LPN Hours/4 Hour PT treatment cycle	8	9.576	1.576	19.70%
LPN/PCT Hours per Patient	0.727	0.871	0.1435	19.74%
Total Hours Per Patient	2.177	1.3056	-0.871	-40.03%

Kings County Hospital Dialysis – 26 Stations

- 41% Reduction in Total Unit Staff
- 52% Reduction in RN Hours per Patient
- 16% Reduction in Total Direct Care Hours per Patient (RN, LPN and PCT)

Kings County Patient Care Staffing – HHC and Big Apple Dialysis FTEs

Category	HHC FTEs	Big Apple FTEs	Difference	Percentage Change
Nursing Director	1.0	1.0	0	
Head Nurse	1.0	0.0	-1	
Staff Nurse	15.0	5.4	-9.6	
LPN	8.0	5.4	-2.6	
PCT	9.0	8.2	-0.8	
Total	34.0	20.0	-14	-41.18%

Kings County Hospital – HHC Patient Care Staffing and Hours Per Day – 6:00 am to 12:00 am, Mon-Sat

	RN	RN Hours	LPN/PCT	LPN/PCT Hours	Total Daily Hours
Module A – 6 Stations	1	18	1	18	
Module B – 6 Stations	1	18	1	18	
Module C – 12 Stations	3	54	3	54	
Total Outpatient Chronic	5	90	5	90	
Module E – Isolation	0	0	0	0	
Module D – Acute Care	2	25		0	
Total	7	115	6	90	205

Kings County - Big Apple Dialysis Patient Care Staffing Model – 6:00 am to 7:30 pm, Mon-Sat

	Big Apple FTEs	Effective Staff*	Weekly Hours	Daily Hours
RNs	5.44	4.7872	179.52	29.92
LPNs	5.44	4.7872	179.52	29.92
PCTs	8.16	7.1808	269.28	44.88
Total	19.04			104.72
Effective Daily Staffing		Patients		
RNs	2.3936	24		
LPNs/PCTs	5.9840	24		
Total	8.3776	24		

*Assuming that staff are on paid leave (vacation, holidays, sick time, personal time, etc.) for 6 weeks per year and the standard RN industry workweek of 37.5 hours. This means that each FTE is provides 88% of 37.5 hours of time worked per week or 33 hours per week of time worked. As a result, one FTE working a 37.5 hour schedule will only cover an average of 33 hours per week over the course of a year.

Comparative Staffing – HHC and Big Apple at Kings Co. Hospital – Per 4 Hour Dialysis Treatment Cycle

	HHC	Big Apple	Difference	Percentage
Number of RNs	5	2.3936	-2.6064	-52.13%
RN Hours/4 hour PT treatment cycle	20	9.5744	-10.4256	-52.13%
RN Hours per Patient	0.833	0.3989	-0.43407	-52.11%
Number of LPN/PCT	5	5.984	0.984	19.68%
LPN Hours/4 Hour PT treatment cycle	20	23.936	3.936	19.68%
LPN/PCT Hours per Patient	0.833	0.9973	0.1643	19.73%
Total Hours Per Patient	1.666	1.3963	-0.2697	-16.19%

Lincoln Hospital Dialysis - 8 Stations

- 64% Reduction in Total Unit Staff
- 70% Reduction in RN Hours per Patient
- 47% Reduction in total Direct Care Hours per Patient (RN, LPN and PCT)

Lincoln Hospital Patient Care Staffing – HHC and Big Apple Dialysis FTEs

Category	HHC FTEs	Big Apple FTEs	Difference	Percentage Change
Nursing Director	0	1.0	+1	
Head Nurse	1.0	0	-1	
Staff Nurse	15.0	2.72	-12.28	
LPN	0.0	2.72	+2.72	
PCT	7.0	1.72	-5.28	
Total	23.0	8.26	-14.72	-64.00%

Lincoln Hospital – HHC Patient Care Staffing and Hours Per Day – 6:00 am to 12:00 am, Mon-Sat

	RN	RN Hours	LPN/PCT	LPN/PCT Hours	Total Daily Hours
6:00 am - 12:30 pm	4	26	2	13	
12:30 pm - 4:30 pm	8	32	4	16	
4:30 pm - 12:00 am	4	30	2	15	
Total Hours per Day		88		44	132

Lincoln Hospital - Big Apple Dialysis Patient Care Staffing Model – 6:00 am to 7:30 pm, Mon-Sat

	Big Apple FTEs	Effective Staff*	Weekly Hours	Daily Hours
RNs	2.72	2.3936	89.76	14.96
LPNs	2.72	2.3936	89.76	14.96
PCT	1.72	1.5136	56.76	9.46
Total	7.16			39.38
Effective Daily Staffing		Patients		
RNs	1.20	8		
LPNs/PCTs	1.95	8		
Total	3.15	8		

*Assuming that staff are on paid leave (vacation, holidays, sick time, personal time, etc.) for 6 weeks per year and the standard RN industry workweek of 37.5 hours. This means that each FTE is provides 88% of 37.5 hours of time worked per week or 33 hours per week of time worked. As a result, one FTE working a 37.5 hour schedule will only cover an average of 33 hours per week over the course of a year.

Comparative Staffing – HHC and Big Apple at Lincoln Hospital – Per 4 Hour Dialysis Treatment Cycle

	HHC	Big Apple	Difference	Percentage
Number of RNs	4	1.20	-2.8	-70.00%
RN Hours/4 hour PT treatment cycle	16	4.787	-11.213	-70.08%
RN Hours per Patient	2	0.598	-1.4016	-70.08%
Number of LPN/PCT	2	1.95	-0.05	-2.50%
LPN Hours/4 Hour PT treatment cycle	8	7.81	-0.2	-2.50%
LPN/PCT Hours per Patient	1	0.975	-0.025	-2.50%
Total Hours Per Patient	3.00	1.573	-1.427	-47.49%

Metropolitan Hospital Dialysis – 12 Stations

- 30% Reduction in Total Unit Staff
- 78% Reduction in RN Hours per Patient
- 60% Reduction in total Direct Care Hours per Patient (RN, LPN and PCT)

Metropolitan Hospital Patient Care Staffing – HHC and Big Apple Dialysis FTEs

Category	HHC FTEs	Big Apple FTEs	Difference	Percentage Change
Nursing Director	0	1.0	+1.0	
Head Nurse	2.0	0	-2.0	
Staff Nurse	6.0	2.0	-4.0	
LPN	2.0	2.0	0	
PCT	0.0	2.0	+2	
Total	10.0	7.0	-3.0	-30.00%

Metropolitan Hospital – HHC Patient Care Staffing and Hours Per Day – 7:00 am to 10:00 pm, Mon-Sat

	RN	RN Hours	LPN/PCT	LPN/PCT Hours	Total Daily Hours
Staffing Plan	4	68	3	51	119

Metropolitan Hospital - Big Apple Dialysis Patient Care Staffing Model – 6:00 am to 7:30 pm, Mon-Sat

	Big Apple FTEs	Effective Staff*	Weekly Hours	Daily Hours
RNs	2.0	1.76	66	11
LPNs	2.0	1.76	66	11
PCT	2.0	1.76	66	11
Total	6.0	5.28	198	33
Effective Daily Staffing		Patients		
RNs	0.88	12		
LPNs/PCTs	1.76	12		
Total	2.64	12		

*Assuming that staff are on paid leave (vacation, holidays, sick time, personal time, etc.) for 6 weeks per year and the standard RN industry workweek of 37.5 hours. This means that each FTE is provides 88% of 37.5 hours of time worked per week or 33 hours per week of time worked. As a result, one FTE working a 37.5 hour schedule will only cover an average of 33 hours per week over the course of a year.

Comparative Staffing – HHC and Big Apple at Metropolitan Hospital – Per 4 Hour Dialysis Treatment Cycle

	HHC	Big Apple	Difference	Percentage
Number of RNs	4	0.88	-3.12	-78.00%
RN Hours/4 hour PT treatment cycle	16	3.52	-12.48	-78.00%
RN Hours per Patient	1.25	0.293	-0.957	-76.53%
Number of LPN/PCT	3	1.76	-1.24	-41.33%
LPN Hours/4 Hour PT treatment cycle	12	7.04	-4.96	-41.33%
LPN/PCT Hours per Patient	1.0	0.5867	-0.413	-41.33%
Total Hours Per Patient	2.25	0.88	-1.37	-60.89%

3. Inadequate Patient Care Staffing For Acute Patients

The drastic cuts in staffing for the chronic, out-patient clinics noted in the preceding section will also negatively affect the ability of nurses to provide emergency or regular acute, in-patient dialysis to HHC patients.

The applicant's contract to acquire the clinics involved in this CON application requires Big Apple to devote staff to provide acute dialysis treatments at the bedside or in the clinics. This acute in-patient service is to be provided by on-site staff from the clinics and will require the RNs to either leave the clinic to perform the dialysis at the patient bedside or to do so in the clinic in a section equipped for acute care treatments.

HHC's staffing pattern at Lincoln, Metropolitan and Harlem include overlapping shifts that provide extra staffing in the afternoons to permit nurses to provide bedside treatments. At Kings County there is a separate acute module to which 2-3 RNs are assigned exclusively to acute dialysis treatments.

The Big Apple staffing model will eliminate the overlapping shifts, and will reduce the hours of operation of the clinics. In the absence of shift overlaps, any acute care treatments during business hours will require one or more nurses to leave the chronic clinic to address acute care patient needs.

The tightly compressed chronic work schedules and the bare-bones RN staffing will raise serious questions about the effect on patient care in the chronic clinics. In some clinics the RN staffing is so low that any use of those nurses to perform acute dialysis will leave little or no RN coverage of the clinics. In some units there will only be one RN on duty, precluding her use for acute patients.

The paucity of staffing, and particularly of RN staffing, will create pressures to cut corners and to shorten dialyzing treatment times (either through shorter prescribed treatment times or through errors or other factors that have the effect of reducing interrupting proper treatments).

The applicant has failed to address this issue in its proposed staffing plans, raising serious questions of patient care and safety for both the chronic and the acute patient populations.

4. The Applicant Has Not Disclosed That Hours of Operation Will Be Reduced

The applicant has not provided any information to the DOH or the PHHPC in the CON application regarding its planned hours of operation of the four clinics. The application is entirely silent on this matter.

Based upon the sample staffing model for the Kings County clinic, which was provided by the applicant to HHC in 2012, Big Apple clearly indicated it intent to sharply reduce the hours of operation of that clinic to a 13 ½ hour daily schedule.

The staffing models submitted in the CON application clearly indicate to us that this same schedule will be imposed on all of the HHC clinics. The RN FTE staffing levels being proposed are clearly insufficient to provide staffing for more than a 12 ½ hour work day in each clinic (with unpaid meal periods providing the extra hour of operation, as the employees will be working a 13 ½ hour long work day). It is also clear that the applicant intends to maintain or increase the number of treatments provided in each facility (see CON application, schedule 13-B-1), so there is not room to stretch the length of the business day by decreasing the number of patients. Based on the projected patient volume and the submitted FTE staffing, there is no capacity to maintain the existing hours of operation.

Based upon our knowledge of the operations of the HHC clinics we believe that the following operational schedules are currently in effect:

Harlem Hospital:	Monday to Saturday	5:30 am to 1:00 am	19 ½ hours
Kings County Hospital:	Monday to Saturday	6:00 am to 12:00 am	18 hours
Lincoln Hospital:	Monday to Saturday	6:00 am to 12:00 am	18 hours
Metropolitan Hospital:	Monday to Saturday	7:00 am to 10:00 pm	15 hours
Big Apple Model:	Monday to Saturday	6:00 am to 7:30 pm	13 ½ hours

The change in the hours of operation of the clinics will confer obvious financial benefits for the owner.

The compression of the hours of operation allows significant labor cost savings by eliminating the overlap of work shifts. The compression of the hours of operation, in conjunction with the reduced hours of patient care time discussed above, will allow the applicant to generate extra profits by moving patients through the treatment process in shorter times and with fewer care givers.

The impact of the compressed operational schedule, however, will further exacerbate the expected decline in the quality of care and patient outcomes.

The shortening of the business day to 13 ½ hour will allow only 4 ½ hours of time to turn over each patient shift. If the standard treatment time of 4 hours is prescribed, this schedule leaves only ½ hour per patient shift to usher them into the treatment area, to assess each patient before and after treatment, to take specimen samples, to clean and disinfect the patient treatment areas and equipment, to "hook up" and "unhook" each patient, and to provide any needed educational or clinical advice and direction.

With the added pressure of sharply reduced staffing levels there will be a natural tendency to seek to shorten dialysis treatments times in order to maintain the necessary schedules and avoid incurring overtime costs and causing the "line" to back up. This tendency will be reinforced by a corporate business plan that requires strict time discipline to meet projected revenues and profits.

We can thus expect to see a further impetus for worse quality and patient outcomes as a result of the change in schedules.

The reduced operating hours are also problematic in that they violate the public policy favoring increased availability and access to dialysis services for ESRD patients. Pursuant to NYCRR Section 670.6(b)(3), one of the criteria for approval of a CON application for establishment of a dialysis facility is "evidence that the facilities hours of operation...will promote the availability of services..." Reducing the hours of operation of an existing dialysis facility is on its face not an action that will have the effect of promoting the availability and access to the facility.

The CON application filed by Big Apple does not divulge the intent to reduce the hours of operation of the existing facilities.

5. Failure to Disclose the Elimination of After-Hours Shifts for Working Patients

The reduction in the hours of operation of the clinics discussed in the preceding section will also violate the provision of NYCRR Section 670.6(b)(3) relating to increasing access and availability of dialysis services to patients outside of working hours so that they can maintain their employment and independence.

Currently, three of the HHC facilities – Kings County, Harlem and Lincoln – offer patient treatment shifts starting after 5:00 pm (See: CMS Dialysis Facility Compare website). Each of these facilities operates until midnight or later to allow access to employed patients.

It appears that the applicant will be eliminating patient care shifts beginning after 5:00 pm in these three HHC based on the sample staffing plan submitted for King County in 2012, which clearly indicates that the hours will be reduced to 6 am to 7:30 pm.

In addition, the staffing patterns clearly indicate that it is neither intended nor possible to operate the clinics with the proposed level of staffing beyond those hours.

The CON application fails to provide any information regarding the availability or elimination of after-hours patient shifts.

On page 4 of Schedule 17C the applicant was required to provide "evidence" that "the hours of operation and admission policy of the facility will promote the availability of dialysis at time preferred by the patients, *particularly to enable patients to continue employment.*" (Emphasis added).

The applicant's response was: "As this is for a change in ownership of an existing end stage renal disease center, this section is not applicable. However this will be reflected in the policies and procedures as implement by the facility, subject to review of the New York State Department of Health."

The applicant not only failed to divulge "evidence" of compliance with this policy, it effectively misled the DOH by implying that because this CON is a change in ownership, that there would be no change in the existing hours of operation and policies of the existing owner.

Given the change in the hours of operation, the planned elimination of after-hours shifts at Kings County and the other facilities and the evasiveness of the response to the questions raised in the CON application, the application should be denied.

6. The Application Is Inconsistent with State Policy and the "Triple Aim"

The public health policy of the State of New York, as embodied in the principles of the "Triple Aim" is to reform our healthcare delivery system by achieving the following goals:

a. To improve the quality of healthcare services;
b. To improve the health and well-being of the population; and,
c. To reduce the per capita costs of healthcare.

This application violates or fails to further each of the precepts of the Triple Aim.

As noted in our discussion of the total healthcare track record of the other facilities owned or operated by principals of Big Apple, their overall mortality and other indicators are significantly poorer than those of the current operator. We have also noted that the reductions in RN and total patient care staffing that the applicant will impose on these clinics will most likely lead to lower quality of care and will negatively impact the health outcomes of patients. The applicant is also reducing the availability of existing services, which the DOH staff found to be in short supply in the New York City area in issuing its recommendation of approval, by reducing its hours of operation and eliminating after-hours shifts.

Approval of this application will thus tend to undermine the first two principles of the Triple Aim by worsening the quality of care and causing worse health outcomes.

In addition, although money and costs are obviously major motivating factors in the underlying transaction between HHC and Big Apple (with HHC wishing to reduce its internal costs and Big Apple wishing to generate gross profits in the 15-20% range), the financial aspect of the Triple Aim is not intended to encourage or enhance private, for-profit healthcare providers to line their pockets.

The intent of the third prong of the Triple Aim is to drive down the broader social and governmental burdens of healthcare cost escalations that exceed the general rate of inflation.

The payment of services for dialysis treatment is largely assumed by government and the providers of such care receive pre-set payments on a per treatment basis. If these providers can reduce costs or otherwise produce "efficiencies" in the delivery of care, the full benefit will go to them and to them only. Neither the state government nor the public at large nor the patients who use these clinics stand to gain any benefit if this proposal is approved.

Given the economic projections included in the CON application and the track record of care that is worse than that provided by the current operator, it cannot be argued that approval of this application will in any way serve to reduce per capita health costs. All "savings" resulting from the slashing of patient care and staffing will be appropriated in their entirety by Big Apple.

For these reasons, the approval of this application would be in direct contravention of the Triple Aim policy of the State of New York. There is simply no reason to approve this CON.

7. DOH Failed to Properly Review the CON Application

The primary function of the Department of Health, and by extension of all committees, councils and other bodies within the general purview of the DOH, is to protect the health of the people of the state.

In the CON application submitted by Big Apple, there are a series of questions in Schedule 17 that require the production by the applicant of information related to various aspect of the process.

Schedule 17A requires the applicant to demonstrate how it will comply with state and federal regulations. The applicant claimed that this question was not applicable and provided no information.

Schedule 17B contains 5 separate questions related to the community needs for the proposed services (including a statement of why the service is needed in a particular community, a description of the community to be served, an analysis of demand for the services, how the applicant reflects the makeup of and intends to meet community needs, how the project fits into the organization's strategic plan, and how the local population receives services). The applicant again claimed that this information requested was inapplicable and provided no information.

Schedule 17B also contains three separate questions intended to establish the applicant's record on quality of care. Question 3 specifically requests that the applicant "describe the applicant's experience or track record serving similar populations."

The applicant again failed to answer this question, claiming it was irrelevant to the application to buy the HHC dialysis clinics.

Schedule 17C relates directly to dialysis clinic operators. On page 4 of Schedule 17C there are five specific requests for information.

The applicant acknowledged that the questions were applicable in providing financial analyses of the costs and revenues projected as Attachment 13B-1.

The remaining four requests were not answered and no information was provided.

The applicant was asked to provide evidence as to how the project would enhance services for underserved populations. The applicant claimed this was not applicable.

The applicant was next asked to answer questions about the hours of operation and availability of after-hours shifts. As was previously discussed, it appears that the applicant will reduce hours and eliminate after-hours shifts. The applicant however provided no information or response to this question, and again stated that the question was "not applicable."

The next question asked the applicant to "provide evidence that the facility is willing to and capable of safely serving patients." This question directly related to the issue of the record of quality in the applicants other dialysis facilities. Again, the response was that this section was "not applicable."

The same pattern of failure to provide information was repeated in separate Schedules submitted for each of the dialysis clinics involved.

The DOH staff that reviewed the CON application issued a recommendation of contingent approval.

It appears that there was no effort by the DOH to require the applicant to provide any of the information requested on the CON forms that related to quality of services, access to care, community needs assessments and the applicant's operations in other facilities.

The DOH staff did not follow up with the applicant on these issues and did not require the submission of any documentation, notwithstanding the blatant refusal to respond on these questions.

The issuance of the recommendation for approval was thus arbitrary and improper and reflects a failure of the DOH to carry out its duties and obligations to ensure that healthcare operators seeking to acquire or build healthcare facilities are providing required information, and to actually screen applicants as to quality of care in other facilities that they are operating.

The DOH appears to have limited its review to the explicit "character and competence" analysis without making any effort to actually investigate the quality of services being provided at the operators other facilities.

The DOH failure to properly review this application requires that this CON be denied or tabled until such time as a proper and complete application is filed and a real investigation of the "track record" of the applicant is carried out.

8. Applicant Provided Incomplete, Inaccurate and Misleading Information

As noted in the previous section, the applicant repeated failed to provide information requested by the DOH as a part of the CON review process.

The applicant refused to provide information and repeatedly relied upon the following rote response: "As this is for a change in ownership of an existing end stage renal disease center, this section is not applicable. However, this will be reflected in the policies and procedure as implemented by the facility, subject to review of the New York State Department of Health."

The applicant gave this answer to many questions that were clearly applicable. Though the applicant correctly notes that the application is largely about the transfer of the licenses of HHC and thus a change in ownership, it is also a change in the operator of these facilities from a public hospital system that treats (at great cost) all people regardless of ability to pay or legal status to a *for-profit* operator that does not have the same organizational motivations.

Thus, it is entirely relevant and "applicable" for the DOH to know whether there will be any changes in existing HHC policies that relate to healthcare services to poor, immigrant and other underserved communities, whether there will be any changes in the policy of providing dialysis treatments free of charge to uninsured patients, whether the level of quality provided by HHC will be maintained, and other similar questions of access to and quality of care.

Furthermore, the series of questions directly related to dialysis operations, such as the questions related to hours of operation and after hours shifts, and the questions of safe patient care are in fact directly applicable. The applicant could and should have provided this information.

In some instances the applicants "not applicable" responses went beyond a mere failure to answer questions. This answer implies that because this is merely a change in ownership or title, the applicant intended to make no changes in the operations or policies of the existing owner. This response might have been less objectionable if the applicant was not intending to change the prior policies by reducing the hours of operation of the clinics and eliminating after hours shifts. In the context of the changes in staffing models, levels of patient care and quality, and the changes in operations, however, the rote non-response "response" is in point of fact actually misleading and disingenuous.

Based on the incomplete, misleading and inaccurate responses given by the applicant and its failure to be forthcoming about the changes that it would be bringing to the existing operator, the application should be denied.

9. Pending Article 78 Proceeding

The underlying transaction between the applicant and HHC to transfer/sell the license and assets and establish a service agreement for HHC patients is the subject of a pending article 78 proceeding (NYSNA v. Health and Hospitals Corporation, Bronx Co., Index No. 260956-2013).

This lawsuit raises various claims regarding the underlying privatization of the dialysis services and the validity of the underlying lease agreement for the premises occupied by the HHC clinics.

If this Article 78 proceeding is successful, the underlying agreements may be voided. If this occurs, it may cause disruptions in care and/or result cause the applicant and HHC to incur unwanted liabilities.

The DOH should not give authorization to a CON application that is potentially illegal on several grounds.

Accordingly, we ask that the consideration of the CON be tabled until there is a resolution of the Article 78 proceeding.

lawsuit by NYSNA challenging the validity of (a) the sale and lease agreements between the current operator (HHC) and the principals of the applicant (Atlantic Dialysis Management Services) in the absence of City Council review and approval, and (b) the legality of the privatization of core patient care services pursuant to the requirements of the HHC enabling statute. The DOH did not analyze or consider these issues prior to issuing its recommendation for approval. Moreover, this lawsuit could void the underlying transaction. Accordingly, approval of the application is premature and could result in disruptions of patient care and significant costs to both the applicant and HHC.

TESTIMONY OF

AGNES M. ABRAHAM, Chair

HHC COUNCIL OF COMMUNITY ADVISORY BOARDS

FEBRUARY 24, 2014

Chairperson Johnson, members of the Health Committee Messrs Aviles and Martin and other senior members of the Health and Hospitals Corporation. My bane us Agnes M. Abraham, I am the Chairperson of HHC's Council of Municipal Community Advisory Boards and also the chairperson of the Community Advisory Board at Kings County Hospital.

I stand before you today to concur with The Road Ahead **as presented by President Aviles and his team. While we may not agree whole heartedly with some aspects of the restructuring, e.g. the outsourcing of the chronic dialysis it would be irresponsible of me, knowing the state of the dire economic constraints faced by the Corporation, not to agree that something has to be done.**

That is where you as our elected officials come in. Given the mission of the Health and Hospitals Corporation

and the closings and threats of closing of hospitals in key contiguous zones served by HHC makes it virtually impossible for HHC to continue to perform its judiciary responsibility to the citizens of New York City. Even given these dire straits the professionals at HHC manage to provide excellent care to all patients.

Thank you for your support in appropriating funds to assist the Corporation in funding its operation. However, you will agree, I am sure, that with a projected $465 million in 2015 and getting progressively higher in 2018 to the tune of 1.3 billion, your constituents, the patients HHC serves will depend on your creative ability, your ingenuity and your will to come up with a solution to stop the financial bleeding.

You see Chairperson Johnson I am a living breathing testament of the miraculous work done at the hospitals

under the auspices of the HHC and more particularly Kings County Hospital. Twenty-nine years ago I suffered a ruptured appendix and was rushed to Kings County Hospitals' emergency room and was treated in the nick of time. Twenty-three months ago I was stricken with a devastating illness that could have killed me and Kings to the rescue again. After my left leg was amputated, I was confined to a wheel chair with a very poor outlook on life. Thank God for the caring health professionals at Kings County Hospital, the Rehab team led by Drs. Beal, Carol Wilson Smith and their colleagues I am still standing. You see ladies and gentlemen I am not only an advocate I am a patient, the recipient of that excellent care I spoke earlier about. I urge you to do all in your power to ensure HHC's financial health for many years to come. Thank you!!!

Sandra Thomas
Northwest Bronx Community & Clergy Coalition

City Council Hearing on the status and review of HHC's Road Ahead
February 24, 2014 at City Hall Chambers

My name is Sandra Thomas. I have lived in the Bronx all my life and am a member of the Northwest Bronx Community & Clergy Coalition. I am here today because Health and Hospitals Corporation has promised to return labor and delivery services to my community. I am concerned that HHC is not planning to keep their promise. Although HHC has recently said it will not be able to reopen labor and deliver services by the committed deadline of April 30th. They have said they cannot recruit the staff needed to reopen. The State has said it will remove those maternity beds if HHC does not.

My family has had a long relationship with North Central Bronx Hospital. I am the proud mother of one son born at NCB Hospital. I am also extremely blessed to be the grandmother of three children born to NCB Hospital. The midwives and staff of NCB Hospital made the experience for me, my husband, and my children and extremely positive one. They made me feel comfortable. There was someone with me at all times checking on me and monitoring me. They were sensitive, warm, and entirely focused on me the entire time. This is the kind of care that every mother and their family should have access to.

It is an outrage that these services have been suspended in a community whose residents are poor, minorities, and immigrants who literally cannot afford to lose them. I am here for the future generations of mothers in the North Bronx. I am here because I want to see them I am here because I do not want to see them have to give birth in ambulances or in cabs on the way to the hospital or in a hospital lobby because it is too far from their community. The removal of these services means chaos in our community for mothers. Mothers who do not use a hospital for labor and delivery services will probably not use it for other services. That means the use of all hospital services will decline. Are we losing another hospital in our community?

On top of that, HHC's strategic plan has proposed more cuts and more consolidation of staff and services and not just for labor and delivery services like ours at NCB. They have done this without asking any input from the community. This sends an alarming message to underserved communities like mine that public hospitals are on the way to being phased out. We desperately need for these services to continue. We need for award-winning programs like NCB's midwifery program to expand. My son is in school to be a doctor. We need investment in educating and training for young people in poor and minority communities to go into healthcare professions so that more young people can get and keep jobs at hospitals in their communities where they will live out their lives. I urge HHC and our City to plan for the future of my community.

Eileen Markey
North Central Bronx Hospital patient, community member.
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resident of Council District 11, Hon. Andrew Cohen.

Testimony for the NYC Council Oversight Hearing:
Examining the Status of "Restructuring HHC: The Road Ahead"

Monday February 24, 2014

Good afternoon.

My name is Eileen Markey. I live in Norwood in The Bronx. Unlike many of the distinguished people who've spoken and will speak today, I'm not an expert on public health. I don't know how HHC works. I'm not conversant in medicaid reimbursements or the challenges of implementing ACA or the pressures on our public hospital system. I'm simply a Bronx woman who gave birth at an excellent HHC hospital, a hospital that is no longer supporting women as they bring life into the world. I'm here first as a proud citizen and then as a heartbroken one. Women and families in my neighborhood are being denied vital, central services at our community hospital – North Central Bronx. It is my hope that through its oversight power this body can set right an ongoing injustice. The issues I'll raise relate to Road Ahead oversight because they spotlight problems with regionalization and lack of transparency and accountability on the part of HHC.

In August HHC suspended labor and delivery services at North Central Bronx Hospital. Overnight thousands of women – overwhelmingly immigrant, poor and working class women of color – were robbed of a safe, supportive and accessible place to bring their children into the world. The ward was closed, we eventually learned, because of a

staffing crisis at Jacobi Medical Center. Because of endemic turnover, doctor to patient ratios were dangerously low at Jacobi. Our skilled nurses, midwives and doctors were reassigned there to help. This rash decision left the women and families of North Central Bronx with a *cataclismically* out of balance staffing ratio: 0 obstetric professionals to tens of thousands of women in a neighborhood the skews young and fecund.

There was no warning, no community input, no notification. For the past six months birthing women have had to travel clear across the borough to deliver at a hospital not their own, far from family, in an environment far inferior to the loving, woman-centered and humane practice we enjoyed at NCB. It takes 50 minutes and two buses or a train and a bus to get from NCB to Jacobi. When my friend Cynthia's daughter gave birth to twins at Jacobi, Cynthia spend most of the first week of her granddaughters' lives commuting between her home (which is three blocks from NCB) and Jacobi, which might as well have been in Connecticut. Her young daughter was alone much of the time, Cynthia was exhausted, the family began in stress.

Some women have been treated at nearby Montefiore Hospital – a facility that does not have a labor and delivery ward. Women are laboring in hallways and the always madhouse emergency room, attended by doctors and nurses who are not specialists in birth. An emergency room is a good place to go for stitches, but its a lousy place to have a baby. We need our labor and delivery unit back.

What I hear from friends who have delivered at Jacobi in these six months is that it is crowded, chaotic, staff don't have time to give careful attention to new mothers – and abyssmal staff ~~morat~~ morale is plainly evident.

Since August we – pregnant women, mothers, fathers, concerned neighbors – have been begging HHC to reopen North Central Bronx' beloved and well-respected, midwife-run maternity ward. We've rallied, we've collected signatures, we've filled public meetings,

we've stood in the cold and sung songs, we've held aloft photographs of our babies who were born well and safely at North Central Bronx. In response HHC has given us obfuscation, shifting stories, an ever receeding reopening date, a mishmash of misinformation.

In December we were told that the labor and delivery ward would reopen April 30. Now HHC says it needs more time. In the meantime, because so much time has ~~past~~ passed and HHC has been opaque about its true intentions, the State Department of Health is threatening to remove North Central Bronx' maternity certification. If that happens, reopening the ward will be a much higher hurdle. Our fear is that the closure of labor and delivery is just the beginning, that in the future we'll suffer the removal of well-woman and prenatal services, pediatrics, the rest of our hospital.

Here's how this body can step in to fix the maternity problem at NCB and at the same time set in place procedures and an orientation that will headoff problems with the Road Ahead more broadly.

Require that HHC more ~~activily~~ actively and sincerely engage with the community of patients, advocates, staff and other stakeholders. The decision to suspend labor and delivery services at NCB was made without consultation or explanation.

Expand the role and function of the Community Advisory Boards and fill them not with patronage posts but with truly exchanged and if-need-be critical community members. MAKE SURE THESE BOARDS MEET FREQUENTLY. When I called the NCB Community Advisory Board in September to complain about the labor and delivery suspension I learned that the next time the board would meet at NCB would be JANUARY! (It alternates between Jacobi and NCB, but meets far more frequently in the east Bronx). I want to see a Community Advisory Board that has teeth. I also want to see a CAB that posts notices of its meetings prominently and that seeks out the opinions and concerns of residents. I've lived in my neighborhood – as a very involved and vocal

member - since 2002. I only learned the CAB existed in September because I read in a newspaper that it didn't object to the suspension of labor and delivery services.

Beyond the Community Advisory Board system, HHC should be required to aggressively seek community input on any proposed changes to health care services. Community and staff should be given forenotice that changes are being considered, so that an honest discussion and joint problem solving effort can be made.

Another issues in the Road Ahead plan is regionalization. Given the financial constraints on our healthcare system, regionalization may indeed make sense in some fields. We probably don't need high level cancer centers or heart transplant operations at every neighborhood hospital. But labor and delivery isn't something you regionalize. It is a basic, central service of a hospital. It's also the way most people form a relationship with a particular facility, ensuring ongoing demand for other services from pediatrics to the emergency room to adult clinics. We need to make sure regionalization isn't just a fancy word ~~of~~ for withdrawal of services.

Now let me tell you my real motivation for being here. Three years ago I found myself pregnant with my second child. From the day I went to North Central Bronx' midwife-run maternity clinic for a pregancy test until the day I walked out of the hospital with my beautiful son I received the highest level of skilled, humane, woman-centered, loving care. I actually enjoyed my appointments. The midwives at North Central Bronx treated us pregnant ladies with concern and respect. I think- particularly as women – we're all familiar with being condescended to, objectified, under-estimated. As patients – men or women – in so many healthcare settings we're used to being treated as numbers, as units, as annoyances, the doctor looking at some screen while we struggle to form a question. North Central Bronx was the opposite of that. The midwives educated, talked to me with my clothes on, discussed everything they were doing. Do you notice that I keep saying midwife? That's key. The kind, respectful, empowering care we all received at NCB was directly linked to the midwife model of care and the ethic pervasive at a ward where midwives are in charge, not guests. I looked forward to those appointments

and to the time in the waiting room with sisters from every corner of the globe, each of our round bellies promising the future of the city.

I said this was my second child. My first was born at a private hospital with a fancy reputation in Manhattan. I felt like a number, a unit, an annoyance, a profit point. I've never had such a sustained experience of dehumanization and disempowerment. At NCB's midwife-run maternity unit, on the other hand, my child and I were supported, respected, cheered – and it sounds odd to say but it's true: loved. I want my neighbors to have that again.

Thank you.

cphs*

*putting the public back in public health

Testimony for the Oversight Hearing on "Restructuring HHC: The Road Ahead"

Feb 24, 2014

Anthony Feliciano, Director of cphs*

Thank you for the opportunity to testify in front of you today. The Commission on the Public's Health System has been a supporter of the health care safety net and access to health care services for everyone, particularly in low-income, medically underserved, immigrant and communities of color.

The New York City Health and Hospitals Corporation (HHC) is a vital safety net resource for all New Yorkers. HHC plays a major role in providing health services to low-income and uninsured New Yorkers. We understand that HHC is striving to transform their care delivery systems and comply with the 2010 Affordable Care Act (ACA) against a backdrop of unprecedented financial challenges. That is why we thank the Health Committee Chair and committee members for scheduling this hearing to examine the Road Ahead-HHC's strategic plan.

There have been already steep expenditure reductions and movement to privatize important patient care services like dialysis care in order to achieve savings, and closing of vital health services like labor and delivery services at North Central Bronx Hospital (*note the L&D services is not part of the Road Ahead's plan, but it indirectly connected to HHC's structural issues*). All this has been disturbing and could lead to deterioration of the importance HHC plays in New York City's health care infrastructure and access to health care for all New Yorkers.

When the Road Ahead was developed in 2010 by Deloitte, LLP, the final report for HHC included a flawed analysis of the public hospital system and sweeping structural recommendations. The Road Ahead" did not address the basic questions about maintaining the quality of care with dramatically fewer employees and changes to access to services. Thankfully, HHC did not accept all of the recommendations in the report, but what they did accept will and

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have caused pain to community and workers. In addition, it is important to point out that there was no community or labor involvement. HHC did host a meeting for community advocacy organizations in which recommendations were made by the groups. However the report and its details were not shared before its release. Now, it has been three years since the plan was developed and with the help of the City Council, several issues are imperative to be addressed:

1. **Ensuring and monitoring that HHC creates a mechanism for more community and labor involvement in their decision-making process. This could be done by making sure that HHC will**

   - Renew, sustain, and create new collaborations with community groups and support networks.

   - Expand the role, powers, and function of the Community Advisory Boards (CAB's). The CAB's should be given more oversight powers to hold HHC accountable for its decisions. They should be more representative of the community and their interests, and they need to be entirely free of political pressures and patronage. The CAB's should be more involved in setting, approving, and directing the priorities of HHC. More resources, including trainings, should be given to ensure the successful functioning of the CABs.

   - Develop adequate planning protocols when considering changes to health care services. We would like to see for the future that HHC does the following in all its facilities:
     - Convene community members to seek input on any changes to health care services in their communities. HHC must agree that in future the community and staff will receive proper notice of any perceived need for changes in health care services, and that a discussion of possible solutions will be held prior to the final decision being made.
     - Once a change has been decided upon, a communication plan must be developed to give hospital staff, patients, and community members adequate notice of the impending change and to explain the reasoning behind it.
     - Work with the Community Advisory Board at each facility in setting up community meetings to gather feed-back from community residents, and in expanding relationships with local organizations.

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- Quickly Identify HHC board members who have an ongoing commitment to the mission of the public hospital system, to patient care, and to expanding accessibility. There is a need for reforms in the current HHC Board structure. We need more patients, advocates, and direct staff serving on the HHC Board.

2. **Ensuring that HHC preserves and expand access to quality health care services by:**

- Stopping privatization of any additional clinical and non-clinical services. There is very little evidence that past privatization initiatives have improved either quality or access. Proposal to privatize many services is troubling. The worst is the contracts that have been entered and new ones being entered into to privatize all dialysis services. Atlantic is the company that has taken over dialysis services. CPHS found two of the current Atlantic clinics with poor records of care, located in the South Bronx and Central Brooklyn. Currently there is approval waiting from the state DOH Public Health Council for other networks in the HHC system to privatize dialysis.

- Preventing more cuts or reductions in health services and programs. The plan already implemented the closing of five Child Health Clinics and a dental clinic. The removal of access to care in the Northeast Bronx and Central and North Brooklyn was deplorable.

- Carefully reviewing the move to consolidate selected specialty care services to one network per borough (called regionalization). Forcing patients to travel long distances outside of their community for services such as rehabilitation and orthopedics, do not make sense and are a hardship to patients.

- Supporting and endorsing evidence-based best practices that have been shown to improve health outcomes. For example, HHC has a long history of employing midwives and is perhaps the largest employer of midwives in the city. But there are variations in how midwives are engaged across the HHC system. Some facilities they are treated as an extra pair of hands, and in other facilities as primary maternity care providers.

- Reducing the very long waiting times for appointments in the HHC clinics and emergency rooms. The plan does not take into account that the

number of patients seeking treatment at HHC facilities is increasing while dollars and services are disappearing.

- Increasing the potential of off-site satellite clinics capacity. These centers are major positives for access to care and a way of attracting and keeping patients.

- Reviewing and developing safe staffing measures in all HHC facilities for nurses, doctors, and other health professionals.

- Improving and reducing any barriers associated with implementation of Health Information Technology to improve delivery of health services, patient health outcomes, and health status of underserved communities. The Road Ahead proposes that HHC contract in information technology services. However, it should not be the only tool or a substitute for the active engagement of consumers and patients and the involvement of health professionals.

3. Secure Resources by

- Working with HHC, the community, and the unions on the proposals that could be money-savers and should be adopted and tried before implementing the cuts, consolidations, and privatization. The proposals include really looking at where patients are referred for inpatient care. Under the title of "Patient Leakage" the Deloitte report details patients being referred out of the HHC system to voluntary hospitals for services such as inpatient surgery. Reducing this seepage could result in additional dollars remaining within the HHC system.

- Ensuring that HHC's plan to convert six Diagnostic and Treatment Centers (D&TC) into Federally Qualified Health Centers (FQHC) is realized. Key actions are required to ensure that Gotham Health's advisory boards are representative of the communities served. Designation would result in enhanced reimbursement from Medicare and Medicaid, as well as other benefits.

- Advocating for fair share of state hospital funding, including dollars to help provide care to the uninsured, go to the public system.

- Securing an increased share of city funding for HHC. For example there should be an increase in HHC's unrestricted operating subsidy, which is

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currently at $6 million. Resist additional cuts to HHC services during tough budget years.

4. Evaluate Resources by

- Undertaking a thorough review of the Road Ahead (HHCs strategic plan) to see what has been done, what has not been done, and what should be undone. We hope that the hearing is just one step in the process for city council to monitor and when needed ensure access and quality of health care are not compromised.

- Holding accountable all HHC Affiliates (Physician Group (PAGNY), NYU Hospital, and Mt Sinai Hospital) accountable. Transparency, leadership and functioning must be improved. Expanding the direct hire of physicians should be taken into account. As the budget of HHC was reduced in almost every area, it continued to climb for the affiliation contracts. CPHS for years, have raised the issue of NYU's use of Bellevue as a cover to demonstrate they are supposedly providing care to the poor and uninsured. There are very good NYU doctors that care about the patients regardless of who they are and where they are from. However, the reality is that the agreement has allowed NYU to have some of the worst patient friendly policies in the city, which discriminates against low-income and people of color.

- Reviewing the quality and patient and hospital staff engagement of current HHC programs and functioning. For Instance, It will be necessary to develop relationships with other providers and community-based organizations. It is also essential to develop a plan to recruit and ensure the availability of specialty providers to reduce the long waits for specialty services at many of the HHC facilities.

We believe the aforementioned actions will strengthen the public hospital system and ensure that vital health services and programs provided by HHC hospitals, and jobs are protected, expanded, and improved.

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Committee of Interns and Residents
SEIUHealthcare

Testimony Before the New York City Council Health Committee

Oversight: Examining the Status of "Restructuring HHC: The Road Ahead": What Progress Has Been Made and What Challenges Lie Ahead?

February 24, 2014

Good afternoon, Chairman Johnson and members of the Committee. My name is Dr. Samrina Kahlon. I'm an Emergency Medicine fellow at Metropolitan Hospital Center in Manhattan, and one of the Regional Vice Presidents for the Committee of Interns and Residents/SEIU Healthcare, the labor union representing over 2,000 resident physicians within the HHC system. We want to thank you very much for this opportunity to share our unique perspective as physicians-in-training at this moment of rapid, transformative change both for HHC and for healthcare as a whole.

The *Road Ahead* report clearly identified the fiscal challenges confronting the nation's largest public hospital system, and recognized that the only way to guarantee the social mission of providing exceptional healthcare to all patients regardless of the ability to pay is to start getting more control over costs—not just the costs of maintaining and operating such a sprawling system, but the cost of providing that care in the first place.

However, the proposed solution was imperfect. Much of the streamlining and consolidations were similar to cost control efforts we see from the corporate world: an overemphasis on cuts, and an under-emphasis on systems improvement; an approach that was top-down rather than collaborative; and a lot of energy spent on ramming through controversial one-time decisions like the privatization of services, and insufficient time spent getting to the heart of the problem.

It is no surprise, then, that even after so much of the *Road Ahead* has been implemented, the fiscal challenges facing HHC continue. Moving forward we need to innovate, not just amputate. Today, HHC has an opportunity to focus on quality improvement and patient safety to get at some of the fundamental questions of controlling costs long-term.

All of healthcare reform centers on the basic belief that the days of fee-for-service reimbursement without accountable metrics to demonstrate we're providing better care, our patients are healthier, and we're utilizing best practices are, in essence, over. This is the basic message of the "triple aim" espoused by health policy experts and economists, to the *Affordable Care Act,* to the reforms of the New York Medicaid Redesign Team. More and more, public healthcare programs like Medicare and Medicaid are adopting the principles of value-based purchasing, whereby reimbursement is determined not just on the number of procedures, but on clinical processes and patient satisfaction.

Even after the monumental reforms of the ACA and MRT, nearly every change to government payments for healthcare has been set up in such a way that quality metrics and patient population health must be taken into account when determining reimbursement. The recently-negotiated Medicaid Super Waiver for New York State ties much of its additional funding for the Medicaid program not to how providers and institutions are doing on quality metrics like reducing preventable hospital readmissions. The most recent example is the deal pending in Congress to eliminate the Medicare SGR formula and replace it with a system that ties physician fees under Medicare to quality metrics, including a bonus for those who are willing to use an alternative

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payment model like accountable care organizations, patient centered medical homes, or other patient-centered, pay-for-quality models for 25% or more of their services.

That is where all of healthcare is moving. The genie is out of the bottle. Since HHC's finances are overwhelmingly based on public healthcare programs including Medicare and Medicaid, our hospitals don't just need to focus on quality improvement, patient safety, and patient satisfaction to improve—they need to focus on them to survive.

When it comes to quality improvement, the two biggest determinants of success are 1) how much the health system truly puts the patient at the heart of its restructuring, and 2) how much sustained engagement it gets from its frontline providers, especially its physicians.

From years of experience, we know labor-management partnerships have been among the most successful models for improving quality and patient safety while lowering costs. Perhaps the best example of this is the body of work accomplished by the Labor-Management Partnership between Kaiser Permanente and the Coalition of Kaiser Permanente Unions. Since 1997, they've achieved measurable gains in quality and cost control, even without the immediate drivers of operating deficits or national and state healthcare reform. The chief lessons learned by their successful work has been that integrated care reduces costs, and that an empowered workforce can get to the heart of inefficiencies in the delivery of care, thereby reducing errors as well as cost—saving lives, and saving money.

My union, the Committee of Interns and Residents, has our own track record of labor-management partnerships with hospitals here in New York City to make meaningful changes in the same quality indicators that reimbursements will be tied to moving forward. Our labor-management quality improvement projects at Bronx-Lebanon, a voluntary but still safety-net hospital in the Bronx with a similar patient population to HHC, have been able to reduce length of stay by .75 days and improve patient satisfaction scores by 32%. At Maimonides, a safety-net hospital in Brooklyn, we have worked together to improve medication reconciliation to 100% in some departments. Finally, we have worked together to improve pneumonia and flu inpatient vaccinations to 100% at Kingsbrook Jewish Medical Center. None of these partnerships existed three years ago. All of them have yielded immediate, measurable improvements in precisely the areas that safety-net institutions need to improve in order to maximize their reimbursements. This isn't just better care, it's more cost-efficient care. In this model, the patient is front-and-center, not a side-effect of cost reduction focused on the bottom line.

We have begun to establish this level of partnership at HHC, though it is still just scratching the surface. Although the level of engagement between residents and management still lags behind other voluntary hospitals in New York City, we've made progress. This year, we conducted a Resident Safety and Quality Literacy Survey in order to evaluate the current training of residents in patient safety and quality improvement, identify best practices already present in the system, and suggest subsequent projects that will address training deficits and improve the care we provide to patients. Participating in this survey were 728 resident physicians, out of a total resident physician population of 2,000.

But an even more robust way to tackle costs through innovation, quality improvement, and patient safety at HHC is ready, and it's ready today. Our House Staff Patient Safety Councils have been operating at individual hospitals within the HHC system, and our newly formed HHC-wide Quality Improvement and Patient Safety Council is about just about to begin. We have formed these councils with the good will of the administration of HHC and out of a recognition that house staff have a unique understanding of the systems in which they practice, and are therefore also uniquely positioned to make high impact changes in the way we treat our patients to reduce errors and costs—to save lives and money.

I have seen the effectiveness of the House Staff Safety Council at my hospital, Metropolitan, in Manhattan. Specifically, we have been able to reduce the "dwell time," which is the time between when patients walk in the door and when they are either admitted or walk out the door. This metric has a major effect on patient satisfaction scores, and our ability to improve on this also reduced our "walk out" rate—the rate of patients who simply give up and are never treated—by over 30%.

In conclusion, what does our experience with quality improvement at HHC prompt us to recommend for for the road *after The Road Ahead*?

HHC has a golden opportunity to not just deal with its year-to-year operating deficits but also to put it on a long-term path to a culture of improvement and innovation:

- HHC should support and expand the work of the HHC-wide House Staff Quality Improvement and Patient Safety Council.
- As that body continues to make improvements to the health system, HHC should use it as a model for other labor-management partnerships to engage front line providers of care in quality improvement work.
- Fundamentally, HHC should realize the values of resident physicians and our union, like that of every other frontline provider of care, are aligned with the mission of the public's hospital system. Use us. Use our perspectives and our expertise.

Our common goal is to provide the best, highest-quality care for patients. We want HHC to succeed. And we want to be part of the solution. We know the administration of HHC understands this intellectually, but they haven't always followed through. They should.

Being able to transform complex public healthcare systems like HHC to hit the triple aim of better care, better health, and lower costs is important not just to make sure HHC can close its budget gap year to year, but to prove that it's possible on a large scale for precisely those patients who have been persistently underserved by our American healthcare system in the past. These partnerships and the work of building this culture of quality improvement and healthcare innovation are good not just for HHC, but for patients everywhere.

Thank you.

For more information or to follow-up with Dr. Kahlon, please contact Tim Foley, CIR's Political Director, at tfoley@cirseiu.org or 212-356-8100.

February 24, 2014

Testimony of Doctors Council SEIU
Presented by Frank Proscia, M.D, President
Before the City Council Health Committee
Oversight- Examining the Status of "Restructuring HHC: The Road Ahead": What Progress has Been Made and What Challenges Lie Ahead

Good afternoon Chairman Johnson and members of the Health Committee. I would like to thank each of you for convening this hearing on HHC, our public hospital system for New York City.

My name is Frank Proscia, M.D., and I am the President of Doctors Council SEIU. Our union represents doctors in the metropolitan area and in states throughout the country. This includes the attending physicians and dentists in HHC hospitals and facilities.

In 2013, our doctors at HHC facilities served more than 1.5 million patients, approximately 40% of whom were uninsured.

We are a united voice for doctors, our patients and the communities we serve. We take seriously our role as patient advocates. One of our key goals has been and continues to be advocating and engaging with HHC to increase doctors', other health care workers' and patients' and communities' input, increasing timely access to patient care services and improving health care outcomes and patient satisfaction.

To truly get HHC to be a provider of choice and not last resort we must work together to not just survive but to thrive in the years ahead. There can no longer be business as usual.

With all the changes occurring in healthcare, including the implementation of the Affordable Care Act, HHC becoming an Accountable Care Organization (ACO) and transforming into a Patient Centered Medical Home (PCMH), the HHC Diagnostic & Treatment Centers becoming a Federally Qualified Health Center (FQHC), the use of electronic medical records and changes in how health systems are reimbursed, now more than ever we must all work together.

As doctors, we view things through the prism of health care and the impact on our patients. Our doctors work in HHC because they are dedicated to public health care through the professions of medicine and dentistry. Doctors are the frontline clinicians in our communities who actually treat and take care of our patients and need to be equal partners with hospital administration and management.

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That is why we are doing a number of exciting initiatives on Quality Improvement work. We are partnering with Cornell University. First, we are working on a white paper that underscores quality improvement and empowering frontline doctors. It is a call to action for HHC to meaningfully and substantively engage physicians in addressing quality improvement. Second, we are doing two surveys- the first of our leaders and the second of all our HHC members, on quality and system improvement activities in the HHC system.

Third, we are doing three pilot projects that will require doctor input and involvement in areas to benefit patient care and improve quality and patient satisfaction. These projects may examine areas such as:

- Cycle time in the Emergency Department (ED) at Harlem Hospital in terms of reducing the amount of time for a patient to be treated and discharged in the Emergency Department or to be admitted to a floor if medically needed;

- Census/volume of patients at Gouverneur D&TC in terms of how we can attract more patients and why we may be losing some; and

- Waiting times to see a Primary Care Physician, and get a follow up appointment and test results in the Medicine out-patient department at Jacobi Medical Center.

In the near future, the members of the Council, the Mayor, Public Advocate, other elected officials and the new President of HHC will receive a copy of our white paper- which offers a transformative view of patient care in the HHC system.

There is a new Mayor and many new elected members of the City Council. There will be a new President of HHC, with whom we have worked with in New York and in Cook County, Chicago as we also represent the doctors in the Chicago public health and hospital system. This can be the dawn of a new day for our public healthcare hospitals and facilities here in New York City.

We call on HHC to have a partnership with the doctors to be involved in quality improvement. And, as doctors, we know that means not only listening to and empowering the frontline clinicians who take care of our patients, but also involving the patients from the communities we serve and the other health care workers as part of the patient care delivery team.

We are cautiously optimistic that things will begin to change and doctors become appropriately valued for our commitment and expertise in public healthcare in our communities.

Doctors Council SEIU stands prepared to be HHC's partner in this effort.

We are stronger together.

I would also like to add that Doctors Council SEIU stands united with our community and union allies in calling for the re-opening of labor and delivery services at North Central Bronx Hospital. The community needs these services. After extensive advocacy from our union and the coalition, HHC committed to reopen this by April 30th. Now the State DOH will decertify those beds absent a plan and action by HHC. This is unacceptable. We are working with our partners in the Council to call on HHC to reopen by April 30th. The patients, the women and the community served deserve no less.

Thank you for your time today and I'd be happy to answer any questions.

About Doctors Council SEIU

Doctors Council SEIU, a professional organization for doctors, is the oldest and largest union of attending physicians and dentists in the United States, with members in New York City, and in states across the country. Formed in 1973, Doctors Council SEIU is a national union for doctors and a voice for patients, and represents attending physicians and dentists at Health and Hospitals Corporation (HHC) facilities and hospitals, including doctors employed by the affiliates New York University School of Medicine, the Mount Sinai School of Medicine and the Physician Affiliate Group of New York (PAGNY). HHC is the largest public hospital system in the nation. Doctors Council SEIU also represents doctors in the New York City Mayoral agencies including the Department of Health and Mental Hygiene (DOHMH) as well as doctors working at Rikers Island, the largest correctional facility in the nation. Affiliated with SEIU, Doctors Council SEIU is a national union representing doctors employed in the public and private sectors.

Testimony-New York City Council Public Hearing
NY City Council Health Committee
Oversight - Examining the Status of "Restructuring HHC: The Road Ahead"
February 28, 20014
By Ralph Palladino, 2nd Vice President DC 37 Local 1549- Clerical-Administrative Employees

Local 1549 represents approximately 16,000 employees of the City of New York. We represent 5000 employees in the NY City Health and Hospitals Corporation (HHC) including Metro Plus HMO. Our jobs in HHC include Financial Counseling, Patient Registration, Billing, Patient Appointments, Communications, Interpreter services, Information, Admitting, and signing up the uninsured for Health Insurance among other things. I also choose to be a patient at Bellevue Hospital and worked at HHC for almost 35 years.

My experiences stem from my use of primary care, specialties, inpatient and emergency room. There are no better group of health care professionals and support staff anywhere.

HHC is the leading public health system in the country. It is the most cost effective system and yet still provides high quality. Unfortunately the federal, state and city governments have not seen fit to adequately fund HHC or public health in general. This includes hospitals like Bellevue, Elmhurst and Queens Hospital that received no additional aide despite having to increase patient load by up to 20% after other local private hospitals closed. Nor is receiving additional assistance for the increased patient load that will occur thanks the federal reform.

"The Road Ahead" developed five years ago was a blue print for downsizing health services, introduction of new technology and privatizing including excessive contracting out. **This plan was developed with no input from unionized employees, the Community Advisory Boards, Area Policy Community Boards and with no community needs assessment being performed. In short, it was not about healthcare. It was about finances.**

Under the plan HHC increased the use of private contractors providing various service duties including clerical. Currently we estimate anywhere from 7 to 10% of the clerical civil service lines are being filled by private employees. There is no quality or absentee control over these positions nor employee training requirements. Our members are required to take a civil service test and are vetted and our union contract mandates training. These private employees are paid very low wages with no benefits. Some we know are on Medicaid. This means the lions' share of the public dollars awarded for these contracts go to the owners of these agencies.

As a patient I can give you a first-hand account of the problems and errors that occur with over use of private temps and understaffing. This includes wrong appointments, long waits for phone answering, being transferred to wrong phone numbers, etc.

The new technology used in Ambulatory Care at Bellevue is more difficult and cumbersome to use by the employees. It also forces patients to constantly call the Call Center and clinics for appointments in order to get the date they need. Under the old system they could be made up to six months in advance while the new system allows only ninety days.

The staffing shortages have forced HHC to consolidate some clinic services such as inoculations, phlebotomy etc. This means that instead of the more patient friendly one shop shopping of services patients must go elsewhere in the institution and at time have to re-register. There is a big problem when one employee must be at a clinic desk registering patients, making appointments and answering phones with dozens of patients are sitting in the area waiting for service.

On the reverse side I offer some ideas on rectifying these problems. The main idea concerning healthcare is to enhance patient care quality and services.

Recommended

- HHC is the most cost effective vehicle for the delivery of quality health care despite the problems. HHC needs to be the main and central component in the expansion of health services in the city. Community Health Clinics should be opened in areas in need and affiliated with public hospitals in the vicinity.
- Given that HHC provides services to the largest number of uninsured and Medicaid patients in the city it should receive a large share of federal health care waver funding just awarded to the state. The funding should be equivalent to the percentage of needy patients that come to HHC.
- Review HHC's private contracting. There is no oversight of HHC's contracting by the public or the city council. HHC primarily receives public funding. How can this be allowed to continue? What funding sources does HHC use in awarding these contracts?
- ADD TRAINED, QUALITY STAFF IN ORDER TO TAKE CARE OF THE ADDITIONAL WORK LOAD AND MEET THE DEMANDS OF HEALTH CARE REFORM.
- Finally, be all inclusive and more democratic in the health care planning process.

Thank you for holding these hearings which were long over due. We will be glad to meet with for more discussion.

The New York Times | http://nyti.ms/1dk0E3k

MIRANDA RICHARDSON

N.Y. / REGION

Hospitals' Dialysis Plan Is Under New Scrutiny

By NINA BERNSTEIN FEB. 12, 2014

For 400,000 people across the country with failed kidneys, dialysis care is a matter of life and death. It is also a lucrative business, in part because Medicare pays for such treatment regardless of age.

But as for-profit clinics and chains have grown to control about 85 percent of the dialysis market over the last decade, researchers have documented starkly higher mortality rates in centers owned by for-profits compared with nonprofits.

Now the New York State Public Health and Health Planning Council is set to vote Thursday on a deal to turn over dialysis at four of New York City's public hospitals to a for-profit franchise called Big Apple Dialysis despite government data showing the company's centers did not perform as well as the hospitals themselves.

The deal was approved more than a year ago by the city's Health and Hospital Corporation, the public hospital agency, which says the terms of the contract ensure that quality will remain high, and that shifting dialysis patients to Big Apple, part of a company called Atlantic Dialysis, will save the financially troubled hospital system $150 million over the next nine years. Atlantic, based in Queens, has agreed to pay the city $1.6 million in annual rent and $1.1 million to buy equipment at the 57 dialysis stations that now treat about 1,000 patients at the four city hospitals — Harlem Hospital, Kings County Hospital, Lincoln Hospital Center and Metropolitan Hospital.

But the contract, which hinges on the planning council approving the company for a "certificate of need," is now under new critical scrutiny. The New York State Nurses Association and patient advocates are pointing to government data on death rates, adjusted by Medicare for patient mix and severity of illness, that show Atlantic's operations performed 3 percent worse than the national norm between 2009 and 2012, while the four hospitals, over all, performed 17 percent better than average.

"We believe that selling patients into the commercial dialysis market is in direct conflict with H.H.C.'s public service mission and governing statute," Carl Ginsburg, a spokesman for the nurse's union, told the planning council committee that considered the matter on Jan. 30. He urged that the committee give the new city administration a chance to review it.

Late on Wednesday, that request was echoed in a letter emailed to the planning council by the City Council speaker, Melissa Mark-Viverito, the chairman of the Council Health Committee and members representing the affected districts.

Both sides agree that part of the expected savings for the hospitals, and for the 20 percent profit margin that the company projects on annual revenue of $15 million, is based on replacing nurses with lower-paid technicians, and increasing the patient capacity of each dialysis unit. Such measures are out of the public hospitals' reach, officials say, for lack of capital to add about 60 dialysis stations and because they must pay higher fringe benefits.

In an interview on Tuesday, Alan Aviles, the departing president of the Health and Hospitals Corporation, said that there were legitimate concerns about the impact of profit-making models, but he strongly defended the quality of this deal, part of a comprehensive cost-cutting plan adopted by the public hospitals corporation in 2012 to address a $1 billion budget gap.

Mr. Aviles said that Atlantic Dialysis, owned and run by two doctors who previously worked at city hospitals, had a superior track record where

it counted: running both acute and chronic dialysis at Elmhurst Hospital since 2006, under the same model called for in the larger contract.

The contract requires oversight and quality assurance by the city hospitals' own doctors, Mr. Aviles emphasized; it includes a guarantee that unauthorized immigrants will have access to treatment, and it prohibits the company from transferring the business without consent. There will be no layoffs, because nurses will be transferred to other positions.

"Yes, it is unusual for a public system to contemplate doing this kind of thing," he said. "But we did it because we had an operator with a track record."

Although over all Atlantic had a higher adjusted death rate than the four city hospitals, Medicare data show the company's center at Elmhurst hospital had a mortality rate that was 23 percent lower than average — outperforming two of the four city hospitals, and all the company's other centers.

But opponents point out that Medicare-calculated death rates at five of those nine private centers, including Central Brooklyn Dialysis, New York Renal Associates in the Bronx and Ridgewood Dialysis Center in Queens, were much higher over four years than at the city hospitals nearby, and as much as 30 percent above the state and national average.

"The fact is, these people are in it for the money," said Agnes Abraham, chairwoman of the public hospitals' council of community advisory boards, who opposes the deal and wants it scrutinized by Mr. Aviles's successor, Dr. Ramanathan Raju. "Big Apple does not have the same moral obligation to the people of New York City as the Health and Hospitals Corporation."

Joseph Sala, a vice president at Atlantic Dialysis, said the most recent data showed that its centers met or exceeded national and state norms. "Our mortality across the board has improved; it continues to improve," Mr. Sala said, adding that as a local, physician-owned company it is different from the publicly traded chains that have fueled opposition to for-profit dialysis.

The nurses' union contends that for-profit dialysis results in documented patterns of reduced staffing, less patient education, lower quality needles and tubing, and a history of profitable anemia drugs used at levels that hurt patients — all factors linked to a shorter life expectancy for dialysis patients in the United States.

Dr. Jodumutt Ganesh Bhat, co-owner and medical director of Atlantic and Big Apple, and the company's lawyer, Howard Fensterman, are both members of the planning council committee that was considering the matter last month, but they left the room, declaring a conflict of interest. Of the remaining 10 members, six abstained from a vote to ratify the State Health Department recommendation. Instead, they asked for more data and deferred the vote to a special meeting at 9:45 a.m. on Thursday, just before it goes to the full council.

A version of this article appears in print on February 13, 2014, on page A21 of the New York edition with the headline: Hospitals' Dialysis Plan Is Under New Scrutiny.

New York State NURSES ASSOCIATION® One strong, united voice for nurses and patients

City Council Committee on Health Oversight Hearing

Examining the Status of "Restructuring HHC: The Road Ahead": What Progress has been made and what challenges lie ahead

February 24, 2014
Corey Johnson, Chair

Good afternoon.

My name is Anne Bove and I am a registered nurse and member of the New York State Nurses Association. I have worked at Bellevue Hospital Center for more than 25 years and am president of my union's HHC executive council.

We are pleased to see the large numbers of New Yorkers signing up for insurance for care at HHC, including many young people. But no matter the income, no matter the legal status, *no matter*, we provide care to New York. During floods and snowstorms, our doors are open. What a great tradition.

We have a new mayoral administration that will emphasize the issue of income disparity – the Tale of Two Cities. The way to bring the Tale of Two Cities to an end is first and foremost to provide quality healthcare to all New Yorkers. And the HHC system does that; we are the example of equality that needs to define all of New York.

Privatization undercuts that quality. At the very time we are told that access to care should be growing, threats to quality are growing too.

The example I have for you today on how privatization is the wrong prescription comes in the realm of kidney dialysis.

We are submitting with my testimony copies of a report prepared for a Department of Health hearing on the privatization of dialysis which details some of which I am now going to relate.

HHC wants to sell its dialysis clinics -- the equipment, supplies, drugs, and care services for End Stage Renal Disease patients, those who have lost kidney function -- to a for-profit entity known as Big Apple Dialysis.

This for-profit will use the clinic space inside four HHC hospitals under terms of a service agreement to treat HHC patients and others. This is part of the Road Ahead plan, with projected dialysis savings of $2 million a month.

The same people who own Big Apple own Atlantic Dialysis Management Services. They own or manage 12 dialysis clinics in the greater New York City area.

In their application to the DOH, Big Apple was asked to describe its "experience or track record" in providing patient care at other facilities.

What a good question: what quality Big Apple has provided to its patients.

But, there is no information given by Big Apple to the question of the quality of care it provides.

On question after question posed in the DOH application, Big Apple answers "AS THIS IS FOR A CHANGE IN OWNERSHIP OF AN **EXISTING** END STAGE RENAL DISEASE CENTER, THIS SECTION IS NOT APPLICABLE. You can see this on pages 22-24 of our submission to the DOH.

The track record of Big Apple Dialysis in providing care to similar populations is most definitely relevant. The question is why didn't Big Apple provide answers to these questions?

One reason is this: the adjusted death rate of patients at the Big Apple associated clinics was 24% higher than at the 4 HHC facilities that are being sold. That's for a period covering four years, 2009-2012, the most recent data from the federal government.

To put is simply: Big Apple patients live less than HHC patients.

At five of Big Apple's clinics death rates -- actually termed standardized mortality ratios -- rates are significantly higher than the expected norm or average.

Why would we consider selling these patients to a for-profit provider with that kind of record? The New York Times report that is attached with my testimony cited this fact. You may have read that.

In contrast HHC has a fine record of care provided to dialysis patients at its four facilities-- which are Harlem, Metropolitan, Lincoln and Kings County. We, at NYSNA, are proud of that record. Our dialysis nurses are highly skilled and very committed.

There are also a lot more of them on duty to care for patients than Big Apple will be providing. They are going to cut nurse staffing by more than half if they take over.

Ask the patients how they feel about having a dedicated nurse with time to care for them. Ask them.

But I guess that $2 million a month is $2 million a month.

And, it should be noted, the owners of Big Apple make 20% annual return on their investment; they make millions. Win. Win.

The bad news, of course, is for the patients at the rest of the Big Apple affiliated system, and the patients of HHC who are likely to see worse care and fewer nurses.

This is shown by our analysis of the quality data and the staffing plans of Big Apple and is corroborated by reports we have received from healthcare professionals and a patient inside the Big Apple Dialysis system.

Other problems that have been brought to our attention include high rates of infections at catheterization points, cherry picking patients with good insurance, an internal investigation of system infections at one of their Bronx facilities, failure to report patient care problems to MDs, reports of poor medical judgment and other similar issues.

Those who conveyed these reports to NYSNA are not here today because they have been intimidated, disciplined or are simply afraid.

Why DOH, or HHC or any entity of our government would allow this is very disturbing. After all, aren't we talking about ending healthcare disparities?

We are not against savings, not at all; we just believe that savings should not come through the shortened lives of dialysis patients.

So, that's the end of my story on privatization-- a chapter in the Tale of Two Cities. What I know for certain is that the process by which privatization's been carried out in this part of HHC is a sham... and a shame.

New York City can do much better. We urge you to bring this dialysis privatization effort to a halt or at least to investigate these issues further.

Thank you.

Outline Labor Program for HHC

Approved 12/18/13 by HHC MLC Unions

1. **Recognition of the role of HHC in providing healthcare to the People of New York City**
   - HHC is the largest hospital network in the City of New York and provides a disproportionate share of health care for the uninsured, the underinsured and other medically underserved populations.
   - HHC is the only hospital network that provides full healthcare services to any person who seeks assistance, regardless of insurance coverage and ability to pay. Unlike private hospitals that provide some "charity care", HHC provides full access to all.
   - The general quality of care provided by HHC is equal to or superior to that offered by private sector hospitals, as evidenced, for example, by recent CMS reports regarding quality measures, and by the range of specialized and general services provided at the various HHC hospitals.

2. **HHC and the City of New York must take the lead in addressing the healthcare needs of New York City**
   - The healthcare system is in the throes of an ongoing crisis (nationally, in NY state, and locally).
   - Hospitals are being closed, services are being reduced and there is a concerted effort to "right size" the hospital system and to reduce acute care capacity in favor of ambulatory care.
   - Hospitals are increasingly starved of necessary resources as government support and reimbursement rates continue to be slashed.
   - The current restructuring of the healthcare delivery system has exacerbated the ongoing financial crisis faced by many hospitals in the City, including the HHC system, as resources are diverted to for-profit private providers who engage in abusive or predatory market practices that further weaken the financial viability of vital hospitals in many areas of the city.
   - Large swathes of New York City are virtual healthcare deserts, and these communities experience widespread unmet healthcare needs.
   - The state of New York and the City under Mayor Bloomberg failed to take action to address the issue of unmet healthcare needs in a systematic way, relying instead upon the "free market" to provide solutions to the crisis.
   - The HHC system, as the largest integrated healthcare network in the City, with a statutory mission of providing care to all on the basis of need, is uniquely positioned to play the lead role in a concerted, planned effort to address the healthcare needs of the people of New York.
   - The incoming mayor has pledged to address this crisis, to resist any efforts to downsize or reduce the scope of services provided by HHC, and has indicated a

firm commitment to resolve the crisis in healthcare in a manner that benefits the needs of the vast majority of working people.

- The City of New York and HHC should spearhead an effort to conduct detailed health needs assessment in every community, and to implement a plan to expand healthcare delivery capacity to address identified needs, with HHC playing a leading role.

3. **Existing HHC services must be maintained and expanded to address unmet healthcare needs**
   - The level of services currently provided by HHC play an indispensable and vital role in protecting the health of the people of New York as a whole.
   - The current level of services must be maintained and there can be no further cuts or reductions in the scale and scope of medical services provided by HHC.
   - As part of a strategic plan to address unmet health needs and provide universal access to care throughout the city, HHC services should be expanded and enhanced.

4. **Recognize that the HHC public system is the most efficient and cost effective provider of healthcare**
   - Despite consistent efforts by proponents of the "free market" and "private enterprise" ideology to paint the public hospital system as unreasonably expensive and inefficient, the facts clearly show that it is the prevalence of market based, for-profit and corporate providers and insurers that is the underlying cause of the current crisis.
   - Large segments of the healthcare industry are dominated by private, for-profit corporations and partnerships that are primarily motivated by the desire to generate income and profit. This tendency is also apparent in the segments of the industry that are technically not-for-profit (hospitals, FQHCs, primary care clinics, etc.), where public policy and market oriented reimbursement and competitive structures create pressures for non-profit providers to emulate the practices of for-profit competitors.
   - The prevalence of profit-oriented providers and market mechanisms diverts resources from areas with high needs and low incomes to market segments with high incomes and relatively low levels of need for additional services.
   - Private providers of health care, both for-profit and non-profit, compete with each other for market share and for the most lucrative patient population segments, with a resulting proliferation of wasteful and redundant oversaturation of services and resources in some areas, and a concomitant dearth of services in others.
   - Private providers seeking high revenue streams and profits siphon off the most lucrative patients (with the best insurance or with the most profitable types of conditions/treatments) from safety-net and vital access providers (including HHC), leaving these systems to treat the uninsured and a disproportionate share of Medicaid and Medicare patients.
   - These predatory competitive practices leave the safety-net and vital access providers with escalating losses as they lose the ability to offset the treatment of

underinsured or uninsured patients with the revenues from the patients that have been siphoned away.

- Contrary to the assertions of the free-market proponents, HHC and other safety-net hospitals do not suffer operating losses because they are inefficient or mismanaged.
- HHC is actually more efficient at delivering services at a lower per patient cost than any private hospital operator.
- HHC offers prices that are lower than those charged by most private hospitals.
- HHC loses money because it treats patients whose insurance or ability to pay is insufficient to cover the cost of care.
- This reimbursement structure is set up this way by design – in fact, it is the existence of this structure that imposes operating losses on HHC and which simultaneously guarantees that private hospitals can operate at a profit.
- The City of New York must take the lead in changing this structure and insuring that HHC and other safety-net providers share in the revenue streams of the private hospitals that do not provide their fair share of the burden of meeting the healthcare needs of New Yorkers.

5. **Maintain and improve the quality of patient care at HHC facilities**
   - As previously noted, HHC provides patient care that is generally equal to or superior to that in the private sector.
   - The ongoing starvation of funding for HHC threatens to lead to deterioration in the quality of care.
   - The City of New York must provide sufficient support to allow HHC to maintain and improve the quality of care provided.

6. **Establish Hospital Cooperatives to coordinate hospital and health services on a city-wide basis.**
   - The ongoing crisis in the provision of care and the maintenance of vital hospital resources requires a coordinated and planned response that is systematically implemented at the local and city-wide levels.
   - The current competitive, market based system in which hospitals compete for revenue and profits, has demonstrably failed.
   - Various proposals to create hospital co-operatives, consortiums or other coordinating structures have been proposed.
   - The mayor-elect has also issued a proposal to create a consortium of hospitals in Brooklyn to address the crisis in that borough.
   - The new Mayor and HHC should take the lead in creating co-operative hospital organizations to engage in systematic and comprehensive local health needs assessments, pool their resources and efforts to address those needs in a co-operative manner, and to stop the wasteful and counterproductive competitive activity that undermines our ability to address needs in a comprehensive and efficient manner.

7. **Establish democratic local planning bodies to assess community health needs and develop plans to meet needs and allocate health care resources accordingly.**
    - Under our current healthcare system, decisions about the distribution and allocation of healthcare funding and resources are made in corporate boardrooms and the offices of state bureaucrats.
    - Market forces seek to maximize revenues and profits rather than to actually address health needs of the broader community.
    - Patients and communities are treated as profit centers and source of revenue.
    - The decision making process can no longer remain the exclusive prerogative of corporate executive and bureaucrats.
    - The City of New York and HHC should take the lead in the establishment and creation of democratic, local health planning bodies that will have a direct say in the identification of local health care needs and the implementation of plans to address these needs.
    - The local planning bodies will have direct power in determining the manner in which existing resources are distributed and allocated, and will have a say in decisions about the extent of future needs for resources.

8. **Provide adequate funding and reimbursement rates for HHC and other safety-net hospitals to fully compensate for the costs of treating Medicaid, Medicare and uninsured patients**
    - As previously noted, the reimbursement rates for Medicaid and Medicare patient are less than the cost of their treatment.
    - Conversely, the reimbursement rates under most private insurance plans are higher than the cost of treatment.
    - The distribution of revenues provided by this model creates pressure to gain market share among insured patients and provides no incentive to provide care for underinsure or uninsured populations.
    - Even among privately insured patients, there are wide variations in reimbursement rates, as stronger players are able to exert more leverage in negotiating rates with insurers than small or weaker hospitals.
    - The City of New York must make a concerted effort to change this dynamic and should seek to implement policy changes that will create uniform distribution of reimbursement rates to allow all hospitals to devote themselves to improving the level of care and access to care on an even playing field.

9. **Expand the network of public hospitals and other services to accommodate identified community needs**
    - Based on the needs of local communities, HHC should take the lead in expanding services, at both the in-patient and out-patient level, as needed.
    - The City of New York should support HHC as the most efficient and capable provider of necessary expansions of service to address unmet community needs.

10. **Implement minimum patient care staffing ratios in all HHC health facilities (for nurses, doctors, LPNs, aides, and other patient care staff) and expand to include private sector facilities**
    - There is a direct correlation of the quality of care and the level of staffing provided for patient care
    - HHC should take the lead in promoting mandatory, statutory minimum staffing levels in all healthcare settings
    - The example set by HHC should be emulated by enacting local legislation to impose staffing standards on all local healthcare providers.

11. **Reverse the privatization of services**
    - The policy of privatization of services pursued by the prior mayoral administration is premised on a bankrupt ideological perspective that is no longer viable and should be repudiated.
    - As noted above, HHC provides direct care and other services at a more cost effective level than private, for-profit entities.
    - Public services are not oriented toward maximization of profits and thus focus on quality of care.
    - The apparent "cost efficiency" of privatized services is realized through the reduction of staffing levels and amount of care time devoted to patients.
    - The premises of privatization are false: privatized services are not cheaper, and do not lead to better quality of services -- privatization just serves to line the pockets of corporate vendors.
    - Privatization encourages fraud, waste and deterioration in services by vendors seeking to maximize profits.
    - HHC and the City should reverse the policy of the prior administration.
    - There should be no further privatization and previously privatized services should be restored to the public sphere.

12. **Create a more democratic and representative corporate structure, and include more patients, advocates and direct care staff on the HHC Board.**
    - Governing structures within HHC, at the corporate-wide, network and facility levels should focus on the quality of patient care and expanding accessibility.
    - Decision-making processes should be democratized and RNs and other caregivers within HHC given direct power over the design and organization of patient care programs.
    - The HHC Board of Directors should be made more representative of community interests through the selection of members representing caregivers, community healthcare advocacy groups, and local populations.
    - The HHC Board of Directors should include at least one member selected by the HHC municipal labor unions to ensure a more democratic composition and to provide direct insight regarding patient care and operational needs of the HHC system.

13. **Expand the role, powers and function of community advisory boards so as to make them more effective watchdogs of the functioning of local facilities.**
    - In conjunction with the democratization of the HHC Board of Directors and other governance functions, the local HHC community advisory boards should be structured to take on a more rigorous oversight role as advocates and defenders of the quality of care, increased access to care, and the distribution and allocation of resources in the communities served by facilities.
    - CAB structures should be expanded to include broad representation of direct caregivers and support staff, local community members and patient populations.
    - CABs should be given greater authority to approve and direct the priorities and operations of their local facilities.
    - CABs should have the power to investigate the operations of local facilities and to compel cooperation and the production of necessary information to properly conduct oversight of local facilities.
    - CABs should have the ability to hire staff to conduct local community health needs assessments and to prepare plans to meet needs to be implemented jointly with local facilities.

14. **Remove unnecessary layers of managerial bureaucracy and other overhead costs, allowing resources to be directed to patient care**
    - Resources should be focused entirely on patient care and meeting community healthcare needs by reducing managerial and other non-care related overhead costs.
    - Frontline caregivers should be given a direct role in the design and implementation of patient care programs and patient care operations and determining staffing ratios consistent with professional practice standards and the needs of local communities.
    - Frontline caregivers should have control over the design and implementation of all patient care procedures and protocols in both in-patient acute and out-patient care settings, allowing them to maximize the effectiveness of patient care, reduce bureaucratic waste, and to provide care consistent with their professional judgment, applicable scope of practice standards and the needs of patients.
    - Workers engaged in patient care support functions should have direct input and control over the design and implementation of support services, staffing for such services and the implementation of procedures and protocols for providing such services in an effective manner.

Testimony For New York City Council Health Committee Oversight Hearing on Examining the Status of the Restructuring of the Health and Hospitals Corporation: The Road Ahead: What Progress Has Been Made and What Challenges Lie Ahead on Monday, February 24, 2014, City Hall, Committee Room 1:00 pm

Thank you Honorable Council Member Corey Johnson and Members of the City Council Committee on Health for convening this important Oversight Hearing on Examining the Status of the Restructuring of the Health and Hospitals Corporation: The Road Ahead: What Progress Has Been Made and What Challenges Lie Ahead.

My name is Barbara Edmonds and I am the Field Operations Director for District Council 37 AFSCME. I am representing Lillian Roberts, Executive Director of District Council 37, AFSCME. District Council 37 represents 120,000 municipal employees and 50,000 retirees. I am also the facilitator for the Health and Hospitals Corporation Municipal Labor Subcommittee (HHC MLC Subcommittee), which consists of a coalition of leaders of the labor unions in HHC representing over 27,000 employees serving in administrative, ancillary, blue collar and trades, and direct patient care civil service titles who meet with senior officials from HHC on various labor management issues impacting HHC employees on a regular basis.

This afternoon I speak on behalf of the 18,000 members of District Council 37 (DC 37) employed by the New York City Health and Hospitals Corporation (HHC). Our members live and work in the communities where our City's public hospitals are located. Our members serve each patient who comes through the doors of HHC, regardless of ability to pay, with compassion, dedication and professionalism. They are the Nurses Aides, Dietary and Housekeeping Aides, Clerical Associates, Respiratory Therapists, Social Workers, Computer Aides and Laborers on the front line every day of the year. Whether it is a disaster, a snowstorm or a regular day, our members are working hard to care for all in need of health care. Our members also use the quality centers of excellence at HHC's nationally recognized eleven (11) acute care hospitals, four (4) skilled nursing facilities, six (6) federally qualified health centers, 32 primary care clinics in the community, Health Home Care division and the MetroPlus Health Plan, Inc.. We serve over 1.3 million patients a year.

Overview

In May of 2010, HHC released its Four Year Cost Containment and Restructuring Plan to address a growing budget deficit due to reductions in funding at all levels of government, particularly in the area of Disproportionate Share Hospital (DSH) funding that is vital to covering the ever increasing indigent care costs. HHC retained the services of Deloitte Consulting (Deloitte) to develop a series of clinical and operational strategic approaches that would meet the savings and revenue targets through cost-containment and revenue generating actions.

HHC senior leadership formed various work groups in September of 2009, and established a Restructuring Steering Committee, to which none of the HHC MLC Local Unions, nor HHC Community Advisory Board Members, nor community and patient advocates were invited to participate. There was little input limited to pro forma meetings between HHC with the abovementioned key stakeholders regarding their recommendations on HHC's strategic direction.

While HHC did not implement some of the most drastic recommendations issued by Deloitte, including, but not limited to, elimination of most of the outpatient specialty services and consolidation of these services into one acute care facility, and elimination of nearly all HHC long term beds, it is DC 37's contention that HHC's restructuring plan took a slash-and burn approach to choosing changes to guarantee the fiscal soundness of New York City's public health-care system.

HHC reported that in FY 2011 nearly three-quarters of HHC's funding is from Medicaid-$4.42 billion and another 15 % of HHC's funding comes from Medicare. In FY 2010 HHC had nearly 30,000 employees. According to the September 17, 2013, HHC Finance Committee report, since 2009, HHC has cut staff by **3,737** positions through a hiring freeze, attrition and layoffs. In President Alan Aviles' testimony before the City Council in May of 2013, he indicated HHC had reached target attrition and headcount reduction a year ahead of schedule. The bulk of these cuts came from our membership – 1,331 Housekeeping and Environmental Services, 930 Clerical, 799 Aides and Orderlies, 433 Techs, 22 Managers, and 47 physicians. Cash Savings due to the Road Ahead initiatives as of December 2013 are $70.8 million, but $43 million of this is actually from a prior Dietary initiative which I will speak more about in a few minutes.

These projected savings, aggressive staff reductions to meet targets and alleged standardization of work, consolidation and elimination of critical services, out-sourcing of vital direct and indirect patient care, have been a high price to pay for the patients, the underserved communities, and the dedicated civil servants who provide the care. In an electronic communication forwarded to all HHC employees last November 8th, by Alan Aviles, President and Chief Executive Office of HHC, President Aviles acknowledged the poor results of Press Ganey Employee Satisfaction Surveys Surveys and the need by senior leadership of HHC to seriously address the issues raised in the survey, which details employees' complaints regarding low morale, lack of communication at all levels of the HHC, inadequate staff and manning and the need to acknowledge hard work and commitment of the staff.

In the brief time that I have, I would like to put a face on the statistics and survey results in my testimony to detail how we can change the Road Ahead or to a Positive Future For HHC, the Patients, the Community and the Workers.

Outsourcing of Environmental Services Management

HHC contracted with Crothall Services, Inc., a large national for-profit firm engaged in supply chain purchasing and the management of the Housekeeping and Environmental

Services. The contract is worth $192 million over nine years, with a projected savings of $20 million per year. The savings are allegedly coming from work standardization and efficiencies.

Common issues that have impacted many of the facilities due to the out-sourcing of management since Crothall took over these services include:

- Over zealous managers who are not well trained as supervisors with poor communication skills, who rely heavily on harsh discipline rather than progressive disciplinary practices due to unfamiliarity with union contracts that create hostile work environment.
- Over reliance on agency personnel to address shortages of staff in Housekeeping Aide, Service Aide, Clerical Associate, Respiratory Therapist and other critical titles and increased hiring of part-timers who receive less benefits than full-time employees.
- Shortages in supplies and equipment as a result of a just in time policy of ordering equipment as needed and not having it available when needed by personnel (i.e., bags, chemicals and others supplies), and frequent breakdown in equipment.
- Cheaper but less durable equipment such as masks and defibrillator pads are ordered that end up costing more as they do not even last long enough for one use.
- Lack of adequate proper protective equipment for the Grounds Crew.

Outsourcing Laundry and Linen

Contracting-out of laundry and linen services was implemented by HHC in 2012, at a projected savings of $6.1 million through the closure of Brooklyn Central Laundry and the farming out of these services to Sodexho and its partner, Unitex Laundry. Although no layoffs took place in 2012, there was a net loss of eighty-seven (87) entry level positions in good jobs with benefits. According to HHC in the minutes of the December 10, 2013, Strategic Planning Committee Meeting, one-hundred-fifty-six (156) workers were redeployed by HHC out of Linen and Laundry Operations to Environmental Services. Staff reductions to date have included over 300 full time employees. Total savings to date was reported as $16 million exceeding the target of $13 million with fewer workers. This is an area where the privatization has led to savings on paper but high costs as inadequate staffing leads to delays in delivery of clean laundry, delays in room set up and changeover, and longer patient waits for a room.

Similar complaints regarding the lack of full-time staff, over reliance on agency and part-time personnel and managers and supervisors needed training on how to communicate with workers have also been experienced in the Laundry and Linen area. In addition, HHC has had to implement a loss linen program due to substantially higher than projected losses. At the December 10, 2013 Strategic Planning Minutes Joseph Quinones, Senior Assistant Vice President of Operations stated that the first two years of the contract implementation was $13.5 million. Over the first two fiscal years, HHC

achieved savings of $9.2 million in laundry services. However, the target savings was lower than projected.

Housekeeping staff has been reduced through attrition. Productivity has increased through the increased square footage staff are cleaning. There comes a point when you can only do but so much in a day, and when a worker is faced with a room that is a wreck because the patient was vomiting, crashing, or violent, just to name a few things that occur every day, it will take longer to clean the number of patients' rooms. Cleaning hospital rooms is not like cleaning hotel rooms. In order to meet infection control and the new Hospital Consumer Assessment of Healthcare Providers and Systems scores for patient satisfaction standards, if anything, cleaning staff need more time to clean rooms than before. The managers of Crothall are expected to show productivity increases but there are no salary increases for them built into the first four years of the nine year agreement. We have already witnessed high turnover in the managers in Crothall. Of the thirty-eight (38) managers transferred from HHC to Crothall, only one remains, according to a report made by Joseph Quinones at the HHC Strategic Planning Committee meeting of December 10, 2013. Turnover will inevitably cause training costs and setbacks in productivity initiatives.

Outsourcing of Plant Maintenance Management and Staff Reductions

As part of HHC's five year capital plan with a targeting savings of $32 million, HHC contracted-out the management of construction and maintenance personnel, a 30%. HHC reduced its workforce of 1,200 electricians, carpenters, plumbers, painters, metal workers, laborers and other workers by a total of one hundred and fifty employees (150). In DC 37, nearly eighty (80) employees serving in titles ranging from Laborer, Radio Repair Operator and other trades titles were laid off through no fault of their own for the valuable work that they contribute to keeping HHC hospitals and clinics open twenty-four seven. HHC has rehired only several of the Laborers off of civil service preferred lists and some of these members are facing eviction proceedings and losing and major financial loss taking a terrible toll on their families. In addition, HHC has not backfilled many of the blue collar trades positions putting further strain on hospitals ability to pass the unannounced surveys with the JCAHO, which the Union feels is partially due to inadequate numbers of staff in the Environmental and Facilities Management Departments.

According to a report by Joseph Quinones at the HHC Strategic Planning Committee Meeting Minutes of December10, 2013, actual savings after the first year of implementation of Johnson Controls, Inc., was $900,000, which was $400,000 less than Johnson Control's first year target of $1.3 million.

Dietary Cook Chill Initiative

According to the minutes from the HHC December 10, 2013, Strategic Planning Committee Meeting, HHC has reduced staff in the Dietary Cook Chill Program run by Sodexo management from 1,400 full time employees to 963 full time employees.

This astounding reduction in staff has resulted in the over reliance on agency personnel being hired, part-time per-diem personnel and hours of full-time employees being changed, lack of morale and poor managerial skills creating a hostile work environment by the Sodexo managers.

A major complaint has been the lack of hot food and varieties and taste of food impacting the long term care patients, who have different tastes and needs compared to patients in acute care hospitals who have shorter stays.

In the December 2013 strategic planning minutes, the savings identified were $43 million over the first eight years. There are three (5) year options remaining with a target savings over 15 years of $150 million, which is a daunting figure to achieve and would require additional cuts in food or labor, neither of which appears likely based on the above feedback. Please note that the $43 million is the largest accounted for savings of all the restructuring initiatives but the dietary one actually predates the Road Ahead plan.

Centralized Labs

We are still awaiting the implementation of the next phase of the contract with a commercial lab to manage HHC's four major labs, standardize equipment and reagent contracts and use, and implement a STAT lab only mode for all HHC acute care facilities for a savings of $30 million. We are concerned how this plan will be implemented in a centralized manner and if the actual savings will be achieved by HHC. We understand the plan has been delayed due to problems with acquiring a suitable site. Since we were wary of how effective it would be to send patient tests to another facility and be properly tracked unless there is a high quality computerized tracking system where all facilities are using the same software and processes, we are not sorry about the delay. We will continue to monitor this closely for impact on patient care and our members serving in Bio-medical equipment and laboratory related functions.

Long Term Care Realignment

HHC projected $47 million in savings and/or increased revenue by improving HHC's long term care bed capacity to patients' demand for skilled nursing and chronic hospital services; consolidating administrative and support services where possible; consolidating under utilized services.

A major aspect of this plan impacting the unions was the closure of Goldwater Hospital and the opening of the new Henry J. Carter Skilled Nursing Hospital and Long Term Care Facility. With the closure of Goldwater Hospital on the Roosevelt Island campus, some of the patients were moved to the Henry J. Carter facility and others patients were

relocated to the Coler Campus or other facilities or alternative housing where appropriate. Impacted employees were redeployed to other facilities.

The negative impact has been a reduction in staffing levels at the Coler and Henry J. Carter campuses, especially in the titles of Respiratory Therapist, Recreation Therapist, Nurses Aide, Patient Care, Dietary Aide, Service Aide and Housekeeping Aide titles. These reductions in staff have put a major strain on patient care. It is critical in long term care facilities to have adequate staffing levels including backfill to avoid excessive overtime due to the chronic, severe and long-term illnesses facing the patients and residents requiring more constant and complex care on a regular basis.

Ambulatory Care Realignment:

The future of creating real savings will be in providing better primary and preventative care to avoid hospitalizations. In order for this to work there must be sufficient doctors to see the patients, and sufficient support staff to assist. This includes clerical support staff. HHC is in the process of using automated call centers and exploring a patient portal system where the patient can make their own appointments on the computer. There must also be real workers for patients to talk to in, if they don't have access to a computer, or if they need to ask questions about their appointment.

Privatization of Chronic Dialysis

HHC is continuing to pursue the next phase of its mis-directed plan to out-source out patient chronic dialysis services. To date, for the first ten months of the contract with Atlantic Dialysis there has been a savings of $825,000. The target savings over nine years is $147 million. There is a pending license for a certificate of need request before the New York State Health and Hospitals Care Committee for Big Apple Dialysis Services to provide services at Kings County Hospital Center, Harlem Hospital, Lincoln Hospital and Metropolitan Hospitals.

The labor unions and community groups and patient care advocates are vehemently opposed to this sell off such a vital healthcare service to an outside entity, especially one with a poor record of care for patients. In addition, HHC should fully assess the patient care outcomes of patients serviced by Atlantic Dialysis services which are currently providing services at several other HHC facilities to ensure such a drastic decision is truly in the best interest of patient care before any further expansion proceeds.

Seek Federally- Qualified Health Center (FQHC) Status for Six Diagnostic and Treament Centers

HHC targeted $40 million in savings by consolidating some specialty outpatient services, closing six satellite clinics with low utilization rates, and pursuing alternative administrative models for delivery of outpatient services.

DC 37 supports HHC's effort to establish Federally-Qualified Health Centers (FQHC) status for its six Diagnostic Treatment Centers. The targeted revenue of 25.4 million in savings is critical to HHC's efforts to take advantage of funding sources through innovative reimbursement streams.

Consolidation and Regionalization of Various Patient Care Services

Notwithstanding this, there are a number of Road Ahead recommendations that resulted in the consolidation and regionalization of services which result in patients in high risk categories to travel long distances for health care. We would urge HHC to reconsider the impact these changes have had on patient outcomes and reverse them to protect patient care (i.e., consolidation of Joint/Spine Surgical Volume to One Location per Borough or HHC Network; Closure of Six Outpatient Clinics; Consolidate Selected Specialty Care Clinics to One Site per Borough or per Network).

Reduction of Information Technology Contract Staff

One of HHC's successful Road Ahead Recommendations implemented was to contract-in Information Technology staff at a cost savings of $3.9 million. DC 37 agrees that this action should be replicated and expanded. Time and time again, we have shown since the CityTime debacle that civil service information technology professionals can perform the functions cheaper and more efficiently than out-side consultants. We urge the HHC to expand this program and continue to provide the necessary recruitment and retraining programs to enhance the Information Technology in-house staff employed by HHC.

Recommendations and Conclusion

We are well aware of the financial challenges facing HHC due to reforms in healthcare. We want HHC to continue to provide the high quality services and we are committed to working with them to find new revenue and achieve rational savings.

In September of 2010, DC 37 released a report titled, "**Public Health Care Under the Knife *DC 37's Response to* "Restructuring HHC: The Road Ahead"** where we expressed our concerns and recommendations in a white paper. We again reiterate our recommendations, to create the Path to A Positive Future for HHC in my testimony before this Committee today.

1. **Engage all stakeholders, including the HHC MLC Local Unions, community and patient advocates. In 2013, HHC conducted Community Health Needs Assessments for each facility and catchment area. Each facility has its own culture and executive management team. HHC needs to apply standard best practices in labor relations in every facility, and direct the senior management teams to work closely with labor and advocates on the implementation plans from the assessments.**

2. **Provide adequate funding and reimbursement rates for HHC and support the definition of a safety-net hospital that ensures full compensation for HHC's true costs of treating Medicaid, Medicare and uninsured and ensure that recent DSH Funds Agreement with State and CMS meets HHC's needs with input from all stakeholders on implementation plan of action.**

3. **Monitor closely the impact of privatization on benchmarks established in compliance with the Centers for Medicare and Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Department of Health (DOH) and HHC Mock Surveys and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS).**

4. **HHC must right size its staff by providing adequate staff where it is needed which will require augmenting staff in many cases (i.e., hiring new staff and back-filling). HHC cannot simply rely on cutting staff with the expectation that it can meet benchmarks for improving quality patient care, patient satisfaction scores and pass CMS, JCAHO and H-CAPS scores.**

5. **HHC must end its over reliance on agency personnel hired by outside contractors and consultants to perform the basic and vital services of a hospital in lieu of filling those positions with dedicated civil service health care professionals who value and are committed to HHC's mission of providing care to all, regardless of ability to pay.**

6. **HHC needs to reverse its decision to contract-out services in dialysis and managerial responsibility for Environmental to Crothall and Laundry Services to Unitex, Maintenance and Grounds Services to Johnson Controls and dialysis in-patient and out-patient services to Big Apple Dialysis Services, Inc., and Dietary to Sodexo and retain the control it has lost of the quality of these services, the respect for the workers who provide these services and the patients who rely upon them.**

7. **HHC and HRA must expand the MAP (Medicaid Assistance Plan) on-site offices to maximize HHC's ability to capture revenue, using the new Certified Application Counselor functions to smoothly enroll new applicants.**

8. **HHC must continue to aggressively develop contracting-in initiatives for fee collection, interpretation services, elevator maintenance and other trades titles.**

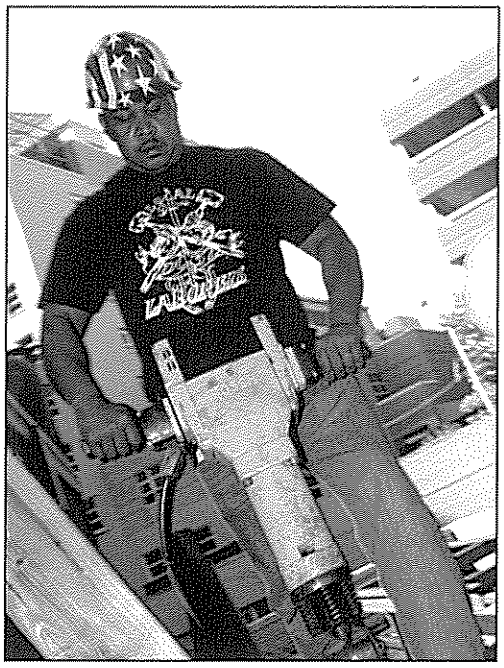
9. **HHC must target revenue-producing and cost-saving job titles for backfilling, training and upgrading.**

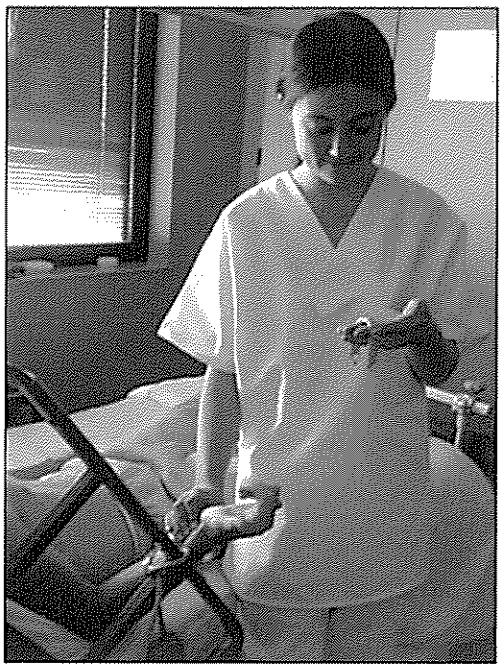
10. **HHC must establish a program to encourage savings by reducing contracting out; creating a task force for training and workforce development.**

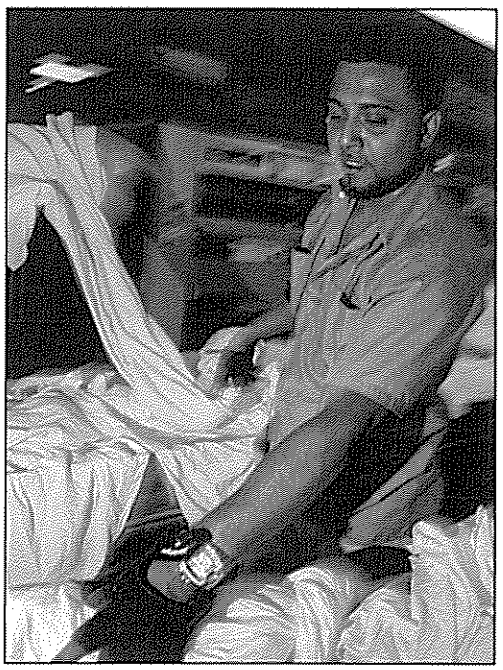
11. **HHC must set up a labor-management committee to engage its labor union partners in a meaningful fashion how best to implement the initiatives which improve revenue generation, patient care, and operation, improve worker morale, and communication on a corporation-wide basis.**

PUBLIC HEALTH CARE UNDER THE KNIFE

DC 37's Response to "Restructuring HHC: The Road Ahead"







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PUBLIC HEALTH CARE UNDER THE KNIFE

DC 37's Response to "Restructuring HHC: The Road Ahead"

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September 2010

Public Health Under the Knife:
DC 37 Responds to the New York City Health and Hospital Corporation's Restructuring Plan

Introduction

The Health and Hospital Corp.'s restructuring plan, released in May, takes a slash-and-burn approach to choosing changes to guarantee the fiscal soundness of New York City's public health-care system.

Boiled down to its essence, this faulty approach is based on:
- Conflicts of interest,
- Unsubstantiated cost-efficiency analyses,
- Ideologically driven contracting out, and
- Reckless downsizing

The union's analysis found that the process of developing the plan was fundamentally flawed by relying on Deloitte, LLP, a management consultant with serious conflicts of interest and without broad experience studying public hospital systems. We question whether this was the appropriate firm to recommend the restructuring plan.

Deloitte has direct client relationships with Sodexo Corp. and Angelica Linen Services — companies that would benefit from additional contracting out of HHC services — rendering the plan's recommendations in these areas highly suspect.

While the economy shrinks and jobs disappear, HHC paid Deloitte almost $4 million for a blueprint for the future that fails to consider seriously the healthcare concerns of the community and working people. The union is troubled by the potential impact of the plan on the workers, their communities and the city's economy.

District Council 37, AFSCME, which represents more than 18,000 workers at HHC, is concerned that carrying out the plan could undermine the system's ability meet its mandate to provide high-quality health care to all regardless of ability to pay.

The plan would eliminate 1,200 jobs through attrition and lay off hundreds more this year and eliminate a shocking 3,700 full-time equivalent employees by fiscal year 2014 through attrition and layoffs. HHC has already put skilled trades workers and laborers on the chopping block and revived privatization plans for Brooklyn Central Laundry.

The plan heavily targets certain types of jobs: entry-level jobs, lower paid jobs, unskilled jobs, support staff jobs, jobs that start a worker on a career ladder in health care – jobs that are predominantly represented by DC 37.

DC 37 locals include 45 percent of the workers in the hospital system. Members work in HHC's 11 hospitals, four skilled nursing facilities, six diagnostic treatment clinics, Brooklyn Central Laundry and 80 primary care clinics in the five boroughs. The employees generally live in the communities where they work, and they often use HHC as their health-care provider.

DC 37 members working in HHC facilities are skeptical – and feel betrayed. As dedicated health-care workers, they and their union have consistently fought for the federal, state and local funding that keeps the public-hospital system running. Along with patients who stand to receive poorer services, the hospital system's frontline staff will feel the pain of the restructuring as they lose their jobs and contend with downsizing and overwork.

Relying on a cost-efficiency analysis, Deloitte's restructuring report places an exaggerated emphasis on personnel costs. The methodology provides management with a rationale to make deep cuts in headcount that will ultimately jeopardize patient care. The press release announcing the plan focused on the "rising pension and healthcare costs" of HHC employees. Similarly, HHC President Alan Aviles referred to "skyrocketing fringe benefit costs" in his speech about the plan.

In public statements and in the restructuring report, the administration does not use the same alarmist language to describe the long-term decline in government assistance and the growing need for services. But the ongoing declines in funding and health care insurance coverage are the real culprits here.

"Restructuring HHC: The Road Ahead," does address serious challenges facing the city's public health-care system and compellingly lays out its fiscal troubles.

- Over the last three years, HHC's annual Medicaid reimbursement from New York State has fallen by $240 million, and HHC expects $100 million in annual cuts in upcoming years.
- The number of HHC patients without health insurance increased by 14 percent, from 396,000 to 453,000 between 2006 and 2009.
- Approximately 500,000 immigrants who reside in New York City without legal documentation will continue to depend disproportionately on HHC for their health care. They are not covered by the federal health care reform legislation.

In light of this funding crisis, any restructuring plan must address ways to boost revenue dramatically. Relying overwhelmingly on contracting out and cutting personnel instead, will significantly harm patient services. Even the $200 million in FMAP funds expected under the new federal jobs bill will not go far enough toward closing HHC's $1.3 billion budget gap.

Rising patient care costs, uncompensated care and reduced reimbursements are major challenges in HHC's budget deficit. The focus on personnel expenses skews the overall picture painted by the report and gives the false impression that the crisis is largely the result of employee benefit and pension costs.

DC 37 and other municipal unions recognize the fiscal challenges facing HHC and have made clear their willingness to be partners in change. HHC rebuffed our offer to help create a restructuring plan. In the process, the administration allowed for only superficial labor input, essentially locking out the representatives of frontline workers.

Given that designing the plan was contracted out to a consultant with limited knowledge of public hospital systems, it not surprising that the formulaic result calls for laying off hundreds of trades workers and extensive contracting out of services, such as the Brooklyn Central Laundry.

Decimating HHC staff and increasing contracting out would undermine the remarkable turnaround HHC has achieved in recent years in the quality of care it provides the city's most needy residents. This ideologically driven restructuring would thus jeopardize the high ratings that HHC has recently received from accreditation, government and other reputable health-care monitoring agencies in recent years.

Conflict of Interest

Deloitte — whose recommendations include extensive contracting out — has direct client relationships with Sodexo Corp. and Angelica Linen Services, companies that already have contracts with HHC and which would stand to benefit much more if HHC contracts out additional services. Deloitte's relationship with Sodexo raises ethical and practical questions about whether this consultant should have been selected to do HHC's restructuring study.

Sodexo's track record exemplifies the troubles associated with contracting out. Surveys of HHC patients consistently give Sodexo poor marks for its food service. Equally disturbing is Sodexo's behavior elsewhere. In July, New York State Attorney General Andrew Cuomo forced Sodexo to agree to a record $20 million fine for violating the False Claims Act with overcharges to the SUNY system and 21 public schools in the state. We believe HHC should reexamine its current contract with Sodexo and consider bringing HHC's food services back in house.

The portion of laundry services currently provided by Angelica Textile Services is similarly subject to quality control concerns. After years of spotty service, lack of inventory control and delivery delays under Angelica, all but three HHC hospitals eagerly went back to the in-house services provided by HHC's Brooklyn Central Laundry. Those facilities now enjoy better laundry quality and delivery time.

Further privatization of these services, particularly in a manner that may not be "at arms length," would not constitute prudent use of public dollars.

Insufficient Input from the Community and Frontline Staff

The HHC administration failed to solicit meaningful input from the community and the unions for the restructuring plan.

HHC admits that only one-fifth of the workforce responded to surveys. The few meetings with labor representatives were essentially one-sided updates from HHC, with no intention of obtaining meaningful input. The report did not incorporate the municipal unions' written recommendations, and HHC did not allow labor and community representatives to serve on the Restructuring Steering Committee.

HHC's failure to accept input from the community and unions was matched by its willingness to give Deloitte the major responsibility of creating the public health system's blueprint for change. It is unsurprising that the resulting plan reflects a corporate ethos that is inappropriate for non-profit public-service institutions.

Deeply Flawed Cost-efficiency Analysis

The consultant's analysis relies on a cost-efficiency model that is not always appropriate for evaluating an institution dedicated to providing public services.

While the stated principles guiding the plan including a focus on HHC's continuing mission of providing quality care, the actual content of "The Road Ahead" makes it quite clear that the primary goal is cutting costs and that this overrode any concern for patient care.

With that priority, it is not surprising that HHC selected Deloitte, a consulting firm with a corporate approach. Corporate jargon permeates the report, which speaks of "cost-effective, efficient and competitive organization," "cost efficient" models and "target markets," rather than "quality patient care" and HHC's responsibility to help the needy. And the report's 19 pages make scant mention of specific proposals to improve patient services or the quality of care.

The plan indicates that HHC will continue to reduce its staff through attrition as it downsizes personnel through layoffs and contracting out. It simplistically assumes that reducing the staff is intrinsically good and makes no sound argument that patient care will not suffer from these cost-cutting measures.

"The Road Ahead" neither asks nor answers fundamental questions about maintaining the quality of care or appropriate staff-patient ratios with dramatically fewer employees. It does not even study the potential for overtime costs to soar as headcount shrinks and patient care needs rise. In a transparent cosmetic device, the plan calls for the "equitable" step of cutting administrative staff by 10 percent. But, again, it does not examine the potential consequences of that action for services or efforts to increase revenue.

HHC's Restructuring Steering Committee spent less than two days evaluating the consultant's recommendations to decide on $1.2 billion in cost reductions and revenue enhancements over four years. While HHC rejected a few of Deloitte's more draconian recommendations, such as closing one-third of the community health centers and eliminating nearly all long-term care beds. The savings of $125 million a year for four years through employee attrition account for nearly half of the total projected savings and dwarf the $30 million in additional revenue anticipated by the plan.

Lack of Transparency

Deloitte claims to have compared HHC with nationally recognized health industry benchmarks and staffing models. These benchmarks are never identified and their sources and data models are never disclosed. For instance, the restructuring plan says HHC administrative units have "higher wage and fringe benefit rates than benchmarked entities for the same services." The plan does not identify the benchmarks, wages or benefit rates used to reach its conclusion.

A master plan for the future of such a large-scale urban health care provider cannot be evaluated or even taken seriously with no citations, no sources and no public data. Did Deloitte use benchmarks and staffing model ratios appropriate for public health care delivery in the New York Metropolitan area? The omission of this information makes it nearly impossible to subject Deloitte's conclusions to a rigorous analysis.

Slash-and-Burn Restructuring

Privatization and Contracting Out

With "The Road Ahead," HHC seems to have adopted an ideology-driven goal of contracting out public responsibilities to private firms, even where costs could increase, savings are unproved or trivial, or the quality of service could decline. Support services like testing patients' blood, providing clean linens and maintaining buildings and grounds are vital responsibilities in achieving HHC's mission.

In our studies of many city agencies, DC 37 has found massive waste of public funds as well as corruption, conflicts of interest and a lack of accountability in contracting out work that dedicated, experienced employees can generally do more efficiently at lower cost. Contracting out undermines the civil service system, which selects workers based on merit and fitness rather than cronyism, nepotism and political patronage, and usually amounts to union busting. Employees of private companies doing public work are often unrepresented, uninsured *(saddling HHC with their health-care costs)* and so poorly paid as to constitute an economic burden.

Brooklyn Central Laundry: Over 100 union employees currently work at Brooklyn Central Laundry. Firing them would be a severe blow to their families and the economy of the East Flatbush community.

"The Road Ahead" claims that privatization of HHC's laundry and linen services would save $6.1 million — less than one one-thousandth (0.09 percent) of the corporation's $6.7 billion annual budget. HHC's Request For Proposal for contracting out the laundry work makes it clear that the plan aims to save this minuscule amount only by further depressing wage rates in an already low-paid job.

HHC has been down this road before. In its previous experience with contracting out laundry services, HHC hospitals experienced inventory control problems and delivery delays that may be acceptable when vendors launder cleanup rags and commercial uniforms but were intolerable for public hospital linen supplies. DC 37 and HHC reached an agreement that improved machinery and reduced costs, and most HHC hospitals happily resumed using the in-house services of the Brooklyn Central Laundry.

Ignoring the lessons of history this time around, HHC has shown no interest in discussing the matter. In direct violation of its agreement with DC 37 to bring all laundry work in-house, HHC met with potential bidders Aug. 16 to begin contracting out the laundry services again. The interested bidders included companies cited for multiple health and safety violations, businesses with track records of poor work and frequent complaints, and employers who have driven wage rates to the bottom.

DC 37 is committed to stopping HHC's plan to privatize Brooklyn Central Laundry. We will fight at the bargaining table, in the courts, the streets and the Legislature.

Dialysis services: DC 37 opposes further contracting out of dialysis services, which the restructuring plan estimates would save $5 million. We believe these services can be provided more efficiently in house. We should note also that HHC has already invested millions of dollars to upgrade dialysis equipment at Bellevue Hospital despite its claim of lacking the capital funds to continue to support these services.

Laboratories: DC 37 also opposes the recommendation to contract out HHC's four major labs to a commercial laboratory firm, claiming that test costs are lower at high-volume commercial labs. The report provides no information about the data and sources Deloitte used, and we would like to examine the data more closely. We do not believe the administration's analysis has taken into account potential indirect and new costs associated with contracting out, such as delays and shipping expenses. We are also concerned that the potential for cutting corners to increase profits could affect privacy and accuracy.

Reckless downsizing

Laying off maintenance workers: On Sept. 17, HHC plans to lay off 72 skilled blue collar workers, including 59 Laborers, seven Locksmiths, two Supervising Locksmiths, three Radio Repair Mechanics and a Printing Press Operator, all represented by DC 37 local unions.

In addition to the workers in DC 37, HHC has targeted 73 Carpenters for layoff. All told, HHC expects to save $32 million by letting go 450 unionized workers from its 1,200-member trades staff.

Apart from our concerns about the devastating effects of the layoffs on the workers involved, the union opposes these firings because of the impact the action would have on HHC itself. Without sufficient in-house trades staff, HHC will not be able to maintain its physical plants and grounds. We already have word that HHC intends to rely on outside contractors unfamiliar with its facilities, although the report does not attempt to evaluate the potential costs of this move, which could increase. The loss of the in-house employees will directly affect the timeliness and quality of repair and maintenance work in HHC buildings, potentially endangering the system's Joint Commission on Hospital Accreditation status.

Closing clinics: "The Road Ahead" says that because of low outpatient Medicaid reimbursement rates, HHC will close one dental clinic and five child health clinics that together service 6,000 children, adults and seniors in Brooklyn, Queens and the Bronx. The report says these facilities were selected for closure based on low utilization rates, physical conditions of the clinics and proximity of other clinics.

We urge HHC to reconsider this action and to explore alternatives to these closures, which will negatively impact the communities these clinics were created to serve.

Reducing Access to Services

"The Road Ahead" calls for consolidating services to save several million dollars. This is another example of the folly of "cost-efficiency" analysis based on improving the bottom line at the expense of human need.

HHC contends that it will save $3.4 million by consolidating orthopedic services. DC 37 is deeply concerned that this action will reduce the access of patients with diabetes and debilitating diseases to these services. Over the past decade, HHC abandoned its consolidation of services in several treatment networks after acknowledging that this unduly limited patients' access to care.

HHC also intends to consolidate joint and spine surgeries into one location in each of the city's five boroughs. This action would create a tremendous hardship for many patients. Spine and joint surgeries are major operations that require patients to undergo extensive rehabilitation. Before embarking on this change, HHC should attempt a pilot program.

Positive Initiatives

The union agrees with two of the recommendations.

We are particularly encouraged by the recommendation to contract in information technology services. According to the restructuring report, this will save an estimated $5 million. The report correctly notes that computer consultants generally command market fees that are higher than the salary and benefit costs of unionized in-house employees.

We also support the report's recommendation for increasing HHC's revenue by $135 million. The administration hopes to achieve this through improvements in the documentation of patient care, including better coding of procedures. HHC is also working with insurance providers to expand and diversify its patient base and to encourage more referrals from community physicians.

DC 37 Recommendations

The union has a number of recommendations for savings at HHC and would like to work with HHC to ensure their implementation. These include:

- Terminating the contract with Sodexo and returning HHC's Cook-Chill food service to in-house management
- Increasing the enrollment of patients in HHC's MetroPlus HMO.
- Expanding the MAP on-site offices to maximize HHC's ability to capture revenue.
- Developing contracting-in initiatives for fee collection, interpretation services, elevator maintenance and other trades titles, and
- Targeting revenue-producing and cost-saving job titles for backfilling, training and upgrading.
- Other steps we support include establishing a program to encourage savings by re ducing contracting out; creating a task force for training and workforce development; and setting up a labor-management committee to explore how best to implement the Breakthrough initiatives *(which outline recommendations for improving revenue generation, patient care and operations)* on a corporation-wide basis.

Conclusion

We are concerned that the business-oriented approach of "The Road Ahead" will ultimately jeopardize the Health and Hospitals Corp.'s mission of providing quality care to all New Yorkers, regardless of their ability to pay. We are unconvinced that the contracting-out proposals will achieve the desired savings, though they will certainly destroy a vital community resource – hundreds upon hundreds of good jobs with decent benefits.

District Council 37and its affiliated locals urge HHC to reconsider the flawed restructuring initiatives that we have identified. Instead, we recommend that the HHC administration engage in meaningful discussions with the union about how to provide quality health care services efficiently and effectively.

As our history shows, District Council 37 is deeply committed to the mission of the New York City Health and Hospitals Corp. We helped create HHC in 1970, and over the years we have worked with the community to defend the public health care system against the vicious budget cuts and privatization schemes of governors and mayors. Our union has lobbied in Washington and our members have rallied in Albany to get the funds HHC needed.

As other hospitals close and new national health legislation is implemented, we want to keep HHC healthy to meet the growing health care needs of the people of New York City today and in any future emergencies, such as epidemics or terrorist attacks. It is our responsibility as a public service union to see that HHC does not weaken its ability to respond to a crisis.

Our analysis shows that the privatization plans and staffing cuts of "The Road Ahead" would constitute a self-inflicted wound to the heart of HHC, quality patient care. We are fighting this plan because we care.

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Testimony of Sascha Murillo
Community Organizer, Health Justice Program
New York Lawyers for the Public Interest

Before the New York City Council Committee on Health
Oversight Hearing- Examining the Status of "Restructuring HHC: The Road Ahead": What Progress Has Been Made and What Challenges Lie Ahead?
Feb. 24, 2014

Good afternoon and thank you for the opportunity to testify in front of you today. My name is Sascha Murillo and I am the Community Organizer for the Health Justice Program at New York Lawyers for the Public Interest (NYLPI), a nonprofit civil rights law firm dedicated to advancing health, disability, and environmental justice. Within the Health Justice Program, we work to ensure access to high quality health care for people from medically underserved neighborhoods who face barriers due to racial or ethnic discrimination or limited English proficiency. We work closely with communities of color and immigrant communities to dismantle systemic and institutional barriers to care.

I would like to thank the Health Committee Chair and committee members for convening this hearing to examine the Health and Hospitals Corporation's strategic plan. At NYLPI, we understand that HHC is a vital safety-net provider in New York City and we laud HHC's record of providing quality and culturally competent health services to low-income and uninsured New Yorkers. At this time, HHC is looking ahead to adapt to new changes brought on by the Affordable Care Act and to address daunting financial challenges. However, HHC's response to these challenges to cut vital services and restructure the public hospital system with little to no community and labor input will only reduce access for the communities HHC serves and deteriorate quality of services.

The removal of labor and delivery services at North Central Bronx Hospital demonstrates the consequences of HHC's current modus operandi. On August 12, 2013, HHC suspended Labor and Delivery services at North Central Bronx Hospital and transferred staff and patients to Jacobi Medical Center with only 4 days' notice. The community, including residents, labor, and health advocates, was strongly opposed to the loss of a vital and treasured service. Further, the

changes, a process for gathering community input, and a detailed timeline for any future changes.

We feel that the recommendations outlined for NCBH can be applied across HHC. What has happened at NCBH is part of a larger pattern of the dismantling of health care services in underserved communities. From hospital closures in Brooklyn to service cutbacks at immunization clinics in Queens and the Bronx, our public health infrastructure is under attack. As HHC considers sweeping changes to the public hospital system, they must preserve access to and quality of care by ensuring community participation.

We hope that these recommendations will pave the way for HHC to work with community members to improve health care services in the North Bronx and across New York City. I thank the members of the Health Committee for listening to my testimony.

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Testimony of Mindy Friedman
On behalf of New York Lawyers for the Public Interest
Before the City Council's Committee on Health
Regarding Access to Health Care for People with Disabilities
At Health and Hospital Corporation Facilities
February 24, 2014

Good Afternoon Chairperson Johnson and Members of the Committee on Health. Thank you for convening this hearing. My name is Mindy Friedman and I am a staff attorney at New York Lawyers for the Public Interest.

In October of 2012, the City Council held an oversight hearing regarding the accessibility of health care at HHC facilities in conjunction with the release of our report, "Breaking Barriers, Breaking the Silence" which we co-authored with Independence Care System, and which I have brought copies of today. The report revealed that medical facilities across New York City provide unequal and inaccessible care for people with disabilities, violating their civil rights under federal, state, and local laws.

Inaccessibility is the result of architectural and communication barriers, inaccessible equipment, and provider bias, and the resulting disparities are well documented. Studies have shown that individuals with disabilities are far less likely to access health care services than individuals without disabilities.[1] Women with disabilities, in particular, are significantly less likely to seek or receive quality health care in a timely way, especially in the area of cancer screening.[2] Such significant lack of access to critical services leads to poorer health outcomes for women with disabilities, including higher mortality rates.[3] For example, women with disabilities have the same incidence of breast cancer as women without disabilities, yet they are nearly one-third more likely to die from it.[4]

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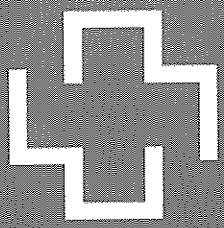
[1] *See, e.g.,* NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES (2009), http://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d?document.pdf; *see also,* JUDY PANKO REIS ET AL., IT TAKES MORE THAN RAMPS TO SOLVE THE CRISIS OF HEALTHCARE FOR PEOPLE WITH DISABILITIES 7 (2004), www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf.

[2] *See, e.g.,* M. A. Nosek and C. A. Howland, *Breast and Cervical Cancer Screening Among Women with Physical Disabilities*, 78 ARCHIVES OF PHYSICAL MED. & REHABILITATION S39 (1997).

[3] *See, e.g.*, Ellen P. McCarthy et al., *Disparities in Breast Cancer Treatment and Survival for Women with Disabilities*, 145(9) ANNALS OF INTERNAL MED. 637 (2006).

[4] McCarthy et al., *supra* note 3, at 637 (cited in JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, MAMMOGRAPHY: ADDRESSING EQUIPMENT DESIGN 5 (2009)).

> Women with SSDI and Medicare who had breast-conserving surgery were also less likely than other women to receive radiotherapy and axillary lymph node dissection. These women had lower survival rates from all causes and specifically from breast cancer. Explanations for such disparities could include lack of early diagnosis, lack of breast health awareness or education on the part



BREAKING DOWN BARRIERS, BREAKING THE SILENCE:

MAKING HEALTH CARE ACCESSIBLE FOR WOMEN WITH DISABILITIES

Independence Care System

New York Lawyers for the Public Interest

Report Co-Authors

Independence Care System

Independence Care System is dedicated to supporting adults with physical disabilities and chronic conditions to live at home and participate fully in community life. ICS operates a nonprofit Medicaid managed long-term care plan (MLTC) serving residents of Manhattan, Brooklyn, the Bronx and Queens. Member-centered care coordination is the heart of our work, aimed at ensuring that our members' needs are comprehensively assessed, that they participate in developing their Care Plans, and that they are followed during transitions from a hospitalization or nursing facility back home. Using an interdisciplinary team model of care management, our Care System is responsive, coordinated, expert, empowering, respectful and flexible.

Founded in 2000, ICS was the only plan in New York focused on the unique needs of people with physical disabilities. Since then, our membership has grown to more than 3,000—both people with disabilities and senior adults. We operate a nationally recognized Disability Care Coordination Model and award-winning specialized care management programs in Multiple Sclerosis, Women's Health, and Wheelchair Evaluation and Support.

New York Lawyers for the Public Interest

NYLPI is a nonprofit civil rights law firm whose mission is to advance equality and civil rights, with a focus on health justice, disability justice and environmental justice, through the power of community lawyering and partnerships with the private bar. Created in 1976 to address previously unmet legal needs, NYLPI combines a pro bono clearinghouse with an in-house practice that blends innovative lawyering, community organizing and advocacy.

NYLPI employs a community lawyering approach that revolves around the concept that change is best affected through a dedicated and organized local constituency responding to self-identified problems within their community. In order to address these concerns, NYLPI combines strategies such as advocacy, outreach, organizing, community education, capacity building, policy work, media, and litigation. NYLPI's close working relationship with our almost 100 member firms enables us to leverage the tremendous resources of the private bar in order to have the most impact on the lives of both our clients and New York's nonprofit community.

NYLPI's Disability Justice Program has created a special project, Access to Health Care for People with Disabilities, to break down the barriers that New Yorkers with disabilities face when seeking accessible health care.

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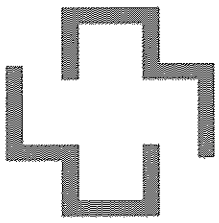

BREAKING DOWN BARRIERS, BREAKING THE SILENCE: MAKING HEALTH CARE ACCESSIBLE FOR WOMEN WITH DISABILITIES

October 2012

"There are too many women with disabilities who have been silenced. We can't be. Some people don't want to tell their stories because it's so painful. When it comes to health care, it's happened so many times, it feels like it's not going to change."

—M. Lyons, Member, Independence Care System

Acknowledgements

Breaking Down Barriers, Breaking the Silence: Making Health Care Accessible for Women with Disabilities was written by Kelly McAnnany, Katherine Terenzi, and Mindy Friedman, from New York Lawyers for the Public Interest, and Marilyn E. Saviola from Independence Care System.

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Independence Care System and New York Lawyers for the Public Interest are deeply grateful to the women who courageously spoke out against injustice by sharing their stories in this report. We also recognize all of the participants in Independence Care System's Women's Health Access Program, whose important contributions have helped advance the struggle for accessible health care in New York City.

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"When we talk about concerns with disparities in access to health care, we don't usually hear people with disabilities mentioned. There are a few reasons for this silence.

The Disability Rights Movement has long fought against society's tendency to label people with disabilities as "sick" and dependent on doctors. During the early days of the Independent Living Movement, in an effort to distance itself from this 'medical model' of disability, advocates focused their energies on other areas, such as transportation, education, and employment. In addition, individuals with disabilities have not as easily spoken out or attempted to break down these barriers because they don't realize accessible health care is a right. Many individuals with disabilities are just grateful for any care they can get – they don't want to risk losing it and think that speaking up will get them in trouble. People with disabilities don't always understand this is not the best they can get, and that they deserve more. As a result, hospitals, doctor's' offices and clinics have remained inaccessible to people with disabilities.

Everyone benefits from accessible care and universal design. At some point in your life, you'll probably need something accessible. When you have an adjustable table with varying heights, pregnant women and the elderly don't have to climb up and it's more comfortable for all patients. It's also easier and safer for the practitioner to provide care. Doctors don't have to worry about hurting themselves or the patient.

It is late in the health care game to finally address this crucial issue, but the health of people with disabilities has suffered for far too long. It's time to make health care accessible throughout New York City."

—Marilyn E. Saviola, Vice President of Advocacy and the Women's Health Access Program, Independence Care System

"The law is clear – medical providers of all sizes across New York City are obligated to provide equal care to their patients with disabilities. Yet, our office has heard from many New Yorkers about unequal access, whether because of provider bias, communication barriers, or equipment inaccessibility. This discrimination has prevented people with disabilities from equally availing themselves of critical health services, which we know leads to health disparities. New Yorkers with disabilities cannot be made to endure this injustice any longer.

We will fight alongside the disability community to ensure that medical facilities come into compliance with the law. Healthcare providers in New York City would be well served by taking immediate steps to make their services accessible."

—— Kelly McAnnany, Co-Director, Disability Justice Program, and Katherine Terenzi, Taconic Policy Fellow
New York Lawyers for the Public Interest

Preface

Independence Care System (ICS) and New York Lawyers for the Public Interest (NYLPI) have long heard complaints from individuals with all types of disabilities about the pervasive inaccessibility of health care in New York City (NYC). These barriers exist in facilities of all sizes, including hospitals, community clinics, and doctors' offices, in contravention of laws that mandate equal access for people with disabilities. ICS and NYLPI have partnered to write this report to illuminate these barriers and to call on medical facilities and state and local government to take immediate action to stop this rampant discrimination. The time for accessible healthcare in New York City for people with disabilities is long overdue.

I try to think about it from the perspective of the doctor. I want to believe that they want to give us the best health care, but sometimes the doctor doesn't think about whether the space is accessible, because they're so busy thinking about the services they're supposed to be providing. I wish they'd think about both.

– M. Lyons, Member, Independence Care System

Inaccessibility is the result of architectural and communication barriers, inaccessible equipment, and provider bias, and the resulting disparities are well documented. Studies have shown that individuals with disabilities are far less likely to access health care services than individuals without disabilities.[1] Women with disabilities, in particular, are significantly less likely to seek or receive quality health care in a timely way, especially in the area of cancer screening.[2] Such significant lack of access to critical services leads to poorer health outcomes for women with disabilities, including higher mortality rates.[3]

The need for accessible care will only increase in the coming years as the baby boom generation ages and life expectancy rates lengthen. Nationally, if the prevalence of major chronic conditions remains the same, the number of individuals with functional limitations will have increased by over 300% by 2049.[4] In New York City, where elderly residents are far more likely to have disabilities,[5] the population over the age of 65 is projected to increase by 44% – or more than an additional 400,000 people – by the year 2030.[6]

Other demographic trends in New York are significant: New Yorkers with disabilities are more likely to be women;[7] over 675,000 adult New Yorkers with disabilities are uninsured or publically insured;[8] and nearly a quarter million adults with disabilities living in New York City earn an annual income that falls below the poverty line,[9] with over half making less than $25,000 in the last year.[10] Despite the obligation of all New York City hospitals to ensure accessibility for their patients, Health and Hospitals Corporation (HHC) facilities have an especially critical role to play in supporting the large number of individuals with disabilities living in poverty[11] who disproportionately rely on the public health system.[12]

With the help of ICS, a few NYC health care facilities, including HHC facilities, have begun to make accessibility improvements for women with disabilities who seek a full range of health services, including breast and cervical cancer screening. These improvements did not generate great expense. Yet, they produced life-changing results for the women who finally benefitted from fully accessible care. These small instances of increased accessibility demand replication, as all New Yorkers with disabilities are entitled to accessible health care.

Medical providers and policymakers have an important role to play in bridging this gap to accessible health care for people with disabilities. This report will provide an overview of the barriers to medical care encountered by New Yorkers with all types of disabilities, as well as outline the legal framework that protects their rights. This report also includes a discussion of the various benefits reaped by medical providers who deliver accessible health care. This report will subsequently probe the specific case of barriers to cancer screening for women with physical disabilities, including the successful steps taken by some New York City providers to be disability inclusive. Finally, this report will make recommendations to medical providers and policymakers on how to fundamentally improve access to health care for New Yorkers with disabilities.

Executive Summary & Recommendations

Executive Summary

Over the years, Independence Care System (ICS) and New York Lawyers for the Public Interest (NYLPI) have heard numerous complaints from individuals with all types of disabilities about the inaccessibility of health care in New York City. Barriers to comprehensive, quality health care appear in facilities of all sizes, including hospitals, community clinics, and doctors' offices. Inaccessibility is the result of architectural and communication barriers, inaccessible equipment, and provider bias. The effect of these obstacles to care is profound; inaccessible health care negatively impacts nearly every aspect of an individual's life, including their social, psychological, physical, and economic well-being. Disparities in access to medical treatment for individuals with disabilities are well documented. Studies have shown that people with disabilities are far less likely to access health care services than individuals without disabilities. Women with disabilities, in particular, are significantly less likely to seek and/or receive quality health care in a timely way, especially in the area of cancer screening. Such significant lack of access to critical services leads to poorer health outcomes for women with disabilities, including higher mortality rates.

Federal, state, and local laws prohibit both public and private health care facilities from discriminating against individuals with disabilities in the provision of medical care. In fact, New York City's local human rights law is one of the most progressive in the country and offers protections beyond the federal laws. Generally, this means that medical providers are responsible for ensuring the accessibility of programs and services by removing architectural and communication barriers, providing reasonable accommodations and accessible medical equipment, training medical and non-medical staff, and making changes to institutional policies and procedures. Compliance with disability anti-discrimination laws benefits patients and providers alike. Not only does the provision of accessible health care ensure a safe environment for patients and employees, but it also reduces the costs associated with patient lawsuits and lost time and expense for worker injuries. Further, medical providers can take advantage of tax incentives for making services and facilities accessible to people with disabilities. Finally, the costs to the health care system are reduced when patients can access care equally, as diseases and illnesses are prevented or diagnosed earlier, and treated for less money, and patients are not forced to rely inappropriately on emergency department treatment.

"My mother and my father both died from cancer, two of my aunts had breast cancer, my brother has cancer, and my sister has breast cancer. Cancer runs in my family so I need to get screened. When I went to one private hospital to get a mammogram the machine didn't lower. During the test my legs started shaking and I felt like I was going to fall and hurt myself. So, I told the woman that I need to sit. She was so rude, she said I could sit when we were done."

—Azzlee Blackwood, Member,
Independence Care System

Barriers to health care disproportionately affect women, and can produce particularly harmful results when they impede effective screening for cancer; disparate treatment can delay or inhibit the early detection of breast or cervical cancers. Although women with disabilities have the same incidence rates of breast cancer as women without disabilities, they are one-third more likely to die from it. Women without disabilities also receive mammograms eleven percent more frequently than women with physical disabilities. Studies have shown that among women with disabilities aged forty and over who had not had a mammogram within the past two years, the most frequently cited reason was the inability to get into the required position.

Although the majority of medical facilities have a long way to go to come into compliance with disability laws, efforts to achieve accessible care are

already underway in New York City hospitals. ICS, which operates a nonprofit Medicaid managed long-term care plan specifically designed for adults with physical disabilities and chronic illnesses, has spent several years developing its Women's Health Access Program. This program seeks to increase the accessibility of breast and gynecological care and other health services for women with physical disabilities. ICS, along with partner medical facilities, has made significant progress in developing and implementing a model of accessible cancer screening for ICS members. The key to this program's success has been a willingness by providers to take necessary steps to change policies and procedures, remove physical barriers, and educate staff to ensure disability competency. The success of these collaborations must be replicated across other healthcare facilities in New York City.

"Women's health care is important, and it is even more important for women who use wheelchairs. People don't realize that when you take away the wheel chair, I'm just a woman looking for health care."

– C. Cruz, Member, Independence Care System

The time for accessible health care has come. New York City medical providers must immediately take steps to remedy the pervasive inequality that leads to substandard health care for New Yorkers with disabilities.

Recommendations to Medical Providers & Policymakers

Medical providers and policymakers have important roles to play in bridging the gap to accessible health care for women with disabilities. The following recommendations, if implemented, will make long overdue changes to our health care system and help guarantee equal access to health care for people with disabilities in New York City.

New York City Medical Providers should:

- Develop and implement a comprehensive plan for treating people with disabilities, including by instituting a non-discrimination policy with accompanying protocols, designating a point person and creating a grievance procedure to ensure patients with disabilities receive disability accommodations
- Develop and conduct mandatory system-wide disability competency provider trainings
- Acquire accessible equipment and remove communication and architectural barriers
- Coordinate care and maintain good data and records on patients with disabilities

The New York City Health & Hospitals Corporation should, in addition to the aforementioned recommendations:

- Convene a task force, including representatives from each facility, experts, stakeholders, and people with disabilities, to develop detailed guidance on ensuring accessibility in health care facilities in compliance with existing law
- Develop and disseminate a patient and provider survey regarding the accessibility of HHC facilities and services

The New York City Council should:

- Pass a comprehensive resolution, which directs New York City medical providers to comply with disability anti-discrimination laws; directs HHC to convene a task force to develop guidance on accessibility; urges the New York State Department of Health to issue and enforce detailed guidance to health care facilities on the provision of accessible care, to create an accessible complaint process, and to amend facility requirements to include disability training and intake; and urges the New York State legislature to pass legislation requiring medical facilities to procure accessible medical equipment and to issue patient notices regarding their right to accessible care
- Include funding in the budget, with terms and conditions, to assist capital improvements at HHC facilities that are designed to increase accessibility for people with disabilities
- Convene annual oversight hearings on the accessibility of medical services and the needs of people with disabilities

The New York State Department of Health should:

- Issue a detailed administrative directive to all medical facilities regarding the obligation to provide accessible services to people with disabilities, and ensure facility compliance with said directive and disability anti-discrimination laws
- Create a robust and accessible complaint process with defined follow-up procedures
- Amend facility requirements on training and intake to include disability

The New York State Legislature should:

- Pass legislation requiring all medical facilities to provide notice to patients of their rights to accessible care
- Pass legislation requiring all medical equipment procured by hospitals and clinics to be accessible in compliance with anti-discrimination laws and regulations

"Our sexual health is extremely important. We are the ones bringing life into this world. Yes, disabled women are also bringing life into this world. It is extremely important."

– Kim Yancy, Member, Independence Care System

Common Barriers to Accessing Healthcare Services

> **"A physician shall support access to medical care for all people."**
>
> – Principle IX, American Medical Association's Code of Medical Ethics [13]

> **"One public hospital mammography supervisor even told me, 'People like you cannot come here.' When I asked where I should go, the supervisor responded 'where people like you go.'"**
>
> – Marilyn E. Saviola, Vice President of Advocacy and the Women's Health Access Program, Independence Care System

New Yorkers with all types of disabilities face barriers to accessing basic health services, whether at hospital-based facilities, community clinics, or doctors' offices. Obstacles include structural barriers, inaccessible equipment, communication barriers, and provider bias. The effect of these obstacles is profound; inaccessible health care negatively impacts nearly every aspect of an individual's life, including their social, psychological, physical, and economic well-being.[14]

Over the years, Independence Care System and New York Lawyers for the Public Interest have heard numerous complaints from individuals with disabilities about the inaccessibility of health care in New York City.[15] The following section provides an overview of such barriers.

Physical Barriers

Physical barriers can impede access to medical care in nearly every part of a doctor's office or hospital, from the building entrance to the examination room.[16] These physical barriers can be structural or architectural in nature, as well as result from the use of inaccessible medical equipment.

Examples of structural obstacles include restrooms without grab bars, intake areas with insufficient turning space for a wheelchair, and hallways that are too narrow.[17] Many doctors' offices in New York City also have one or more steps to the entrance, and are often located in buildings without an elevator.[18] Individuals who use mobility aids, such as a wheelchair or walker, may also face barriers to obtaining comprehensive examinations and testing as a result of inaccessible equipment. They may be unable to get onto an examination table that is too high, or use diagnostic equipment that will not lower.[19] Doctors may then perform an incomplete procedure, including by examining a patient while she remains in her wheelchair, despite the inadequacy of such a method.[20] Individuals with physical disabilities may lack the strength or balance to stand to be weighed, but providers often use weight scales that are not wide or flat enough to allow for a wheelchair or other mobility device.[21] As a result, medical staff may altogether forego weighing the patient.[22]

Studies throughout the country reveal the routine absence of accessible examination tables, weight scales and diagnostic equipment. In a national survey of people with disabilities or activity limitations, 69% of wheelchair users reported that they had difficulty using exam tables, 60% had difficulty being weighed due to inaccessible scales, 45% had difficulty using x-ray equipment (such as mammography equipment), and 43% had difficulty using medical chairs.[23] Only 1% of the providers surveyed in another study had an accessible scale.[24]

The result of medical provider failures to ensure structural accessibility or utilize accessible equipment can range from humiliation to the development of life-threatening conditions that could have been prevented.[25] Lack of access to appropriate health services increases the risk that people with significant disabilities will develop additional health conditions. People with disabilities also generally experience higher rates of secondary conditions than the general population, which compounds barriers.[26]

Communication Barriers

Physical barriers are not the only obstacles that people with disabilities confront when seeking medical care; communication barriers routinely prevent individuals with disabilities from fully understanding or relating their medical condition and treatment needs.

Deaf and hard of hearing New Yorkers regularly fail to receive a qualified sign language interpreter at doctor appointments and during trips to hospital emergency rooms. In addition, deaf or hard of hearing individuals are routinely not provided with communication devices that replace telephones, called videophones, during longer-term stays at hospitals or rehabilitation facilities.[27] The health disparities that result from this kind of unequal care are numerous. Research has shown them to include, "medication errors and missed diagnoses, problems during surgery and anesthesia, missed and delayed appointments, and less complete and accurate information than other patients receive."[28] Basic information about health conditions is also not communicated to the deaf community. In a large survey of patients who are deaf, 62% of patients surveyed could not identify the warning signs of a stroke, 32% could not identify the risk factors of heart attack or stroke, and one in three could not define the word "cancer."[29] Another startling study showed that 70% of deaf individuals said that people who are deaf could not get HIV and 50% did not know the meaning of HIV-positive.[30]

Communication barriers similarly affect the growing population of New Yorkers who are blind or have low vision.[31] People with visual impairments are routinely not provided with important medical information and documents in a format they can read, such as Braille or large print.[32] For example, in a study of Medicare beneficiaries with severe vision impairments, rates of dissatisfaction with the quality of health care received and inadequate information provided about their health conditions were nearly double the rates seen in the general population.[33] During hospital stays, medical personnel may also fail to give blind individuals information about their surroundings, which would otherwise facilitate independence and greater comfort.[34] Doctors may also tell patients they are not allowed to bring their service animal into an appointment.[35]

"I've had the experience where they talk to the aide instead of talking to me to ask what I need and how to transfer. I'm kind of feisty, so I say 'I can answer for myself.' But it dehumanizes me. They don't even attempt to ask, 'what can you do?' or 'why are you here?' Sometimes you feel like it's the elephant in the room."

– M. Lyons, Member,
Independence Care System

Barriers for individuals with developmental disabilities and mental illness also implicate a lack of appropriate and effective communication on the part of medical staff. Doctors and nurses may fail to take the necessary time to explain a procedure or treatment options to a person with a mental illness or an intellectual disability.[36] Medical staff may also fail to ask what steps are necessary to ensure a comfortable and safe environment for an examination, including by offering to provide additional staff to support the individual.[37] Data relating to the health outcomes of people with mental illness are particularly disturbing. For example, individuals with mental illness receive inferior preventive care services, such as osteoporosis screening, blood pressure and cholesterol monitoring, vaccinations, and mammography.[38] In high-income countries, there is a 20-year and 15-year life expectancy gap, respectively, for men and women with mental illness.[39]

Attitudinal Barriers & Lack of Training

The lack of cultural competency leads to a number of incorrect and detrimental assumptions about people with disabilities made by healthcare providers. Discriminatory perceptions have led providers to believe, for example, "that people with disabilities do not have a good quality of life; that people with developmental disabilities do not feel pain and, therefore do not require anesthesia; that people who are deaf have cognitive deficits because they may not be fluent in standard English; and that women with disabilities do not require reproductive counseling and care because they are not sexually active."[41] Research shows that these stereotypes and biases negatively affect the quality of care patients with disabilities receive.[42]

Research reveals that physicians have not received training on the fundamental aspects of working with people with disabilities. In a 2007 survey of primary care physicians, 91% of them revealed that they had never received training on how to serve people with intellectual or developmental disabilities.[43] According to a national study of physicians, only 2.6% of respondents demonstrated specific awareness of the ADA.[44] Another survey of more than 500 physicians revealed that nearly 20% of respondents were unaware of the ADA and more than 45% did not know about its architectural requirements.[45] Moreover, less than a quarter of the respondents had received any training on physical disability issues in medical school, and only slightly more than a third had received any kind of training on disability during their residency.[46] However, nearly three quarters of the physicians surveyed acknowledged a need for training on these issues.[47]

The following section will provide an overview of the multiple laws that shield patients with disabilities from the aforementioned discrimination that exists in medical facilities in New York City.

"The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law..."

– American Medical Association Opinion 10.01(4), "Fundamental Elements of the Patient-Physician Relationship"[40]

"Another young lady with a disability was [at the gynecologist's office] when I was there and the doctor raced around the place saying, "Oh my god, she's pregnant; I can't believe it, she can't be!" She was so loud everyone in the waiting room heard it. I was disgusted. When I went in for my appointment they did a pregnancy test on me even though I didn't request it. When it came back negative, they said "Oh, well thank god you're not pregnant!" I cannot even begin to tell you how upset I was, not only for myself, but for the other woman– she was a grown woman with a job – and they carried on so horribly."

– Kim Yancy, Member, Independence Care System

Legal Framework for Providing Accessible Care

"A physician shall respect the law..."

—Principle III, American Medical Association's Code of Medical Ethics[48]

"When you have a physical disability and you're looking for a gynecologist, you usually have to settle. Most women don't know that the facility should be accessible, so we tend to adapt. We don't know any better, so we settle. For example, I went to one place and the only thing that was accessible was the front door."

– C. Cruz, Member, Independence Care System

Health care providers in New York City have long been legally required to make their services fully and equally accessible to people with disabilities. In addition to prohibiting the outright exclusion or segregation of people with disabilities, laws require public and private medical providers of any size to remove physical barriers, provide accessible medical equipment and communication aids, and make changes to policies and procedures. This section will provide an overview of the specific requirements of relevant federal, state and local laws that pertain to health care providers in New York City.

Anti-Discrimination Laws that Protect New Yorkers with Disabilities

Four key laws collectively prohibit discrimination against people with disabilities in virtually all healthcare facilities in New York City: Section 504 of the Rehabilitation Act of 1973 (Rehab Act), Titles II and III of the Americans with Disabilities Act of 1990 (ADA), the New York State Human Rights Law (State Human Rights Law), and the New York City Human Rights Law (City Human Rights Law).

The Rehab Act applies to programs and institutions that receive federal financial assistance, meaning that all medical care providers that receive payments from Medicaid or Medicare (excluding Part B payments) are covered by Section 504.[49] Title II of the ADA covers state and local governments, referred to as "public entities," and includes "health services," such as state and city hospitals and clinics, without regard to federal funding.[50] Title III of the ADA covers all "places of public accommodation," which are generally places that are open to the public where an individual can go for goods and services.[51] Thus, it covers private doctors' offices, hospitals, and clinics.

The State Human Rights Law generally tracks the protections guaranteed to people with disabilities by the federal anti-discrimination laws described above, in particular the ADA.[52] In New York City, the City Human Rights Law surpasses the protections of federal and state law, as confirmed by the Restoration Act of 2005.[53] The State and City Human Rights Laws both apply to private doctors' offices, hospitals, and clinics as places of public accommodation.[54]

Although the definition of disability under each of the aforementioned laws differs slightly, generally a person with a physical, medical or mental impairment is considered a person with a disability.[55] These laws also protect individuals from discrimination even if they are only "regarded as" having or have a "record" of a disability.[56] Finally, these laws prohibit providers from retaliating against an individual for opposing an unlawful act or practice, such as demanding a reasonable accommodation.[57]

Steps to Providing Accessible Care

While each law has unique features and requirements, generally all of the laws outlined above mandate health care accessibility for New Yorkers with disabilities in similar ways. First and foremost, such laws prohibit medical providers from the outright exclusion of – or the provision of separate and unequal benefits to – people with disabilities.[58] In addition, medical providers must take action to ensure full and equal access to medical care for people with disabilities in the following three general ways: (1) by removing physical barriers; (2) by providing "auxiliary aids and services"; and (3) by making reasonable changes to policies and procedures.

First, both public and private medical providers must remove physical barriers that limit access to medical care for people with disabilities unless such a requirement would fundamentally change the nature of the program or would result in an undue financial or administrative burden.[59] For example, medical providers are required to remove architectural barriers such as steps, narrow doorways or inaccessible toilets.[60] Providers are also responsible for providing accessible medical equipment, such as exam tables that raise and lower, accessible weight scales, and accessible mammography machines.[61] Medical providers are required to alter exam rooms and waiting rooms as necessary to ensure people with mobility impairments have access to these areas.[62] Medical facilities also bear the responsibility of transferring patients to equipment when they are otherwise unable to do so independently; they must not rely on the patient's family member, friend or aide to assist.[63] Providers must train staff – immediately and on an ongoing basis – on the proper transfer techniques, as necessary.[64] Beyond transfer training, providers must train staff to identify and locate "which examination and procedure rooms are accessible and where portable accessible equipment is stored."[65]

Second, in addition to removing barriers, health providers are required to offer "auxiliary aids and services," to individuals who are deaf, blind or have low vision.[66] Auxiliary aids and services can be broadly described as aids or services that help to ensure effective communication is taking place.[67] Such aids and services include qualified sign language interpreters (on-site or through video remote interpreting), the exchange of written notes, assistive listening devices, and information provided in large print or Braille.[68] Medical providers must produce such aids and services unless it would create an undue administrative or financial burden or would fundamentally change the nature of the program or service being provided.[69] Although the language differs slightly, both Title II and III of the ADA obligate medical providers to ensure that they maintain "effective communication" with individuals with disabilities, which may include the provision of auxiliary aids and services.[70] The responsibility to provide the auxiliary aids and services rests with the medical provider, and a hospital or doctor's office "shall not require an individual with a disability to bring another individual to interpret for him or her."[71] In addition, when a medical facility provides an accommodation, such as a sign language interpreter, it cannot ask the individual with the disability to bear the cost.[72]

Third, medical providers must make reasonable modifications to policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability and would not result in an undue financial or administrative burden or fundamentally change the nature of the service or program.[73] For example, a clinic that does not normally allow animals within the facility may need to provide an exception to this policy in order to allow patients to attend appointments with their service animals.[74] Additionally, hospitals, clinics and private practitioners are required to train their medical and non-medical staff on disability competence in order to ensure that patients with disabilities are offered necessary accommodations.[75] For example, staff must take extra time to explain a procedure or course of treatment to a person with an intellectual disability, or to help position a patient with cerebral palsy who experiences spasticity or tremors during a physical examination.[76]

"The provisions of this title shall be construed liberally for the accomplishment of the uniquely broad and remedial purposes thereof, regardless of whether federal or New York State civil and human rights laws, including those laws with provisions comparably-worded to provisions of this title, have been so construed."

– Admin. Code of the City of New York § 8-130

The Costs of Inaccessible Health Care

Compliance with the aforementioned disability anti-discrimination laws benefits medical providers and patients alike. Not only does the provision of accessible health care greatly reduce the likelihood of successful lawsuits against providers for civil rights violations, but it also ensures a safe environment for patients and employees and reduces injury-related costs. Further, medical providers can take advantage of tax incentives for making services and facilities accessible to people with disabilities. Finally, the costs to the healthcare system are reduced when patients have equal access to care.

Increased Liability Exposure

Medical providers who comply with federal, state, and local disability laws can greatly reduce their risk of liability. Conversely, facility and program inaccessibility can subject health care providers to costly litigation, including lawsuits grounded in civil rights and/or torts claims.

Health care accessibility violations, as outlined above in the Common Barriers section, are generally actionable through lawsuits in court and administrative complaints with enforcement agencies.[78] For example, medical providers who have wrongly refused to provide accessible medical equipment, or transfer patients with disabilities who cannot independently use medical equipment, have been found to be in violation of the law.[79] Similarly, doctors who refuse to provide a sign language interpreter to a deaf patient may violate the law for failing to establish effective communication with such patient.[80] Providers who refuse to allow patients with disabilities to bring their service animals into their office also violate the law.[81]

These failures to provide accessible services can also lead to inadequate care, misdiagnosis, improper treatment, and/or injury to the patient. Patients may recover compensatory damages for the physical harm they suffer as a result of these violations.[82] Even in the absence of physical harm, patients with disabilities who are subjected to inaccessible care in violation of civil rights laws can recover compensatory damages for emotional or financial harm.[83] Injunctive relief, such as mandating that the provider make changes to policies and procedures or provide reasonable accommodations at facilities, is another common remedy secured through lawsuits and administrative complaints.[84] Plaintiffs who prevail in lawsuits may be entitled to attorney's fees and costs under relevant federal, state and city laws.[85] Finally, in some cases, judges may impose civil penalties to vindicate the public interest.[86]

"Patients with special needs – and their advocates – are gaining traction in obtaining accommodations to reduce their risks of substandard care... [s]ubstandard preparation puts patients at risk of harm and providers at risk of potentially indefensible allegations of negligence. Practitioners and facilities primed and equipped for special needs patients are more likely to avoid the most egregious and damaging errors (and lawsuits)."

– Pamphlet on Patient Safety, Academic Group, A Medical Malpractice Insurance Provider[77]

Increased Incidence of Patient & Worker Injury

Beyond limiting exposure to liability, facilities can protect the health of patients and workers, as well as reduce costs, by providing a combination of universally accessible equipment, lift and transfer equipment, and staff training on safe transfer techniques for patients with mobility impairments.

First, patient safety is enhanced by a combination of accessible equipment, proper lifting/transferring techniques, and mechanical lifts and repositioning devices. As discussed in the Legal Framework Section, medical providers should use universally accessible equipment whenever possible, but when equipment cannot be used independently by a person with a disability, it is the responsibility of the medical provider to provide assistance. When such assistance involves transfers, providers can ensure patient safety by implementing safe patient handling techniques, which incorporate lift and transfer equipment and training, as opposed to solely manual lifting techniques that are proven to be unsafe.[87] Manual lifting methods hurt patients, who "both physically and mentally feel the impact of a lift."[88] As detailed in a report on safe patient handling, transfer technology that assists nurses and technicians can help prevent major injuries to patients, such as falls.[89] Safe patient handling also "lessens patient anxiety and enhances patient dignity and autonomy" while simultaneously reducing "the potential for patient injury (e.g., skin tears, joint dislocations, falls)."[90]

"[T]raining staff to properly assist with transfers and lifts, and to use positioning aids correctly will minimize the chance of injury for both patients and staff."

–Department of Justice Guidance, Access To Medical Care For Individuals With Mobility Disabilities

In addition to protecting patient safety, health care facilities that provide accessible services not only protect their workers, but also expend less time and money. To begin with, the use of universally accessible equipment, such as adjustable exam tables, can "reduce the frequency and time required in using a lift team, lift equipment and/or providing transfer assistance from staff."[91] When such equipment is not available – and medical staff must assist with patient transfers – providers can reduce worker injuries by using the aforementioned safe patient handling methods and patient lift technology.[92] Finally, studies of medical providers who have invested in safe patient handling programs reveal significant cost savings due to a reduction in employee injuries, worker's compensation costs, medical/indemnity costs, and lost work days or absenteeism.[93]

Small facilities and for-profit health care entities, such as private doctor's offices, may not experience the same level of savings as hospitals that serve a large in-patient population that requires transfers on a regular basis. However, such entities are still responsible for making their services accessible to patients with limited mobility. These entities can take advantage of tax incentives for accessibility improvements to buildings and services under the "Disabled Access Credit." This credit allows small businesses – defined as those with thirty or fewer employees or total revenue of $1 million or less[94] – to apply for a tax credit of up to $5,000 or half of eligible expenses per year.[95] Eligible expenses include barrier removal, whether facility or communication based, and provision or modification of equipment.[96] Businesses of any size can also utilize a tax deduction of up to $15,000 per year for removing barriers in facilities.[97]

Increased Costs to the Healthcare System

The costs of inadequate care extend beyond calculations of healthcare facility savings and limited liability exposure; our healthcare system incurs significant costs due to unequal access for people with disabilities. When patients with disabilities receive inadequate health care, it may mean that a diagnosis is missed and the disease progresses, which can cost more to treat. For example, late diagnosis of breast cancer, which occurs at a higher rate for women with disabilities due to barriers to mammography,[98] is more costly to treat and takes more lives than when it is caught early.[99] Inaccessibility and barriers to care may also lead people with disabilities to more frequently utilize emergency departments for preventive services than the general population,[100] all at a greater cost.[101] A national survey calculated that receipt of non-urgent care in an emergency department was seven times more expensive than receipt of the same services in a health center.[102] Providing quality accessible care to people with disabilities in all health care settings would eliminate these high costs to the healthcare system.

Case Study: Accessible Cancer Screening Services for Women with Disabilities

Barriers to health care disproportionately affect women with disabilities. While they appear everywhere, including routine exams and procedures, when such barriers prevent proper screening for cancer, the consequences can be deadly.[103] We must eliminate this insidious inequality to protect the nearly half a million women with disabilities living in New York City who should be receiving regular gynecological care, the vast majority of whom should also be receiving annual mammograms.[104]

Health disparities for women with disabilities are startling, and they can lead to delayed or missed diagnoses of breast or cervical cancers. For example, women with disabilities have the same incidence of breast cancer as women without disabilities, yet they are nearly one-third more likely to die from it.[105] When data from a national survey was analyzed for a subsection of the disability community comprising women with major mobility impairments, researchers found that these women were nearly 20% less likely to have received a mammogram in the last two years.[106] Disparities for women with mental disabilities are even starker; after adjusting for comorbid conditions, women with mental illness were more than 30% less likely to receive a mammogram[107] and only 12% of women with intellectual disabilities received timely mammograms.[108] Mortality rates for women with disabilities due to breast and cervical cancer could be significantly reduced if timely screening and treatment was made accessible for all women.[109]

"A solid body of evidence confirms disparities in care – especially cancer screening services – for women with disabilities. For example, our studies using nationally representative databases find that women with physical disabilities are significantly less likely to receive Pap tests to screen for cervical cancer; disparities in mammography screening also exist, although patterns of these differences vary by disability type. These large national surveys typically do not reveal why disparities exist, but our studies using focus groups and in-depth individual interviews provide clues. Clinicians may erroneously think that women with disabilities are sexually inactive and therefore not at risk of exposure to the human papillomavirus linked to cervical cancer. Women with physical disabilities tell me that their clinicians often do not have accessible examining tables and examine the women while they sit in their wheelchairs – hence, no Pap test! Our research finds that these disparities in care can increase mortality and morbidity and also worsen quality of life of women with disabilities."

– Lisa I. Iezzoni, MD, MSc, Director of the Mongan Institute for Health Policy at Massachusetts General Hospital & Professor of Medicine at Harvard Medical School

This section will identify the multiple obstacles women with physical disabilities face in accessing breast cancer screening and gynecological care, and reveal how those barriers have been dismantled at a handful of private and public health facilities in New York City. While these changes have focused solely on the barriers encountered by women with physical disabilities, similar changes must be made to eliminate barriers encountered by women who, for example, are deaf or hard of hearing, or have mental disabilities. Medical providers must eliminate obstacles and ensure that women with disabilities receive quality, accessible care in accordance with civil rights laws.

Improving Cancer Screening Accessibility in New York City

The vast majority of medical facilities in New York City have work to do to come into compliance with disability anti-discrimination laws. However, incremental improvement in accessibility is already underway thanks to the efforts of one New York City advocacy organization. These efforts must not remain limited to this tiny sliver of the healthcare community – all medical providers must ensure that patients receive the accessible care to which they are entitled.

"No one wants to get a mammogram. But if you're going to be treated like you're a problem because of your disability, it's even more of a hassle and no one is going to want to go."

— Marilyn E. Saviola, Vice President of Advocacy and the Women's Health Access Program, Independence Care System

Independence Care System (ICS) operates a nonprofit Medicaid managed long-term care plan specifically designed for adults with physical disabilities and chronic illnesses. The majority of ICS's members are women, and they are all recipients of Medicaid. In response to concerns expressed by its members about their negative experiences seeking health care over the years – they had no fully accessible location at which they could receive breast and gynecological care – ICS decided to take action. In 2008, with the support of the Greater New York City Affiliate of the Susan G. Komen for the Cure®, ICS began developing and implementing its Breast Cancer Screening Project for Women with Physical Disabilities.[110] Recently, with additional foundation funding, ICS expanded its efforts into the realm of gynecological care through its Women's Health Access Program.

In the first year, ICS identified two provider sites with which to partner: New York Presbyterian Hospital-Columbia University Medical Center, a provider site of the Columbia University Breast Cancer Screening Partnership Program, and the Breast Examination Center of Harlem, a program of Memorial Sloan Kettering Cancer Center. Beginning in the fourth year of the project, ICS expanded its advocacy to include gynecological care, as well as breast cancer screening, at two additional facilities: the Morrisania Diagnostic and Treatment Center in the Bronx, a clinic affiliated with Lincoln Medical Center, and Woodhull Medical Center in Brooklyn, at which ICS plans to fully operationalize a program in the coming year. The two most recent partnerships are particularly significant given that they are with Health and Hospitals Corporation facilities (i.e. public hospitals), where most ICS members, as well as underserved New Yorkers, receive their care. Through its two projects, ICS has helped secure more than 200 accessible breast and gynecological cancer screenings for its female members with disabilities.

ICS's projects reveal how a commitment to accessibility from health care institutions can lead to the successful elimination of barriers encountered by women with disabilities. In conducting these projects, ICS identified three major areas in which providers had to make changes to ensure accessibility. The first step was for facilities to identify and eliminate physical barriers to care. The second step was for partner facilities to conduct, with ICS's assistance, disability awareness and sensitivity training for doctors, nurses and staff. Finally, partner facilities altered the coordination and intake process for patients with disabilities to reduce inefficiencies and increase comfort. Each of these steps was critical to ensuring that women with mobility impairments had a positive experience and received comprehensive cancer screening. The fundamental tenets of these projects demand replication by other New York City healthcare facilities.

Remedying Physical Barriers & Inaccessible Equipment

Through both its breast and gynecological screening projects, ICS found a wide array of physical and/or structural barriers in partner locations. Notably, solutions were often readily available and did not incur great cost. As part of the projects, ICS met with clinical and executive staff at each facility to discuss the most prevalent barriers, including those identified by ICS members through surveys, and together made a plan to improve the facility's physical space, procedures and practices to ensure accessibility.

Mammography Project

Equipment barriers were commonplace at the breast cancer screening project partner facilities. For example, mammography machines were often inaccessible for ICS members with mobility impairments who could not stand or hold their arms high enough. Other ICS members experienced uncontrollable movements and could not keep their arms steady in the required position, which made it difficult to successfully complete a mammogram. Although the ideal solution would be universally designed mammography equipment,[111] simple interim solutions helped address these barriers; positioning aides, such as Velcro straps, were used to support the women's arms during the test and additional technologists assisted as necessary to help with positioning.[112] ICS's Nurse Educator accompanied the project participants to their appointments and shared helpful techniques with the technologist regarding positioning and wheelchair placement. She also instructed the technologist on what other assistance was necessary to allow for an accurate and comfortable mammogram, such as using a lumbar pillow for back support. Women who visit the partner facilities are now able to stay in their wheelchair or, in the case of one partner facility, to transfer to an adjustable mammography chair, depending on what is most comfortable and can provide the best screening image.

Design and structural barriers also contributed to concerns about ICS members' ability to fully access care. In one facility the design of the mammography suite presented a major problem; the room had a console in the middle of the floor that obstructed the path to the mammography machine for women in power wheelchairs and scooters. In response, the facility reconfigured the area, moving the console to the edge of the room. This fix allowed for additional space and ensured that women in wheelchairs were no longer denied access to mammograms.

"I have cerebral palsy. [At other places,] sometimes they used a q-tip to examine me because of my spasticity. I was worried about the actual reading, and whether they could really check for cancer cells because they just swabbed the surface, and didn't swab my cervix. I don't know if it was because I couldn't relax enough – I felt like I was going to fall off the table."

– M. Lyons, Member,
Independence Care System

Gynecological Project

Physical barriers were similarly present in partner gynecological care facilities. Equipment, such as examination tables and weight scales, initially were not fully accessible to ICS members who participated in the project. This discovery was consistent with experiences the women had previously had at other facilities. The majority of ICS members who participated in the project had never had an accessible table available to them; the primary reason cited for not having previously received a gynecological exam was that the examination table was too narrow, high, and/or flat.[113] ICS members reported previously having not received full examinations or procedures.[114]

In response to these barriers, Morrisania obtained an accessible weight scale and Hoyer lift for its exam room, as well as purchased and installed accessible features for its height adjustable exam table. Such features comprised adjustable stirrups, leg supports, a movable headrest, and side rails. The modified tables, in particular, completely changed the experience for the ICS members. One ICS member explained that after years of visiting the doctor, her visit to Morrisania was her first fully accessible gynecological experience.[115]

Educating Staff to Address Provider Misconceptions & Ignorance

Provider bias and inadequate counseling prevents women with disabilities from seeking and receiving comprehensive cancer screening.[116] Both ICS projects revealed gaps in knowledge and counseling for members that required sensitivity and cultural competency training to address.

In addition to misconceptions about mammograms, facility inaccessibility and the failure of providers to properly counsel women with disabilities contributed to ICS members' reluctance to get screened. ICS members were often completely unaware that they needed to get a mammogram because their provider had previously failed to recommend it to them or told them they could not receive one since they were in a wheelchair.[117] ICS members were also unable to find an accessible and welcoming location where they could receive the screening.[118] ICS reported that their members were reluctant to get mammograms because they "believe that having one significant medical condition precludes their having another; fear that because of their disabilities they will be unable to endure the exam; or feel overburdened by multiple medical appointments."[119] The inconvenience of mammograms is compounded by the disability-related barriers that women face every day, such as a lack of transportation or the need to coordinate home care services. These additional barriers make it even more critical that providers emphasize the importance of breast cancer screening to women with disabilities. To address this gap in knowledge, ICS organized workshops and instituted a one-to-one outreach program where staff called hundreds of women to educate them on the importance of mammograms and early detection.[120] Once the women heard about ICS's breast cancer screening project, many were relieved that they could actually receive the testing they needed in a facility that was accessible to them.[121]

"[When I went to the gynecologist through the ICS program] it was the first time anyone had ever asked me, 'Would you like to have a child?' I am 37 years old and no one has ever asked me anything like that."

– Kim Yancy, Member, Independence Care System

ICS members had also received inadequate gynecological care because of provider bias. For example, several ICS members reported not being asked by their gynecologist whether they were sexually active.[122] Woman who participated in the gynecological project also reported that their previous physician was insensitive to their needs. The majority of ICS members surveyed who received a pelvic exam and Pap smear before joining the project reported that they did not go back because it was too traumatic.[123] ICS members experienced trauma from the extreme difficulty encountered in trying to get on the exam table, not being able to fit their legs into non-adjustable stirrups, and being made to feel as though they were the problem.[124] One woman reported that her previous gynecologist had threatened to leave if she did not stop the uncontrollable leg spasms she experienced due to her disability.[125] The majority of members reported that their gynecologist had never explained the reason for the test, how it would be performed, or when they could get the results.[126]

To address the barriers identified in both the breast and gynecological care projects, ICS implemented a Disability Awareness and Sensitivity Training program for all partner facility staff, including clerical, support, clinical and administrative workers. The training included elements of cultural competency and technical skills for working with women with disabilities. In particular, the training emphasized the creation of a patient-centered environment through sensitivity to the woman's needs and a consciousness of how provider misconceptions may interfere. For example, in the context of gynecological care, doctors and other staff were instructed not to assume a woman with a disability does not want to have children, to listen to the woman's suggestions for the best positioning, and to thoroughly explain all procedures before performing them. The gynecologist at Morrisania incorporated this knowledge into her practice and ICS members note that when this gynecologist sees them, they feel they are finally being respected fully as women, as human beings, in a way that many providers have previously failed to do.[127] This kind of training must be replicated in other healthcare facilities to ensure that providers are providing culturally competent care to their patients with disabilities.

"My first time in the ICS program, everything was in one room so I didn't have to undress and come in through the back door. I usually have a real hard time with spasticity, but the chair lift worked and I was able to get on the chair pretty much by myself. That the table actually came down to me – that made a huge difference. She did the examination the way it should be done. I'm 49 years old and that was the first time I had a totally accessible experience."

– M. Lyons, Member, Independence Care System

Creating Procedures to Increase Efficiency & Accessibility

The final area addressed at partner facilities through the ICS projects was altering how the facilities scheduled appointments and conducted patient intake. Prior to these adjustments, ICS members had encountered numerous problems with insufficient reasonable accommodations and inefficiency when seeking health care at facilities.

ICS encouraged each partner facility to add a functional assessment section to the intake forms with a series of simple questions, such as whether the woman could transfer or raise her arms, to evaluate what accommodations may be necessary.[128] This form was filled out and sent to the facility in advance of the appointment to allow the facility staff to plan accordingly for the appointment. For example, the staff could ensure that an extra technologist was available, or additional time was scheduled, as necessary. The form remained in the patient's chart so the facility and physician could reference it in the future, as opposed to repeatedly asking the patient to rehash her needs every time she visited. Making procedural accommodations of this sort also prevented women with disabilities from experiencing extensive delays which could cause them to miss their transportation, and take them hours to reschedule.[129] These accommodations also meant that ICS members did not have to worry that their home care worker would go off duty and be unable to accompany them home, or that they would be forced to pay for the additional time.

Another simple, yet helpful, procedural change implemented through the ICS program was to ensure that patients could receive as many elements of care as possible in the same location. For example, when relevant, the facilities took the patient's vitals and weight in the same room in which they were being seen for the mammogram or gynecological screening. Of particular importance, the facilities made changes so that women who used mobility aides were able to change into the patient gown in the mammography suite for breast exams, or the exam room for gynecological visits. This adjustment allowed for smoother transitions and afforded ICS members more privacy; previously the women had to change in one location and move to another using their mobility aid, while trying with great difficulty to keep themselves covered. With this very minor adjustment, women with disabilities experienced a much more comfortable and private visit. For mammograms, this procedural adjustment also reduced the time needed for an exam.[130]

The vast majority of barriers that ICS members identified were successfully addressed by partner providers; however, some providers expressed an unwillingness to implement recommended changes out of misplaced concerns about liability. For example, one provider was reluctant to use positioning aids, specifically Velcro straps, for fear that institutional policies on restraints prohibited the use of such devices.[131] These liability concerns were unsubstantiated. Laws and regulations prohibiting the improper use of restraints, which were passed in response to patient abuse and neglect in mostly in-patient settings, do not apply to positioning aids used for routine medical screenings and diagnostic tests in outpatient settings.[132] In fact, most statutory and regulatory definitions of restraint explicitly exclude the use of assistive devices.[133]

Clearly, not only do medical providers need to commit to making their services accessible, but they could also benefit from additional guidance and oversight from various entities to ensure that their practices comply with the law.

"Where can other women with disabilities [who are not ICS members] go to get these mammograms and pap smears done and be comfortable? There's a lot of people out there who don't get a mammogram or a pap smear..."

– Esther J., Member, Independence Care System

Next Steps for Accessibility Across New York City

Five and a half months into its Breast Cancer Screening Project, ICS was still struggling to find a medical provider that was willing to partner with them. Facilities displayed "reluctance, resistance, discrimination, and outright hostility" when ICS approached them about collaborating to provide accessible services.[131] These responses demonstrate a profound disrespect and lack of understanding of medical providers' legal, ethical, and moral obligations to care for women with disabilities. Sadly, this is the rule rather than the exception in health care facilities across New York City.

New York City has a long road ahead to ensure that all of its healthcare facilities provide accessible care to people with disabilities. Barriers and biases that block men and women with all types of disabilities from obtaining accessible care, must be eliminated in health care settings of all sizes and types. But the accomplishment of ICS's projects – the long overdue accessible care for its members – begs for replication. Medical providers and policymakers have a legal and moral obligation to ensure that New Yorkers are not subjected to inferior care on account of their disability.

"Solutions will require multiple approaches, including ensuring that facilities and equipment are fully accessible to women with diverse disabilities and that clinicians are trained in "disability competency." Trainers in disability awareness could learn volumes from programs such as Independence Care System, with its multifaceted care model that ensures women with disabilities receive the services they desire and need to maximize their health and quality of life."

– Lisa I. Iezzoni, MD, MSc, Director of the Mongan Institute for Health Policy at Massachusetts General Hospital & Professor of Medicine at Harvard Medical School

Recommendations to Providers & Policymakers

People with disabilities encounter a multitude of obstacles to comprehensive, quality health care in facilities of all sizes in New York City. These barriers include architectural and communication barriers, inaccessible equipment, and provider bias. The effects of these obstacles to care are profound; inaccessible health care negatively impacts nearly every aspect of an individual's life, and leads to significant disparities.

New York City hospitals and clinics have an opportunity to take the lead nationwide in providing accessible health care, in compliance with applicable law, to their patients with disabilities. Public and private medical providers, city and state lawmakers, and state agencies all have key roles to play in ending healthcare disparities for people with disabilities. We recommend the following actions be taken immediately:

New York City Medical Provider Recommendations

Medical providers must develop and implement a comprehensive plan for providing accessible care to people with disabilities. The plan should include:

- **The creation and dissemination of a system-wide non-discrimination policy, with accompanying protocols and procedures.** Facilities must come into compliance with disability anti-discrimination laws by providing patients with disabilities with equal access to care. Facility and system administrators must create and implement a policy and accompanying protocols to ensure compliance at all levels. Facilities must also designate a point person to coordinate and ensure the implementation of such policies and protocols. Such protocols must include a grievance procedure for patients with disabilities who are denied accessible care.
- **The development and implementation of mandatory, system-wide disability competency provider trainings.** Facilities must develop a mandatory system-wide training, or series of trainings, in consultation with experts in disability competency. Such training/s must cover the following core concepts: disability awareness and sensitivity; overarching legal obligations to provide accommodations; protocols for positioning and transferring patients with disabilities; the requirement to provide additional staff as needed for certain procedures and tests; and the requirement to fully treat and counsel patients with disabilities, including about basic health information such as when and how to obtain preventative screenings.

"Some of our members have trouble breathing when they have to lay completely flat. They just can't breathe like that. So it is traumatic when they are on a regular table. The table at Morrisania, has a head rest that raises so they can breathe and relax. It is a relief for them that they can finally breathe at a doctor's office. The table also has side rails so women do not feel like they are going to fall off. All of these things make it possible to do the test. The table is one of the most important things."

— Jane Nietes, Nurse Educator, Independence Care System

- **The acquisition of accessible equipment and removal of communication and architectural barriers.** Providers must purchase accessible equipment, including mammography machines, weight scales, examination tables, and Hoyer lifts. Providers must also remove existing barriers, such as by widening doors and installing grab bars, and providing sign language interpreters and materials in alternative print. Finally, providers must utilize positioning aids and supports to assist women with disabilities as needed to facilitate screenings and procedures.
- **Coordinate care and maintain good data and records.** Providers must ensure that the process of scheduling appointments, requesting and providing accommodations runs smoothly for patients with disabilities. Such process shall include a functional assessment prior to the appointment, which would then be stored in the patient's file and referenced prior to each appointment.

"The provision of culturally competent care is required by current laws, regulations and accreditation agencies' standards. At HHC, we ascribe to the belief that the provision of culturally competent care:

•Is an essential component of HHC's mission, vision and values;

•Leads to improvements in quality and patient safety;

•Is necessary to accommodate changing patient and neighborhood demographics;

•Reduces health disparities; and most importantly,

•Is the right thing to do."

– New York City Health and Hospitals Corporation
Comments before New York City Council Committees on Health and Civil Rights
Delivered by Caroline M. Jacobs, Senior Vice President, Safety and Human Development

New York City Health & Hospitals Corporation (HHC) Recommendations

In addition to the aforementioned recommendations that pertain to medical providers, HHC should:

- **Convene a task force to develop detailed guidance on ensuring accessibility in healthcare facilities in compliance with existing law.** HHC should assemble a task force to develop technical assistance to guide facilities on how to ensure their programs and services are accessible. The task force should include a representative from each facility, experts, stakeholders, and people with disabilities who can advise on effective policy and training, accessible equipment procurement, architectural modifications, accessible communication, and disability specific medical protocols (e.g. follow-up after mammograms that produce limited views due to inaccessibility of screening). The task force should issue reports, guidance, and recommendations to help facilities comply with disability rights laws in a consistent manner. Each facility's representative should ensure implementation of the guidance issued by the taskforce. Quarterly, the facility coordinators should meet to review best practices, implementation, and discuss innovative approaches to making their facilities accessible. Stakeholders, including people with disabilities and the public at large, should also be invited to participate in the quarterly meetings to provide their feedback and suggestions.
- **Develop and disseminate a patient and provider survey regarding the accessibility of HHC facilities and services.** The survey should assess the knowledge of providers about their obligations under the ADA and state and city anti-discrimination laws. Providers should be asked about all types of accommodations and how they provide care to people with disabilities. Patients should also be surveyed to understand whether they are receiving the care they need. HHC should use this data to target, through trainings, the gaps in knowledge that staff may display, as well as to inform facilities about ways in which they must make services accessible.

New York City Council Recommendations

- **Pass a comprehensive resolution urging New York City hospitals and medical providers to comply with existing federal, state, and local disability anti-discrimination laws.** The City Council is uniquely situated to communicate the importance of providing accessible health care to all New York City residents, including individuals with disabilities. The City Council should pass a resolution which:
  - o *Directs New York City medical providers to, at a minimum:*
    - Comply with existing federal, state, and city laws regarding people with disabilities, as well as relevant regulations and guidance as issued
    - Develop a guiding non-discrimination policy, designate a point person to coordinate its implementation, and create protocols and procedures staff must follow to ensure facility accessibility
    - Eliminate existing communication, attitudinal, and physical barriers to care, alter physical space as necessary, and purchase accessible equipment
    - Provide mandatory disability competency, awareness, and sensitivity training
    - Notify patients with disabilities of their rights under disability anti-discrimination laws and how to file a complaint
  - o *Directs the New York City Health and Hospitals Corporation to, at a minimum, in addition to the aforementioned reccomendations:*
    - Convene a task force to develop detailed guidance for health care facilities on how to make services accessible in compliance with existing law
  - o *Urges the New York State Department of Health to, at a minimum:*
    - Issue and enforce detailed guidance to healthcare facilities as to their legal obligations regarding making programs and facilities accessible to people with disabilities
    - Create a robust and accessible complaint process with defined follow-up procedures
    - Amend facility requirements on training and intake to include disability
  - o *Urges the New York State legislature to, at a minimum:*
    - Pass legislation requiring that medical facilities procure accessible medical equipment in compliance with anti-discrimination laws and regulations
    - Issue notice requirements for all healthcare facilities to notify patients of their right to accommodations and accessible care

"I would hope that the doctor would see me as a person, but I think they just see the wheelchair. They don't see us as people because they think it will take more time. But with [the ICS Project gynecologist], I automatically felt more comfortable. I felt like she actually saw me as a woman coming for an appointment to be healthy."

– M. Lyons, Member, Independence Care System

- **Include funding in the budget, with terms and conditions, to assist capital improvements at HHC facilities that are designed to increase accessibility for people with disabilities.** At a minimum, HHC facilities should procure Hoyer lifts and, accessible mammography machines, exam tables, and weight scales. As a "term and condition" of HHC funding, the City Council should require that HHC procure all goods in compliance with anti-discrimination laws.
- **City Council should convene annual oversight hearings on the accessibility of medical services and the needs of people with disabilities.** Annual hearings on this issue should be used to assess HHC's progress toward making facilities accessible and whether private providers are serving individuals with disabilities equally. Facilities should be asked to provide information regarding staff training, procurement policies, compliance with the ADA, and the services provided to people with disabilities.

"People jokingly tell me that they would gladly keep the weight from their youthful pasts. Exact weight, however, can matter. A woman whom I interviewed for a research project on women with physical disabilities who develop breast cancer has used a wheelchair since a spinal cord injury in her late teens. Twenty-five years later with breast cancer, her oncologist needed to know her weight to set her chemotherapy dose; however, the academic medical center where she received care did not have an accessible scale. To find her weight, her oncologist scooped her up from her wheelchair and stepped onto a scale holding her in his arms."

—Lisa I. Iezzoni, MD, MSc, Director of the Mongan Institute for Health Policy at Massachusetts General Hospital & Professor of Medicine at Harvard Medical School

"ICS's GYN project was the first time I've been accurately weighed."

—M. Lyons, Member, Independence Care System

New York State Department of Health Recommendations

- **Issue a detailed administrative directive to all medical facilities regarding their obligation to provide accessible services to people with disabilities, and ensure facility compliance with said directive and disability anti-discrimination laws.** DOH should issue a detailed directive to medical facilities operating in NYS instructing them on how to come into compliance with disability anti-discrimination laws by making facilities physically accessible, providing reasonable accommodations, and training staff on disability competency and techniques for providing assistance to patients with disabilities. The directive should also include clarification that positioning and support aids are not considered "restraints" when used to position patients with disabilities during routine exams or procedures. The directive should instruct providers to follow the DOJ and Access Board's regulations and guidance regarding access to medical care for people with disabilities as issued. DOH should use its authority to ensure compliance with anti-discrimination laws and the specific components of this directive.
- **Create a robust and accessible complaint process with defined follow-up procedures.** DOH should create and implement an accessible complaint process that includes a clearly defined follow-up procedure, including investigation of non-compliant facilities. Complaints received through such process should be reviewed when making decisions regarding

"Being weighed has always been an issue. They say, 'let's do it approximately.' Before they prescribe medication they should know my weight, but sometimes they'll say 'let's try this dose and you can come back to change it if we need to.' Sometimes they'll just ask how long ago I was weighed and how much, and just write that down instead of weighing me. I'm not sure if it's because they don't have the right equipment, or because they don't want to be bothered. When you're a disabled person and you go to get care, it will take more time. But we live in a society where everything has to be done quickly. Unfortunately, it's going to take an extra minute for people with disabilities."

– M. Lyons, Member, Independence Care System

the selection of facilities for compliance review. Information about the complaint process, including how and where to file a complaint and the process for investigation, should be conspicuously posted on the DOH's website and on materials distributed to patients.

• **Amend facility requirements on training and intake to include disability.** DOH should amend existing requirements for intake processes at in- and out-patient facilities to include a disability accommodations needs assessment. This assessment should give the patient an opportunity to identify and request reasonable accommodations so the facility can take steps to make care accessible (i.e. if patient identifies that she cannot hold her hands above her head, facility will note that positioning aides or extra technologist must be available for exam). DOH should also amend facility quality assurance training requirements to include mandatory ongoing disability competency training for all staff. DOH should exercise its authority to the fullest extent possible to ensure that medical providers practicing in NYS are properly trained on how to provide equal care to people with disabilities. As mentioned in the "Medical Providers Recommendations," such training/s, which should be developed by the facility, must cover several concepts that are fundamental to providing accessible care.

<u>New York State Legislature Recommendations</u>

• **Pass legislation that requires all meical facilities to provide notice to patients of their rights to accessible care.** Medical facilities must be required to clearly post throughout facilities, and make available in accessible formats, notices regarding the availability of – and process by which to request – disability accommodations. This notice should be conspicuously posted on each healthcare facility's website, in e-mail notifications to patients, and in brochures and other patient materials.

• **Pass legislation requiring procurement of accessible medical equipment by healthcare facilities.** The legislature should pass legislation requiring that all medical equipment procured by healthcare facilities and clinics comply with anti-discrimination laws and regulations, and that all newly purchased equipment follow principles of universal design and be accessible to people with disabilities.

"It's important because my mother had breast cancer and if I don't get that mammogram I could get cancer and not know it. If I get the mammogram maybe I could catch it in time. I like to have my mammogram every year."

– Esther J., Member,
Independence Care System

Endnotes

[1] *See, e.g.*, NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES (2009), http://www.ncd.gov/rawmedia_repository/0d7c848f_3d97_43b3_bea5_36e1d97f973d?document.pdf; *see also*, JUDY PANKO REIS ET AL., IT TAKES MORE THAN RAMPS TO SOLVE THE CRISIS OF HEALTHCARE FOR PEOPLE WITH DISABILITIES 7 (2004), www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf.

[2] *See, e.g.*, M. A. Nosek and C. A. Howland, *Breast and Cervical Cancer Screening Among Women with Physical Disabilities*, 78 ARCHIVES OF PHYSICAL MED. & REHABILITATION S39 (1997).

[3] *See, e.g.*, Ellen P. McCarthy et al., *Disparities in Breast Cancer Treatment and Survival for Women with Disabilities*, 145(9) ANNALS OF INTERNAL MED. 637 (2006).

[4] REIS ET AL., *supra* note 1, at xiii ("If the age-specific prevalence of major chronic conditions remains unchanged, the absolute number of Americans with functional limitations will rise by more than 300 percent by 2049.").

[5] In New York City, only 4% of children between 5 and 17 years old have a disability, while well over a third of the population over 65 years old have a disability. U.S. CENSUS BUREAU, 2011 AM. CMTY. SURVEY, DISABILITY CHARACTERISTICS NEW YORK CITY, NEW YORK, tbl.S1810 (2011).

[6] N.Y.C. DEP'T OF CITY PLANNING, NEW YORK CITY POPULATION PROJECTIONS BY AGE/SEX & BOROUGH, 2000-2030 (2006).

[7] U.S. CENSUS BUREAU, *supra* note 5, at tbl.S1810.

[8] *Id.* at tbl.B18135.

[9] *Id.* at tbl.B18130.

[10] *Id.* at tbl.B1811.

[11] *Id.* at tbl.B18130.

[12] Independence Care System, 2011 Community Breast Health Grantee: Final Report 2 (Apr. 30, 2012) (unpublished grant report) (on file with Independence Care System) [hereinafter Independence Care System, Final Report].

[13] AM. MED. ASS'N, CODE OF MEDICAL ETHICS [hereinafter CODE OF MEDICAL ETHICS], *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page (last visited Oct. 22, 2012).

[14] M.T. Neri & T. Kroll, *Understanding the consequences of access barriers to health care: experiences of adults with disabilities*, 25 DISABILITY & REHAB. 85, 94 (2003).

[15] In addition to complaints received through its intake line, NYLPI has heard stories of inaccessible care from individuals with disabilities during education and outreach events. ICS has received complaints from its members through group discussions, education and outreach events, and from the participants in the Women's Health Access Program.

[16] *See* Catherine Leigh Graham & Joshua R. Mann, *Accessibility of Primary Care Physician Practice Sites in South Carolina for People with Disabilities*, 1 DISABILITY & HEALTH J. 209, 212 (2008).

[17] JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, HEALTH CARE (CLINIC / OUT-PATIENT) FACILITIES ACCESS 7, 8, 13 (2d ed. 2009), http://www.cdihp.org/briefs/4.%20Brief-Health%20Care%20(outpatient_clincs)%20Facilites%20-%20FINAL%20Edition%202_1.5.09.pdf.

[18] NYLPI has heard such complaints expressed by numerous New Yorkers, particularly when it comes to specialty care. These barriers can be further compounded by the absence of accessible providers within provider networks or HMOs.

[19] DISABILITY RIGHTS EDUC. & DEFENSE FUND, DISABILITY HEALTHCARE ACCESS BRIEF 1-2, http://www.dredf.org/healthcare/Access_Brief.pdf.

[20] *See, e.g.*, Lisa I. Iezzoni et al., *Physical Access to Barriers to Care for Diagnosis and Treatment of Breast Cancer Among Women with Mobility Impairments*, 37 ONCOLOGY NURSING FORUM 711, 714 (2010) [hereinafter Iezzoni, et al., *Physical Access to Diagnosis and Treatment of Breast Cancer*]. When accessible tables are not available in a facility, doctors may also be reluctant to suggest necessary procedures or fully examine a patient. Kristi L. Kirschner et al., *Structural Impairments That Limit Access to Health Care for Patients with Disabilities*, 297 JAMA 1121, 1121 (2007).

[21] JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, IMPORTANCE OF ACCESSIBLE WEIGHT SCALES (2004).

[22] *See, e.g.*, U.S. DEP'T OF JUSTICE, AMERICANS WITH DISABILITIES ACT: ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES 18 [hereinafter U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE], *available at* http://www.ada.gov/medcare_ta.htm (last visited Oct. 22, 2012) ("A patient's weight is essential medical information used for diagnostics and treatment. Too often, individuals who use wheelchairs are not weighed at the doctor's office or hospital, even though patients without disabilities are routinely weighed, because the provider does not have a scale that can accommodate a wheelchair.").

[23] JUNE ISAACSON KAILES, CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, REHAB. ENGINEERING RES. CTR. ON ACCESSIBLE MED. INSTRUMENTATION, 5 "G's:" GETTING ACCESS TO HEALTH CARE FOR PEOPLE WITH DISABILITIES (v.1 2008), http://www.cdihp.org/Five%20Gs%20apr21.pdf.

[24] Graham & Mann, *supra* note 16, at 212.

[25] *See* Kirschner et al., *supra* note 20, at 1122.
[26] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 23 (citing HENRY J. KAISER FAMILY FOUND., HEALTHCARE FOR PEOPLE WITH DISABILITIES (2004), http://www.kff.org/medicaid/7202.cfm).
[27] NYLPI has represented deaf clients who have encountered numerous communication barriers in all types of health care facilities, including at hospitals and rehabilitation facilities in New York City.
[28] Lisa I. Iezzoni et al., *Communicating About Health Care: Observations from Person Who Are Deaf or Hard of Hearing*, 140 ANNALS OF INTERNAL MEDICINE 356, 360 (2010).
[29] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 71 (citing Helen Margellos-Anast et al., *Cardiovascular disease knowledge among culturally Deaf patients in Chicago*, 42 PREVENTIVE MED. 235 (2006); SINAI HEALTH SYS. AND ADVOCATE HEALTH CARE, IMPROVING ACCESS TO HEALTH AND MENTAL HEALTH FOR CHICAGO'S DEAF COMMUNITY: A SURVEY OF DEAF ADULTS (2004)).
[30] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 71 (citing M.F. Goldstein, et al., *An HIV Knowledge and Attitude Survey of Deaf U.S. Adults*, 22(1) DEAF WORLDS 163 (2006)).
[31] Aging is one of the leading causes of vision loss. NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 73 (citing R.N. Bailey et al., *Visual Impairment and Eye Care Among Older Adults – Five States, 2005*, 55 MORBIDITY & MORTALITY WEEKLY REPORT 1321, 1321–26 (2006)). As the population ages, the number of people who are blind and the number of people with vision impairments living in the U.S. is projected to increase by an astonishing 70-percent between 2009 and 2020. NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 73 (citing Nat'l Eye Inst., *Causes and Prevalence of Visual Impairment Among Adults in the United States*, 122 ARCHIVES OF OPHTHALMOLOGY 477, 477-85 (2004)).
[32] *See* EQUAL RIGHTS CTR., ILL-PREPARED: HEALTH CARE'S BARRIERS FOR PEOPLE WITH DISABILITIES 3, 22 (2011) (summarizing a national study, which revealed that "[o]nly 23 percent of doctors' offices and hospitals offered patient information in large print, and only 24 percent offered patient information in an accessible format").
[33] The doubled rates of dissatisfaction with the quality of health care received were 8.1-percent versus 4-percent, and inadequate information provided about their health conditions were 11-percent versus 6-percent. Bonnie L. O'Day et al., *Improving Health Care Experiences of Persons Who Are Blind or Have Low Vision: Suggestions from Focus Groups*, 19 AM. J. OF MED. QUALITY 193, 194 (2004).
[34] NYLPI has heard such concerns expressed by New Yorkers with disabilities through its intake line and at outreach and education events.
[35] *See, e.g.*, Settlement Agreement Under the Americans with Disabilities Act Between the United States of America and Dr. Bruce Berenson, M.D., P.A. for Complaint USAO No: 2011-VO-0468/DJ No. 202-18-267, Aug. 1, 2012 [hereinafter "Berenson Settlement"], *available at* http://www.ada.gov/berenson_settle.htm (last visited Oct. 22, 2012) (addressing a complaint against a medical office for refusing to allow a patient with a disability to bring his service animal into the office).
[36] *See, e.g.*, Rolanda L. Ward et al., *Uncovering Health Care Inequalities among Adults with Intellectual and Developmental Disabilities*, 35(4) HEALTH & SOCIAL WORK 280, 286 (2010).
[37] *See* Ward et al., *supra* note 36, at 285–87.
[38] Oliver Lord et al., *Receipt of preventive medical care and medical screening for patients with mental illness: a comparative analysis*, 32 GEN. HOSP. PSYCHIATRY 519, 539 (2010).
[39] Graham Thornicroft, *Physical health disparities and mental illness: the scandal of premature mortality*, 199 BRIT. J. OF PSYCHIATRY 441, 441 (2011).
[40] *Opinion 10.01 - Fundamental Elements of the Patient-Physician Relationship*, AM. MED. ASS'N, *available at* http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion1001.page (last visited Oct. 22, 2012).
[41] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 49.
[42] Silvia Yee, Staff Attorney, Disability Rights Education and Defense Fund, Disability Discrimination in Health Care, Presented at the Jacobus tenBroek Disability Law Symposium (April 2012), at 4, http://dredf.org/healthcare/tenBroek-4-20-12.pdf.
[43] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 48 (citing Gloria L. Krahn & Charles E. Drumm, *Translating Policy Principles into Practice to Improve Health Care Access for Adults with Intellectual Disabilities: A Research Review of the Past Decade*, 13 MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES RES. REVIEWS 160–68 (2007)).
[44] T.J Larsen et al., *Effective Communication with Deaf Patients and Awareness of the Americans with Disabilities Act Among Emergency Personnel: A National Study*, 34 ANNALS OF EMERGENCY MED. S24, S24 (1999).
[45] Michelle A. Larson McNeal et al., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, PROVIDING PRIMARY HEALTH CARE FOR PEOPLE WITH PHYSICAL DISABILITIES: A SURVEY OF CALIFORNIA PHYSICIANS 8 (2002), http://www.cdihp.org/pdf/ProvPrimeCare.pdf.
[46] *Id.* at 11.
[47] *Id.*
[48] CODE OF MEDICAL ETHICS, *supra* note 13.

[49] 29 U.S.C. § 794(b)(3)(A)(ii) defines "program or activity" as "an entire corporation, partnership or other private organization, or an entire sole proprietorship, which is principally engaged in the business of providing . . . health care . . . ." *See also,* 45 C.F.R. Pt. 84, App. A, subpart a.2.

[50] *See* 42 U.S.C. § 12131(1)(A).

[51] *See* 42 U.S.C. § 12181(7) (listing entities that constitute "public accommodations"); 28 C.F.R § 36.104 (defining "place of public accommodation" and listing examples).

[52] *See Rodal v. Anesthesia Grp. of Onondaga, P.C.*, 369 F.3d 113, n.1 (2d Cir. 2004) ("New York State disability discrimination claims are governed by the same legal standards as federal ADA claims.").

[53] "Interpretations of New York state or federal statues with similar wording may be used to aid in interpretation of New York City Human Rights Law, viewing similarly worded provisions of federal and state civil rights laws as a floor below which the City's Human Rights law cannot fall, rather than a ceiling above which the local law cannot rise." N.Y.C. Local Law 85, § 1 (Oct. 3, 2005).

[54] N.Y. EXEC. LAW § 292(9) (explicitly naming clinics and hospitals); Admin. Code of the City of New York § 8-102(9).

[55] *See* 42 U.S.C. § 12102 (ADA definition of "disability"); 29 U.S.C. § 705(20) (Rehab Act definition of "individual with a disability"); N.Y. EXEC. LAW § 292(21) (State Human Rights Law definition of "disability"); Admin. Code of the City of New York § 8-102(16) (City Human Rights Law definition of "disability"). The State and City Human Rights Laws define "disability" more expansively than federal laws. *See Treglia v. Town of Manlius*, 313 F.3d 713, 723 (2d Cir. 2002) ("New York and Second Circuit cases make clear that the New York disability statute defines disability more broadly than does the ADA.").

[56] 42 U.S.C. §§ 12102(1)(B)-(C), 12102(3) (ADA, including within its definition of "disability" "a record of such an impairment" and "being regarded as having such an impairment"); 29 U.S.C. § 705(20)(B) (Rehab Act, incorporating the ADA's definition of "disability"); N.Y. EXEC. LAW § 292(21) (including within its definition of "disability" "a record of such an impairment or . . . a condition regarded by others as such an impairment"); Admin. Code of the City of New York §§ 8-102(16), 8-107(4) (including within its definition of disability "a history or record of such impairment" and defining discrimination to include discrimination based on "actual or perceived" disability); 28 C.F.R. § 35.104 (ADA Title II regulation); 28 C.F.R. § 36.104 (ADA Title III regulation).

[57] 42 U.S.C. § 12203(a); N.Y. EXEC. LAW § 296(7); Admin. Code of the City of New York § 8-107(7).

[58] 42 U.S.C. §§ 12132, 12182(b)(1)(A) (ADA Title II and Title III, respectively); 29 U.S.C. § 794(a) (Rehab Act); N.Y. EXEC. LAW § 296(2)(a) (State Human Rights Law); Admin. Code of the City of New York § 8-107(4)(a) (City Human Rights Law); 28 C.F.R. §§ 35.130(a), 35.130(b)(1)-(2) (Title II regulations); 28 C.F.R. §§ 36.201(a) (Title III regulation).

[59] 42 U.S.C. § 12182(b)(2)(A)(iii)-(iv) (Title III); N.Y. EXEC. LAW §§ 296(2)(c)(iii)-(iv) (State Human Rights Law); Admin. Code of the City of New York § 8-102(18) (City Human Rights Law); 28 C.F.R. § 36.304 (Title III regulation). In addition, new construction at health care facilities must comply with the ADA Accessibility Guidelines for Buildings and Facilities (ADAAG), which contains scoping and technical requirements for accessibility to buildings and facilities. U.S. DEP'T OF JUSTICE, 2010 ADA STANDARDS FOR ACCESSIBLE DESIGN (2010), http://www.ada.gov/regs2010/2010ADAStandards/2010ADAStandards.pdf.

[60] 28 C.F.R. § 36.304(a)-(b) (Title III regulation requiring barrier removal and listing 21 examples of barrier removal).

[61] *See* U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE, *supra* note 22, at Part 4. Although medical providers are already obligated by federal, state and local law to ensure the accessibility of the health care services, the Patient Protection and Affordable Care Act of 2010 (PPACA) calls for even more detailed standards of accessible medical diagnostic equipment. *See* 42 U.S.C. § 18001 *et seq.* The PPACA amends 29 U.S.C. 791 *et seq.* (Title V of the Rehabilitation Act of 1973) by adding § 510(a) – (c), "Establishment of Standards for Accessible Medical Diagnostic Equipment," which authorizes the United States Access Board to develop new access standards for medical diagnostic equipment including "examination tables and chairs, weight scales, x-ray machines and other radiological equipment, and mammography equipment." Access Board to Set Standards for Medical Diagnostic Equipment under Health Care Reform Law, *available at* http://www.access-board.gov/news/medical-equipment.htm (last visited Oct. 22, 2012). Similarly, the Department of Justice is developing regulations for medical equipment and furniture. *See* Nondiscrimination on the Basis of Disability by State and Local Governments and Places of Public Accommodation; Equipment and Furniture, 175 Fed. Reg. 43,452 (July 26, 2010) (to be codified at 28 C.F.R. pts. 35 &36) (comment submissions available at http://www.regulations.gov/#!docketDetail;dct=FR+PR+N+O+SR+PS;rpp=10;po=0;D=DOJ-CRT-2010-0008).

[67] *See* U.S. DEP'T OF JUSTICE, AMERICANS WITH DISABILITIES ACT, ADA TITLE III TECHNICAL ASSISTANCE MANUAL COVERING PUBLIC ACCOMMODATIONS AND COMMERCIAL FACILITIES, III-7.8300 [hereinafter U.S. DEP'T OF JUSTICE, ADA TITLE III TECHNICAL ASSISTANCE MANUAL], *available at* http://www.ada.gov/taman3.html (last visited Oct. 22, 2012); U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE, *supra* note 22, at Part 4.

[63] U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE, *supra* note 22, at 11-15.

[64] *Id.* at 19.

[65] *Id.* at 4,19.
[66] 42 U.S.C. § 12182(2)(A)(iii) (Title III); N.Y. EXEC. LAW §§ 296(2)(c)(ii) (State Human Rights Law); Admin. Code of the City of New York § 8-107(15) (City Human Rights Law); 28 C.F.R. § 35.160(b) (Title II regulation); 28 C.F.R. § 36.303 (Title III regulation).
[67] 42 U.S.C. § 12103(1) (ADA); N.Y. EXEC. LAW §§ 296(2)(d)(ii) (State Human Rights Law); 28 C.F.R. § 35.104 (Title II regulation); 28 C.F.R. § 36.303(b) (Title III regulation).
[68] N.Y. EXEC. LAW §§ 296(2)(d)(ii) (State Human Rights Law); 28 C.F.R. § 35.104; 28 C.F.R. § 36.303(b).
[69] 42 U.S.C. § 12182(b)(2)(A)(iii) (Title III); N.Y. EXEC. LAW §§ 296(2)(c)(ii) (State Human Rights Law); Admin. Code of the City of New York § 8-102(18) (City Human Rights Law); 28 C.F.R. § 35.164 (Title II regulation); 28 C.F.R. § 36.303(a) (Title III regulation).
[70] 28 C.F.R. § 35.160 (Title II regulation); 28 C.F.R. § 36.303(c)(1) (Title III regulation).
[71] 28 C.F.R. § 35.160(c)(1) (Title II regulation); 28 CFR § 36.303(c)(2) (Title III regulation).
[72] 28 C.F.R. § 35.130(f) (Title II regulation); 28 C.F.R. § 36.301(c) (Title III regulation).
[73] 42 U.S.C. § 12182(b)(2)(A)(ii) (Title III); 28 C.F.R. § 35.130(b)(7) (Title II regulation); 28 C.F.R. § 36.302 (Title III regulation).
[74] 28 C.F.R. § 35.136(a) (Title II regulation); 28 C.F.R. § 36.302(c)(1) (Title III regulation); *see also* U.S. DEP'T OF JUSTICE, ADA TITLE III TECHNICAL ASSISTANCE MANUAL, at III-4.2300, *supra* note 62.
[75] *See* U.S. DEP'T OF JUSTICE, ACCESS TO MEDICAL CARE, *supra* note 22, at 19.
[76] *See id.* at 16.
[77] Jock Hoffman, *Are You Ready?*, STRATEGIES FOR PATIENT SAFETY, ACADEMIC GRP. (April 2010), *available at* http://www.academicins.com/articles/SPS-academic-4-2010.html (last visited Oct. 22, 2012) (emphasis added).
[78] 42 U.S.C. § 794(c) (Rehab Act); 42 U.S.C. § 12133 (Title II, incorporating the enforcement provisions of the Rehab Act); 42 U.S.C. § 12188 (Title III); N.Y. EXEC. LAW § 297 (State Human Rights Law); Admin. Code of the City of New York §§ 8-109, 8-502 (City Human Rights Law); 28 C.F.R. § 35,170 (Title II regulation); 28 C.F.R. § 36.502 (Title III regulation). Note that medical providers might also be liable for negligence and/or medical malpractice in cases where they fail to provide safe, accessible care.
[79] *See* Settlement Agreement Between the United States of America and Medical Specialists of the Palm Beaches, Inc., Sept. 28, 2012 [hereinafter "Medical Specialists of the Palm Beaches Settlement"], *available at* http://www.ada.gov/mspb-settlement.htm (last visited Oct. 22, 2012) (requiring medical provider to provide an accessible scale, as well as training for staff on ADA requirements and transferring patients with disabilities to an examination or imaging table); Settlement Agreement Between the United States of America and Marin Magnetic Imaging, July 21, 2006, at ¶¶ 4, 9 [hereinafter "Marin Magnetic Imaging Settlement"], *available at* http://www.ada.gov/marinmagim.htm (last visited Oct. 22, 2012) (summarizing investigation in which U.S. DOJ determined that medical office failed to reasonably accommodate a patient with a disability by "not providing him the equipment and/or assistance he needed to get onto the exam table, in violation of Title III of the ADA" and requiring that the medical office pay $2000 to the patient); Settlement Agreement Between the United States of America and Valley Radiologists Medical Group, Inc., Nov. 2, 2005, at ¶ 4 [hereinafter "Valley Radiologists Settlement"], *available at* http://www.ada.gov/vri.htm (last visited Oct. 22, 2012) (summarizing investigation in which U.S. DOJ determined that medical office failed to reasonably accommodate a patient with a disability by "not providing her the assistance she needed to get onto the examination table, in violation of Title III of the ADA"); Settlement Agreement Between the United States of America and Exodus Women's Center, Inc., Apr. 26, 2005, at ¶ 4 [hereinafter "Exodus Settlement"], *available at* http://www.ada.gov/exodus.htm (last visited Oct. 22, 2012) (same); Settlement Agreement Between the United States of America and Dr. Robila Ashfaq, Jan. 10, 2005, at ¶ 4 [hereinafter "Ashfaq Settlement"], *available at* http://www.ada.gov/drashfaq.htm (last visited Oct. 22, 2012) (same); *see also* Settlement Agreement Among the United States of America, Plaintiffs Equal Rights Center, Dennis Christopher Butler, Rosemary Ciotti, George Aguehounde, and Marsha Johnson, and Washington Hospital Center, Nov. 1, 2005 [hereinafter "Washington Hospital Settlement"], *available at* www.ada.gov/whc.htm (last visited Oct. 22, 2012) (requiring hospital to implement extensive changes in policies, practices, and medical equipment). Private settlement agreements have also been reached in actions involving inaccessible medical facilities across the country. *See, e.g.*, Settlement Agreement: Metzler et al. v. Kaiser Foundation Health Plan, Inc. et al., March 2001, *available at* http://www.dralegal.org/downloads/cases/metzler/settlement.pdf (last visited Oct. 22, 2012); Settlement Agreement Between UCSF Medical Center and August Longo, *available at* http://lflegal.com/2008/09/ucsf-settlement-agreement/ (last visited Oct. 22, 2012). Information regarding other medical access settlement agreements can be found on The Barrier Free Health Care Initiative's website *at* http://thebarrierfreehealthcareinitiative.org/?page_id=16 (last visited Oct. 22, 2012).
[80] *See, e.g.*, Settlement Agreement Between the United States of America and Northshore University Health Systems, June 25, 2012 [hereinafter "NorthShore Settlement"], *available at* http://www.ada.gov/northshore-uni-sa.htm (last visited Oct. 22,

2012) (requiring hospital to pay $46,990.00 to complainants' heir for hospital's failure to provide sign language interpreters on three occasions). A medical provider's failure to provide for effective communication could result in the failure to obtain informed consent from a patient, effectively understand and diagnose a patient's medical condition, or properly explain treatment or medications. *See id.* at ¶ 30 (listing examples of circumstances in which the length or complexity of the communication warrants provision of a sign language interpreter).

[81] *See, e.g.*, Berenson Settlement, *supra* note 35, at ¶ 3 (summarizing investigation in which U.S. DOJ determined that a medical office effectively denied a person with a disability access to medical services in violation of the ADA when it "inappropriately questioned and objected to the presence of the complainant's service animal in the office's waiting area").

[82] N.Y. EXEC. LAW §§ 297(4)(c), 297(9) (State Human Rights Law); Admin. Code of the City of New York §§ 8-120, 8-502 (City Human Rights Law),

[83] *See* 42 U.S.C. § 12188(b)(2)(B) (Title III); *see e.g.*, NorthShore Settlement, *supra* note 80, at ¶ 48. *See also* N.Y. EXEC. LAW §§ 297(4)(c), 297(9) (State Human Rights Law); Admin. Code of the City of New York §§ 8-120, 8-502 (City Human Rights Law); Mary Pat Gallagher, *Jury Awards $400,000 to Deaf Patient for Denial of Interpreter Services*, N.J. L. J., Oct. 17, 2008, *available at* http://www.law.com/jsp/article.jsp?id=1202425326286&Jury_Awards_400000_to_Deaf_Patient_for_Denial_of_Interpreter_Services&slreturn=20120916114420 (last visited Oct. 22, 2012).

[84] *See* 42 U.S.C. § 12188(a)(2) (Title III). "[I]njunctive relief shall include an order to alter facilities to make such facilities readily accessible to and usable by individuals with disabilities to the extent required by this subchapter. Where appropriate, injunctive relief shall also include requiring the provision of an auxiliary aid or service, modification of a policy, or provision of alternative methods, to the extent required by this subchapter." *Id.*; *see also* N.Y. EXEC. LAW §§ 297(4)(c), 297(9) (State Human Rights Law); Admin. Code of the City of New York §§ 8-120, 8-502 (City Human Rights Law). *See also, e.g.*, Medical Specialists of the Palm Beaches Settlement, *supra* note 79; Berenson Settlement, *supra* note 35; Northshore Settlement, *supra* note 80; Marin Magnetic Imaging Settlement, *supra* note 79; Ashfaq Settlement, *supra* note 79; Washington Hospital Settlement, *supra* note 79; Valley Radiologists Settlement, *supra* note 79; Exodus Settlement, *supra* note 79.

[85] 42 U.S.C. § 12205 (ADA); 42 U.S.C. § 794a(b) (Rehab Act); Admin. Code of the City of New York, § 8-502(f) (City Human Rights Law).

[86] 42 U.S.C. § 12188(b)(2)(C) (Title III provision, that a court "may, to vindicate the public interest, assess a civil penalty against the entity in an amount (i) not exceeding $50,000 for a first violation; and (ii) not exceeding $100,000 for any subsequent violation"); N.Y. EXEC. LAW § 297(9) (providing for assessment of "civil fines and penalties in an amount not to exceed fifty thousand dollars, to be paid to the state by a respondent found to have committed an unlawful discriminatory act, or not to exceed one hundred thousand dollars to be paid to the state by a respondent found to have committed an unlawful discriminatory act which is found to be willful, wanton or malicious"); Admin. Code of the City of New York, § 8-404 (providing that "the trier of fact may, to vindicate the public interest, impose upon any person who is found to have engaged in a pattern or practice that results in the denial to any person of the full enjoyment of any right secured by chapter one of this title a civil penalty of not more than two hundred fifty thousand dollars").

[87] U.S. DEP'T OF HEALTH & HUMAN SERV., NAT'L INST. FOR OCCUPATIONAL SAFETY & HEALTH, AND CTRS. FOR DISEASE CONTROL & PREVENTION, SAFE HANDLING TRAINING FOR STUDENTS OF NURSING: CURRICULAR MATERIALS 6 (2009), http://www.cdc.gov/niosh/docs/2009-127/pdfs/2009-127.pdf [hereinafter HHS, SAFE HANDLING TRAINING FOR STUDENTS OF NURSING] (citing AUDREY L. NELSON ET AL., THE ILLUSTRATED GUIDE TO SAFE PATIENT HANDLING AND MOVEMENT (2009), http://www.mtpinnacle.com/pdfs/Guide-to-Safe-Patient-Handling.pdf); STAFF OF SUBCOMM. ON WORKPLACE SAFETY, SUBCOMM. ON LABOR, SUBCOMM. ON HEALTH, N.Y. STATE ASSEMBLY, SAFE PATIENT HANDLING IN NEW YORK: SHORT TERM COSTS YIELD LONG-TERM RESULTS 6 (Comm. Print 2011) [hereinafter SAFE PATIENT HANDLING IN NEW YORK]; MARTIN H. COHEN ET AL., FACILITY GUIDELINES INST., PATIENT HANDLING AND MOVEMENT ASSESSMENTS: A WHITE PAPER 18, 21-22 (Carla M. Borden, ed., 2010), http://www.dli.mn.gov/WSC/PDF/FGI_PHAMAwhitepaper_042710.pdf.

[88] SAFE PATIENT HANDLING IN NEW YORK, *supra* note 87, at 6; COHEN ET AL., *supra* note 87, at 21.

[89] SAFE PATIENT HANDLING IN NEW YORK, *supra* note 87, at 6.

[90] COHEN, ET AL., *supra* note 87, at 24 (citing A. B. de Castro, *Handle with care: The American Nurses Association's Campaign to address work-related musculoskeletal disorders*, 9(3) ONLINE J. OF ISSUES IN NURSING, 103 (2004)).

[91] JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITIES ISSUES & THE HEALTH PROFESSIONS, IMPORTANCE OF ACCESSIBLE EXAMINATION TABLES, CHAIRS AND WEIGHT SCALES 3 (2010).

[92] *See* Cohen et al., *supra* note 86, at 24 (citing J. W. Collins et al., *An evaluation of a 'best practices' musculoskeletal injury prevention program in nursing homes*, 10 INJURY PREVENTION 206 (2004); Bradley A. Evanoff et al., *Reduction in injury rates in nursing personnel through introduction of mechanical lifts in the workplace*, 44 AM. J. OF INDUS. MED. 451 (2003); Hester J. Libscomb et al., *Evaluation of direct workers' compensation costs for musculoskeletal injuries surrounding interventions to reduce patient lifting*, 69 OCCUPATIONAL & ENVTL. MED. 367 (2012); Audrey Nelson, et al., *Development and Evaluation of a Multifaceted Ergonomics Program to Prevent Injuries Associated with Patient Handling Tasks*, 43 INT'L J. OF NURSING STUDIES 717 (2006); A. Nelson & A. Baptiste, *Evidence-based practices for safe patient handling and movement*, 9 ONLINE J. OF ISSUES IN NURSING 3 (2004), http://asphp.org/wp-content/uploads/2011/05/Audrey_Nelson_Paper_on_Safe_Patient_Handling.pdf).

[93] SAFE PATIENT HANDLING IN NEW YORK, *supra* note 87, at 7 ("In nine National Institute of Occupational Safety and Health case studies, there were: 60-95-percent reduction in injuries; 95-percent reduction in workers' compensation costs; 92-percent reduction in medical/indemnity costs; as much as 100-percent reduction in lost work days (absence due to injury); 98-percent reduction in absenteeism (absence due to unreported injury)."). *See also*, HHS, SAFE HANDLING TRAINING FOR STUDENTS OF NURSING, *supra* note 87, at 6; Cohen et al., *supra* note 87, at 43 (citing Collins et al., *supra* note 92; Evanoff et al., *supra* note 92; Nelson et al., *supra* note 92; Nelson & Baptiste, *supra* note 92).

[94] U.S. DEP'T OF JUSTICE, TAX INCENTIVES FOR BUSINESSES [hereinafter U.S. DEP'T OF JUSTICE, TAX INCENTIVES FOR BUSINESSES], *available at* http://www.ada.gov/taxincent.htm (last visited Oct. 19, 2012) ("Small businesses with 30 or fewer employees or total revenues of $1 million or less can use the Disabled Access Credit."). *See also* I.R.C. § 44 (2006).

[95] U.S. DEP'T OF JUSTICE, TAX INCENTIVES FOR BUSINESSES, *supra* note 94 ("Eligible small businesses may take a credit of up to $5,000 (half of eligible expenses up to $10,250, with no credit for the first $250).").

[96] *Id.* (eligible businesses can use the credit "to offset their costs for access, including barrier removal from their facilities (e.g., widening a doorway, installing a ramp), provision of accessibility services (e.g., sign language interpreters), provision of printed material in alternate formats (e.g., large-print, audio, Braille), and provision or modification of equipment.").

[97] *Id.* ("Under Internal Revenue Code, Section 190, businesses can take a business expense deduction of up to $15,000 per year for costs of removing barriers in facilities or vehicles."). *See also* I.R.C § 190 (2006). Neither the tax credit, nor the deduction may be applied to the cost of new construction and all barrier removal must comply with federal accessibility standards. U.S. DEP'T OF JUSTICE, TAX INCENTIVES FOR BUSINESSES, *supra* note 97.

[98] *See* ME Caban, MD et al., *Mammography Use May Partially Mediate Disparities in Tumor Size at Diagnosis in Women with Social Security Disabilities*, 46(4) WOMEN AND HEALTH 1, 7 (2007).

[99] Martijn T. Groot et al., *Costs and Health Effects of Breast Cancer Interventions in Epidemiologically Different Regions of Africa, North America, and Asia*, 12 THE BREAST J. S81, S88 (2006), http://www.who.int/choice/publications/p_2006_breast_cancer.pdf.

[100] *See* Paul T. Cheung et al., *National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries*, 60(1) Annals of Emergency Med. 4, 4, 7 (2012) (national study of the association between five barriers to primary care, such as limited clinic hours and lack of transportation, and emergency department usage for Medicaid and private insurance beneficiaries). This study by Cheung, et al. found that Medicaid recipients experienced more barriers to primary care than privately insured patients, and were more likely to use the emergency department. *Id.* Other barriers to primary care such as inaccessible medical offices or equipment may likewise increase emergency department usage for people with disabilities. *See also*, DISABLED WORLD, EMERGENCY DEP'T USE FOR ADULTS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, *First North American study to look at ED use by adults with intellectual disabilities* (May 15, 2011), *available at* http://www.disabled-world.com/medical/rehabilitation/emergency-department.php#ixzz29J1QX5GE (last visited Oct. 22, 2012).

[101] *See* U.S. GOV'T ACCOUNTABILITY OFF., GAO-11-414R, HOSPITAL EMERGENCY DEPARTMENTS: HEALTH CENTER STRATEGIES THAT MAY HELP REDUCE THEIR USE 2 (2011), http://www.gao.gov/assets/130/126188.pdf (reporting the significantly higher cost of emergency department visits as compared to health center visits).

[102]

> According to estimates from the 2008 Medical Expenditures Panel Survey (MEPS), the average amount paid for a nonemergency visit to an emergency department was $792, while the average amount paid for a health center visit was $108. Similarly, the average charge for a nonemergency visit to an emergency department was 10 times higher than the charge for a visit to a health center—$2,101 compared to $203. MEPS is a set of large-scale surveys of families and individuals, their medical providers, and their employers across the United States.

Id. at n.5.

[103] Women with disabilities are significantly less likely to have a doctor recommend they receive a pap smear. Anthony Ramirez et al., *Disability and Preventive Cancer Screening: Results from the 2001 California Health Interview Survey*, 95(11) AM. J. OF PUB. HEALTH 2057, 2061 (2005). Relatedly, several studies have shown that medical providers frequently wrongly assume that women with disabilities are not sexually active. NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 55-56.

[104] U.S. CENSUS BUREAU, *supra* note 5, at tbl.B18101.

[105] McCarthy et al., *supra* note 3, at 637 (cited in JUNE ISAACSON KAILES ET AL., CTR. FOR DISABILITY ISSUES & THE HEALTH PROFESSIONS, MAMMOGRAPHY: ADDRESSING EQUIPMENT DESIGN 5 (2009)).

> Women with SSDI and Medicare who had breast-conserving surgery were also less likely than other women to receive radiotherapy and axillary lymph node dissection. These women had lower survival rates from all causes and specifically from breast cancer. Explanations for such disparities could include lack of early diagnosis, lack of breast health awareness or education on the part of the woman herself, inaccessible or unreliable transportation, and cultural capacity of the treating facility. Inaccessible equipment and other physical barriers could also add to the problem.

Id.

[106] Lisa I. Iezzoni et al., *Mobility Impairments and Use and of Screening and Preventative Services*, 90(6) AM. J. OF PUB. HEALTH. 955, 957 (2000), http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.90.6.955.

[107] Siran M. Koroukian et al., *Mental Illness and Use of Screening Mammography Among Medicaid Beneficiaries*, 42(6) AM. J. OF PREVENTATIVE MED. 606, 608 (2012).

[108] Joanne E. Wilkinson et al., *'It's Easier Said Than Done': Perspectives on Mammography from Women with Intellectual Disabilities*, 9 ANNALS OF FAMILY MED. 142, 143 (2011) (citing N. Davies & M. Duff, *Breast cancer screening for older women with intellectual disabilities living in community group homes*, 45 J. INTELLECTUAL DISABILITY RES. 253 (2001)).

[109] Joann M. Thierry, *Observations from the CDC: Increasing Breast and Cervical Cancer Screening among Women with Disabilities*, 9(1) J. OF WOMEN'S HEALTH & GENDER-BASED MED. 9, 9 (2000) (citing Centers for Disease Control and Prevention, *National breast and cervical early detection program*, 45 MMWR. 484 (1999)).

[110] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT FOR WOMEN WITH PHYSICAL DISABILITIES: A REPORT ON PRELIMINARY FINDINGS, APRIL 1, 2008 – MARCH 31, 2010. 2 (2011), http://www.icsny.org/sitemanagement/wp-content/uploads/2011/03/FINAL-KOMEN_report.pdf [hereinafter INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT]. ICS was also a recipient of the Susan G. Komen Grantee of the Year Award in 2012.

[111] Many frequently used mammography machines are inaccessible to women with physical disabilities. *See* INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 5.

[112] Depending on the severity of the disability, ICS found in its project that between 12%-42% of women with disabilities needed an additional technologist to receive a mammogram, and the time required for the test ranged from 19 to 33 minutes. INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 3; Independence Care System, Final Report, *supra* note 12, at App. A-1. *See also* Iezzoni, et al., *Physical Access to Diagnosis and Treatment of Breast Cancer*, *supra* note 20, at 714.

[113] Telephone Interview with Jane D. Nietes, Nurse Educator, Independence Care System (Oct. 9, 2012) [hereinafter Telephone Interview with Jane D. Nietes (Oct. 9, 2012)].

[114] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113.

[115] Telephone Interview, Member, Independence Care System (Oct. 4, 2012) [hereinafter Independence Care System Member Interview].

[116] NAT'L COUNCIL ON DISABILITY, *supra* note 1, at 58-59.

[117] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note113.

[118] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note113; Telephone Interview with Jane D. Nietes, Nurse Educator, Independence Care System (Oct. 21, 2012) [hereinafter Telephone Interview with Jane D. Nietes (Oct. 21, 2012)].

[119] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 4; *see also* Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113.

[120] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 4.

[121] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113.

[122] Telephone Interview with Jane D. Nietes (Oct. 21, 2012), *supra* note 118.

[123] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113; Telephone Interview with Jane D. Nietes (Oct. 21, 2012), *supra* note 118.

[124] Telephone Interview with Jane D. Nietes (Oct. 21, 2012), *supra* note 118.

[125] *Id.*

[126] Telephone Interview with Jane D. Nietes (Oct. 9, 2012), *supra* note 113.

[127] Independence Care System Member Interview, *supra* note 115.

[128] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at App. B-2.

[129] Telephone Interview with Jane D. Nietes (Oct. 21, 2012), *supra* note 118.

[130] Independence Care System, Final Report, *supra* note 12, at App. A-2.

[131] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 5.

[132] *See* 42 U.S.C. § 290ii; 42 C.F.R § 482.13(e); N.Y. COMP. CODES R. & REGS. TIT. 10 § 405.7(5).

[133] 42 U.S.C. § 290ii(d)(1)(A) defines restraints as "any physical restraint that is a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely, *not including devices*, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, *or any other methods that involves the physi holding of a resident for the purpose of conducting routine physical examinations or tests* or to protect the resident from falling out of b or to permit the resident to participate in activities without the risk of physical harm to the resident." (emphasis added). 42 C.F.R. § 482.13(e)(1)(i)(C) states that: "[a] restraint does not include devices, such as orthopedically prescribed devices, sur dressings or bandages, protective helmets, *or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests*, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm" (emphasis added). 10 NYCRR § 405.7(b)(5) limits the use of restraints "to those patient restraints authorized in writing by a physician after a personal examination of the patient, for a specified and limited period of time to protect the patient from injury to himself or to others."

[134] INDEPENDENCE CARE SYSTEM, BREAST CANCER SCREENING PROJECT, *supra* note 110, at 4.

Oh Council 2/24/14 1PM
Submitted by Lois RAKOFF BHC/CAB for HHC
Hearing — Corey Johnson Council member Comm. Hg Chair

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Advocate, Represent, Inform, Advise

Statement of Need Under discussion

February 2014

Bellevue Hospital Center is a microcosm of our great City of New York, a city of people who speak over 100 languages and come from all over the world. As a public hospital, our doors are opened to provide the highest quality of care for all.

More than 12,000 individuals representing patients, staff, and visitors pass through the Bellevue's doors every single day, including patients who walk in to our emergency room for immediate treatment of illness or injury. Located in a building on First Avenue constructed in 2005 for the express purpose of improving access to clinic services, the ambulatory care clinics at Bellevue see over 550,000 visits a year. The need is tremendous, challenging and gratifying.

Bellevue continues to meet patients' needs through innovative healthcare in primary, specialty and tertiary services. The World Trade Center Health Care Services for those impacted with health effects from 9/11 are housed at Bellevue; and the hospital is also designated for the President of the United States and United Nations officials.

In the Fall of 2013, Bellevue Hospital Administration asked the Budget and Planning Committee of the Bellevue CAB and the Budget and Governmental Affairs Committee of Manhattan Community Board Six (CB6) for support with requests for new or upgraded equipment. CB6 included two of the five requests in its budget priorities for Fiscal Year 2015 (which begins July, 2014).

To that end, the specific requests for equipment are listed below for your consideration and support:

Neurointerventional radiology biplane c-arm replacement ($3,000,000)

- This is an angiogram system that allows the doctors to see blood vessels within the brain and spinal cord both for diagnostic and treatment purposes. Angiograms are required for neurosurgery, trauma, and stroke.

- **The current system was purchased in 1999 and will not be supported after 2013.**
- **Bellevue is the only hospital within HHC that offers treatment for complicated cerebrovascular cases 24 hours a day, 7 days a week. These cases require the availability of biplane angiography (i.e., this equipment)**
- Many referrals to Bellevue Hospital from other HHC facilities are made specifically because of the neurosurgery expertise in this procedure and, consequently, this equipment.
- Bellevue Hospital is the only designated Level 1 Trauma Center in the Borough of Manhattan and averages around 1200-1300 trauma admissions annually. **The certification for Level 1 trauma status now requires 24-hour/7day angiographic support**. Loss of Level 1 trauma status would result in a decrease in the total number of patients brought to Bellevue.
- **Advanced certification as a Comprehensive Stroke Center requires on-site availability of angiography 24/7.**
- The advanced neurosurgical procedures allow physicians at Bellevue to treat patients that would otherwise be deemed "untreatable" because of the exceedingly high risks associated with treatment using conventional methods. There is also the expectation of being able to keep patients within the HHC system, thereby expanding business opportunities, rather than referral out to private hospitals.
- (Request is supported as a CB6 budget priority)

Ophthalmology virectomy equipment replacement ($180,000)

- The equipment is used in the treatment for cataracts and other conditions.
- Virectomy is the removal of vitreous gel in the eye giving the doctor access to the back of the eye to perform retinal surgery
- It is also used in trauma cases of the eye
- **The current system is over 7 years old; currently renting a system**

EP lab hemodynamics and reporting system replacement ($900,000)

- The hemodynamic system is used to monitor patients while undergoing diagnostic or interventional electrophysiology
- New technology has allowed Bellevue to manage atrial fibrillation using ablation therapy that was previously treated medically. Atrial fibrillation is a contributing factor in the development of angina, heart failure, and stroke. The resulting costs to the health care system, especially Medicare, are increasing.
- As Bellevue's electrophysiology program grows, there is an increasing demand for interventional cardiac electrophysiology procedures. At present, Bellevue is utilizing one room for EP and additional cath procedures. There is a finite capacity with the current laboratory space that limits the development and growth of the interventional cardiac programs.
- (Request is supported in CB6 budget priorities)

Radiology Ultrasound machine replacement ($300,000)

- These systems are used to evaluate different organs such as the liver and kidney.
- **One system is currently non functional and cannot be repaired. The other doesn't provide a high quality image because of its age (10 years old) and is not upgradeable.**
- The replacement will provide the level of technology that is the standard of care for diagnostic ultrasound imaging.
- This request would replace the two oldest existing units in the ultrasound suite.

ICU Critical patient transport monitors ($300,000)

- The transport monitors are used to monitor patients while they are transferred for different tests (radiology, ultrasound, etc.) in the hospital.
- **The current monitors were purchased between 1995 and 2000.**

Subject:	Fw: February 26 meeting notice
From:	lois57@att.blackberry.net (lois57@att.blackberry.net)
To:	accinc552@yahoo.com;
Date:	Monday, February 24, 2014 11:46 AM

Sent via BlackBerry by AT&T

From: "CommunityAdvisoryBoard" <CommunityAdvisoryBoard@bellevue.nychhc.org>
Date: Mon, 24 Feb 2014 09:09:13 -0500
To: CommunityAdvisoryBoard<CommunityAdvisoryBoard@bellevue.nychhc.org>
Subject: February 26 meeting notice

Dear CAB members;

The following meetings of the Bellevue Hospital Center Community Advisory Board will be taking place on:

Wednesday, February 26, 2014

4:00 p.m. Patient Care & Advocacy
Location: 12 East 34 (H Building, 12th Floor)

5:00 p.m. Membership
6:00 p.m. Full Board
Location: Rose Room (H Building, 12th Floor)

If you are a member of these Committees and are unable to attend, please inform Chairperson Bobby Lee or the Committee Chairs so an excused absence may be recorded.

Fri March 28, 2014 10:30AM
Bellevue's
CAB Legislative
Breakfast

Lisa Marie Izquierdo
Community Advisory Board Liaison
Public Affairs Department
Bellevue Hospital Center
Tel: (212) 562-6185
Fax: (212) 562-4125

NYC's Healthcare Workers Union

LOCAL 420
DC 37, AFSCME, AFL-CIO

"Three Years Down The Road Ahead."

Monday, February 24, 2014

New York City Council

The Committee on Health

Councilmember Arroyo Johnson, Chair.

Carmen A. Charles, President

New York City Heath Care Workers Union (L420) District Council 37, AFSCME

70 West 36th Street, 16th Floor, New York, NY, 10018. Work: (347) 532-6420 Fax: (347) 532-6432
E-mail: info@local-420.org Web: www.local420union.org

Good Afternoon Chairman Johnson and thank you for this opportunity to discuss with you today Local 420's concerns about HHC's containment and restructuring plan and our hopes for a more inclusive role in its implementation. Not to be remised, I must also extend a very good-afternoon to the other members of this committee, my colleagues of District Council 37, members of the public and my members who are present today.

I begin my remarks with a slide from the New York City's Health and Hospital Corporation's (HHC) website that captures the overall mandate of this organization. 'Patients First' is its core, supported by five revolving principles; prudent resource management, team work, safety for all, continued refinement through learning, and the achievement of excellence.

Four years ago, we were presented with a bleak financial picture for HHC's future that threatened this model. The corporation faced challenges pertaining to health care reform, an increased patient load with decreases in State and Federal healthcare reimbursement subsidies, and increases in the cost of administrating patient care in a an American economy on the brink of collapse. Expenses exceed revenue for HHC. Faced with this apocalyptic demised, Kimberly Comer Mulqueen and Deloitte Consulting LLP were hired with the consulting charge of reviewing HHC's current operations, looking for cost saving ways to strengthen the organization for a sustainable future, with 'Patient First' still at HHC's core.

Today we are here to discuss the resulting restructuring cost containment blueprint that came about from this consulting process, 'The Road Ahead.' 'The Road Ahead' projected a $305 million savings over the next four years from five categories; Administrative/Shared Services, Affiliation Alignment, Acute Care Realignment, Ambulatory Realignment, and Long-Term Care Realignment. Overnight, 'alignment and realignment' became substitute words for outsourcing, doing more with less, less meaning less people. This certainly aligns with one of HHC's revolving principles, prudent resource management, but it weakens the other four principles in its operationalization.

After a careful examination of HHC's records, Local 420 have come to the conclusion that the public is being grossly misled by HHC's presentations of cost containment to date through its five outsourcing initiatives; Sodexo Dietary, Sodexo Laundry, Crothall Environmental Services, Johnson Controls Plant Maintenance, and Atlantic Dialysis Operations, without a true picture of the impact these pariahs to the system are having.

HHC's reporting cavalierly mentions the loss of jobs and the increased safety risk Local 420's members are exposed to, when they are asked to do more work with less supplies in even less time.

These for-profit organizations that were contracted to carry out HHC's cost savings restructuring plan cater to their boards and their bottom lines, generating profits for their shareholders. We the public are not part and parcel of that profit sharing scheme, we are the ones that give up quality service for them to generate their profits.

It's time that we restore the public in public healthcare by working together to find cost saving initiatives. When we examine HHC's Proposed Budget & Financial Plan, its $1.5 billion projected deficit for the year 2014 is half of its Professional Services Contracts and Other Operating Expenditures combined. There in lays the foundation of where that discussion can start. Why is HHC not maximizing their staff, let them do the work and stop paying consultants to tell us

how to do a job we have perfected over the years. I find it grossly insulting to think that a tenured housekeeping aide at one of HHC's facilities cannot offer suggestions on how to maximize his/her duties that provides savings. This institutional knowledge that is free if consulted is wasted when we rely outside consultants.

Let's do more with less, more inclusive consultations with HHC and labor, providing more acceptable services by adhering to HHC's revolving principles of team work, continued refinement through learning, and the achievement of excellence, with less outside for-profit consultants and less masking of the unacceptable services they are providing. 'The Road Ahead' will be stronger for HHC if this is achieved.

Thank you for indulging me today, and I sincerely hope we can move forward as partners, as we strive to continue strengthening the strongest public health care system in America.

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 2/24/2014

(PLEASE PRINT)

Name: Anthony Feliciano

Address: _____

I represent: Commission on the Public's Health System

Address: 45 Clinton Street

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: 2-24-14

(PLEASE PRINT)

Name: Mindy Friedman

Address: 151 W. 30th St. 11th Fl. NY, NY 10001

I represent: NYLPI

Address: 151 W. 30th St. 11th Fl. NY, NY 10001

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Carmen Charles

Address: 70 W. 36 St. 16 Fl., New York, NY 10018

I represent: Local 420, AFSCME - Healthcare Workers

Address: Same as above

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THE CITY OF NEW YORK

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☒ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: Antonio Martin, Executive Vice President

Address: 11 Broadway

I represent: New York City Health + Hospitals Corp

Address:

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: 2-24-14

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Name: Sascha Murillo

Address: 151 W. 30th St, 11th Fl, New York, NY 10001

I represent: New York Lawyers for the Public Interest

Address: 151 W. 30th St, 11th Fl, New York, NY 10001

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Ross Wilson, Chief Medical Officer

Address:

I represent: New York City Health + Hospitals Corporation

Address:

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panel w/ Carmen Charles & Ralph Palladino DC 37

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: Barbara Edmonds

Address: 125 Barclay Street NY NY

I represent: Field Director DC37

Address: (on behalf of Lillian Roberts)

---

panel w/ Barbara Edmonds & Ralph Palladino DC 37

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: Carmen Charles

Address: 125 Barclay Street NY NY

I represent: President, L. 420, DC37

Address: _____

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Leon Bell

Address: _____

I represent: NYSNA

Address: 131 W 33 ST NYC 10001

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: Frank Proscia, M.D. Doctors Council SEIU, President

Address: 50 B'way NY NY 10004

I represent: Doctors Council SEIU

Address:

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Mr. Quashie, RN

Address: _____

I represent: NYSNA

Address: 120 Wall St NYC 10001

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THE CITY OF NEW YORK

Appearance Card

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anne Bove, RN

Address: _____

I represent: NYSNA

Address: 120 Wall St NYC 10001

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THE CITY OF NEW YORK

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☑ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: Lois Rakoff - Community Advisory Bellevue

Address: ~~462 1st Ave~~ 211 Thompson St 10012

I represent: CAB @ BHC for HHC

Address: 462 1st Ave Rm MW2

NY 10016

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THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Agnes M. Abraham

Address: 5455 Kings Hwy 11203

I represent: HHC CABS

Address: _____

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: Samrina Kahlon

Address: _____

I represent: Committee of Interns & Residents

Address: 520 8th Ave, St #1200 SEIU

NY NY 10018

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☐ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: RALPH PALLADINO

Address: _____

I represent: DC37 / CA-1549

Address: _____

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: Marlene Zurack, CFO

Address: _____

I represent: NYC H/HC

Address: _____

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☐ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: Alan Aviles, President NYC H/HC

Address: _____

I represent: New York City Health & Hospitals Corp.

Address: _____

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Date: _____

(PLEASE PRINT)

Name: Fay Muir

Address: _____

I represent: Northwest Bronx Community & Clergy Coalition

Address: 103 E 196th St Bronx NY 10468

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THE CITY OF NEW YORK

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☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Eileen Markey

Address: _____

I represent: North Bronx Community Power

Address: _____

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☐ in favor ☐ in opposition

Date: 2/24/14

(PLEASE PRINT)

Name: LaRay Brown, Senior Vice President

Address: _____

I represent: NYC H/HC

Address: _____

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THE CITY OF NEW YORK

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I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Sandra M. Thomas

Address: _____

I represent: Northwest Bronx Community & Clergy Coalition

Address: 103 E 196th St, Bronx, NY 10468

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