CITY COUNCIL
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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

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HELD AT: Council Chambers
City Hall

B E F O R E:
COREY D. JOHNSON
Chairperson

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Maria del Carmen Arroyo
Rosie Mendez
Mathieu Eugene
Peter A. Koo
Inez D. Barron
Robert E. Cornegy, Jr.
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A P P E A R A N C E S (CONTINUED)

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Mindy Friedman
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Sascha Murillo
Community Organizer, Health Justice
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CHAIRPERSON JOHNSON: …on Health; there are multiple… we're waiting for the camera. Okay, I'll wait.

MALE VOICE: Quiet please.

CHAIRPERSON JOHNSON: Are we all set? Yes. Good afternoon everyone, my name is Corey Johnson; I'm Chair of the Health Committee; before I read my opening statement I just wanna acknowledge the Council Members that are here and there are others that are on their way, but there are multiple committee hearings all happening at once today and so folks are jumpin' around to try to be in each of their committees. We are joined by Council Member Peter Koo, Council Member Rafael Espinal, Council Member Dr. Mathieu Eugene and Council Member Inez Barron.

Today we are conducting an Oversight Hearing examining the New York City Health and Hospital Corporation's 2010 cost-containment and restructuring plan. Their plan, entitled "Restructuring HHC: The Road Ahead," was intended to close a $600 million budget gap over 4 years. The Committee will investigate how this plan has been implemented and how it impacted HHC's ability to

carry out its mission, especially with respect to quality of care, access to care, continuity of care and safety for HHC patients. The hearing will also examine how HHC intends to address new and impending deficits that have developed since the inception of "The Road Ahead." We will hear today from representatives of HHC, organized labor, as well as health advocacy organizations and members of the public.

HHC is the largest municipal hospital and healthcare system in the country and the single largest provider of healthcare to uninsured New Yorkers. One in every six New Yorkers receives health services at an HHC facility. In 2011 HHC served approximately 1.3 million patients of which 478,000, 37 percent of their total patient population, were uninsured. The volume of uninsured care translates into approximately $700 million in uncompensated care annually.

In Fiscal Year 2010, facing a projected $1.2 billion budget gap for Fiscal Year 2013, HHC implemented a gap-closing plan that called for $600 million in cost containment and restructuring and another $600 million in additional revenue. In 2010,

in concert with the private consulting firm, Deloitte, HHC rolled out its restructuring plan, which aimed to make the system more efficient and cost-effective while continuing to serve New York City's patient population, especially the uninsured, undocumented and most vulnerable residents. The plan sought to achieve these goals by making a number of changes across HHC's delivery system and administrative operations, particularly focused on contracting for services formerly performed in-house, including reducing the work force by 3700 full-time employees, largely through attrition, while maintaining service capacity and making changes to the delivery of services to better align with the location volume of patient and community needs.

Four years later, HHC is winding down this restructuring process, having successfully reached its target of $600 million in savings. At the same time, HHC is now facing a new fiscal crisis, with over $1 billion in deficits in the coming years due to in part the Federal Affordable Care Act, State Medicaid redesign and other factors. We don't envy the task for HHC and we look forward to collaborating

with you to help us get our vital system of public hospitals onto firmer footing.

That said, we do hope to hear today from all parties about what worked and what didn't in implementing this plan and how a major restructuring like this has affected HHC's ability to provide access to quality care, continuity of care and to ensure patient safety. We are eager to learn what's next for HHC in dealing with the new crisis; our goal is to draw on lessons for the future. For example, what are the impacts on the community's access to care and continuity of care when clinics are closed in favor of a regional model? How can we reasonably ensure quality of care when services are outsourced to private and for-profit providers? Our focus needs to be on efforts to make the system sustainable while not doing damage to its core principles.

As many of you know, we have our preliminary budget hearing next month; the purpose of today's hearing is to carve out time and space from the annual budget process to take a close look at the road ahead; how HHC has dealt with significant budget deficits in the past so we can learn lessons for the future. I ask my colleagues to try to keep the

restructuring plan the focus of today's hearing, leaving other budget-related issues to next month's hearing that we will have with HHC on their budget.

Finally, I urge HHC to stay throughout the hearing; you are gonna hear from advocates who have critical insight into how this plan has been implemented and recommendations for the future. We need to make sure that these voices are heard so that we can all move forward together.

Before we hear from our first panel of witnesses, beginning with HHC, I would like to thank HHC and all advocates who worked with Council in preparing for today's hearing. I also wanna thank our great committee staff, Dan Hafetz, the Committee Counsel, Crystal Pond, our Policy Analyst and Crilhien Francisco, our Finance Analyst, as well as Alissa Weiss for their work in preparing for this hearing today.

Just a reminder that if you wish to testify you must sign up with the Sergeant of Arms at the back of the room in front of the computer, and I will now turn it over to our first panel, but before I do that I wanna recognize two more council members that have arrived, Council Member Rosie Mendez and

Council Member Robert Cornegy, and with that I turn it over to HHC.

ALAN AVILES: Thank you and good afternoon Chairperson Johnson and members of the Health Committee; I'm Alan Aviles, President of the New York City Health and Hospitals Corporation. I'm joined here this afternoon by Antonio Martin, on my left, who is HHC's Executive Vice President and Chief Operating Officer, and on my right, Dr. Ross Wilson, our Senior Vice President and Corporate Chief Medical Officer. Thank you for the opportunity to provide an update on HHC's 2010 to 2013 restructuring plan, which we call "The Road Ahead."

Before providing a summary of the initiatives and their status, I'd like to provide some context on why we needed to undertake significant restructuring, cost containment and revenue optimization efforts over the last several years; the Chair has addressed this in part; I'll try not to be too duplicative, but the safety-net role of our public hospital system has made HHC especially vulnerable to deep cuts to Medicaid, the cost of serving the rising tide of uninsured patients and the erosion of federal funding have all cut deeply into

HHC's fiscal stability. 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 percent 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 we provided 70 percent of all the hospital-based clinic visits received by uninsured patients in New York City; we provided 43 percent of all the emergency visits by the uninsured, and we provided 34 percent of the inpatient care provided to uninsured New Yorkers.

Since 2008, repeated cuts to Medicaid reimbursement rates at the state level have slashed HHC's revenue base by more than $540 million annually. In addition, HHC has had to absorb astronomical increases in pension and employee health insurance costs -- for example, from Fiscal 2002 to Fiscal 2010, those costs are up by $500 million; Fiscal 2010 through Fiscal 2013 they're up another $180 million. In Fiscal 2010, facing a projected $1.2 billion budge gap for Fiscal 2013, we put together a gap closing plan called "The Road Ahead"

and it called for $600 million in cost containment restructuring actions and another $600 million in additional revenue, principally to come from the City, matching Federal dollars in equal amounts. 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 essentially would then put 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 remain daunting. HHC is projecting continued out-year deficits that grow from $465 million in Fiscal 2015 to actually over $1.3 billion in Fiscal 2018. This partly reflects that Superstorm Sandy made a bad situation worse. HHC lost $142 million net of Federal reimbursements in Fiscal 2013 from the storm. Also, due to further cuts to Medicaid reimbursement and

reduced utilization, HHC lost another $150 million in revenue in Fiscal 13.

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. I will just take you through a series of slides, providing an overview at a fairly high level.

We began our analysis… [crosstalk]

CHAIRPERSON JOHNSON: Council members… excuse me, sir; I just wanna… [crosstalk]

ALAN AVILES: Yeah.

CHAIRPERSON JOHNSON: Council members, the presentation is right behind you, if you wanna turn around and take a look… [interpose]

ALAN AVILES: You should also have a copy, I believe, of the slides as well… [crosstalk]

CHAIRPERSON JOHNSON: Yes, in your packet as well.

ALAN AVILES: So we began our analysis in formulation of a plan in the fall of 2009, as it

became clear to us that we were facing this daunting $1.3 billion deficit just three years out. So the plan itself was initiated in the spring of 2010 and it was put together in collaboration with our entire senior executive staff, including our senior vice presidents, and at the outset we agreed upon a set of guiding principles, and those principles are reflected on this slide and the next to stay true to our HHC mission to serve all without regard to their ability to pay or insurance status, to maintain our focus on patient and community needs; having achieved so much over the last decade and raising the quality of care and the safety of care in our system to maintain that quality and safety going forward, to leverage our vast integrated delivery system and all of its components, including our health plan, Metro Plus, and to engage our workforce, including those at the very frontline of care in the change efforts that were necessary going forward. We also were clear that we had to confront constructively both the unfolding economic downturn that was so clear at that point, late in 2009, as well as the trajectory of healthcare reform that was plainly going to change the underlying landscape dramatically. We also

wanted to and needed to focus on efficiency by streamlining operations, especially in ancillary and support service areas, where it was clear that our costs were above industry benchmarks, and also by deploying the most cost effective models of care and service delivery across our system, and finally, we also wanted to ensure that we leverage technology, both clinical and business systems technology, to increase our effectiveness and overall efficiency.

So essentially there were five broad areas of focus that encompass some 39 initiatives; those areas are listed here on this slide and again, the projected savings or new revenue from these initiatives was targeted at about $300 million annually once they were fully implemented. I'll take you through each of them very briefly.

So starting with administrative and shared services, our goal was to focus on targeted cost-effective shared services operations in four principal areas; they included materials management and supply chain; that is the procurement, the purchasing of the vast quantities of materials and supplies that are necessary in a system of our size and to leverage our size in order to reduce the per

unit cost to the maximum degree possible; we have made a great deal of progress along that front. This fiscal year we project… actually, last fiscal year we saved $15 million; we project a greater amount this fiscal year, and going into next fiscal year we're projecting an additional $15 million from supply chain efficiencies.

For both plant maintenance and environmental services we determined to contract out for the management of both of those areas; that is, using outside managers to manage our own staff in both of those arenas. We have saved about $9.2 million on the plant maintenance front and some $20.2 million in environmental services, which is essentially our housekeeping service.

Laundry and linen was an area that we had previously contracted for in part in the past, but continued to run a large laundry plant on the Kings County campus that was quite antiquated and inefficient and we contracted for all of our laundry and linen service to be provided and that was done as an outsourcing of both management and labor -- saved about $9 million since 2012. We did not, however, lay off any staff here, all staff were redeployed

within our system and we have been taking attrition over time.

Moving to the next slide. We also sought to reduce other costs, administrative and otherwise; we focused very early on in reducing our central office operating costs and reduced our FTEs and central office by about 40. We also reduced our information technology contract staff -- these were the consultants that were used -- and we in-sourced 140 IT jobs and effectively saved and are saving about $9 million a year by using directly employed staff as opposed to contractors.

We also were forced to reduce our skilled trades labor force in light of the fact that at this point we were seeing a major reduction in the funding of our capital program, about 30 percent reduction for the subsequent two fiscal years, and therefore we took a commensurate reduction in the size of our trades workforce; that was the one initiative that was done principally by lay-off, so the workforce was reduced by about 350 FTEs in total.

And then finally, we have begun the implementation of a laboratory services standardization, ultimate consolidation; this is a

joint venture that we are working on with North Shore-LIJ to combine the lab work of both of our very large systems; it will result in some 18 million lab tests a year being performed at one large shared lab facility, which is going to be constructed in Queens. That obviously will take some time; we don't think that new facility will be up and running till perhaps 2016, but we have already begun standardization of equipment and reagents and transferring some work that was sent to outside commercial labs to the North Shore-LIJ lab, which is providing that service at a lower cost. We've already saved $21 million so far this past year and we anticipate another $22 million in projected savings on top of that as we complete the full consolidation.

Turning to our work in long term care, "The Road Ahead" projected a reduction in skilled nursing facility beds in line with State and Federal policy direction, which is focusing more and more on community-based long term care alternatives.

We effectively reduced both long term acute care beds and skilled nursing facility beds, the LTACH, long term acute care hospital, beds were reduced in part because of a change in Federal

reimbursement policy that has now very strictly reduced the eligibility for LTACH reimbursement -- the patients who can be admitted to an LTACH in New York State has now been narrowed very considerably. We took the opportunity, as part of this initiative, to actually repurpose the North General Hospital campus, after that hospital closed, in order to effectively replace the Goldwater Long Term Care Facility on the southern end of Roosevelt, Island, which was built in the 30s and sorely needed replacing, by retrofitting the old North General Hospital for the LTACH portion of the Goldwater operation and then building a brand new skilled nursing facility on the parking lot. So effectively, Goldwater has now moved to that location in Harlem in a state-of-the-art facility named after Hank Carter, who is a longtime philanthropist who has provided more than $20 million of contributions through a non-profit he runs to the Coler-Goldwater community and its residents.

Now we also worked with a number of community-based organizations to create appropriate housing options for many of our lower acuity skilled nursing facility residents, who really no longer

required that level of care, but who did not have a viable housing option in the community. As a result of that work, we managed to place more than 200 skilled nursing facility residents into affordable community housing; this was in partnership with HPD and NYCHA in terms of Section 8 vouchers that were important as part of this process. And that was accomplished by September of 2013; we now project that we will have helped more than 350 skilled nursing home residents to move into community housing by this coming summer. Next slide.

We also took on a number of other targeted projects related to long term care, consolidating some select administrative support and underused therapy services that has saved us about $2.5 million annually; we also looked to optimize reimbursement opportunities; this is particularly true in connection with the skilled nursing facility, pharmacy billing, or some changes in law opened up opportunities for us to do discreet billing on the pharmacy side and that's brought in a projected $7 million for this fiscal year and then we did rebalance long term care staffing mix in part by having some staff shared with some local acute care

facilities where that made sense, about $2 million in savings from doing that. Next slide.

On the affiliation side there was a projection in the original "Road Ahead" plan of attempting to achieve some $50 million in savings on the affiliation contract front; although we did manage to reduce the cost of affiliation contracts and right-size some of the physician staffing to actual volume and we have reduced the rate of increase of the physician affiliation contracts, we fell short of the goal of $50 million; we achieved about $23 million in savings and that included a workforce reduction of physicians of about 52 physician FTEs. Next slide.

On the acute care side we focused on trying to reduce average length of stay in the original "Road Ahead" plan; as we began to operationalize that, and particularly because the Federal government in the interim had begun to impose penalties for above-average rates of 30-day readmissions and because third-party payers were scrutinizing one-day stays more closely and denying reimbursement in many of those cases, we refocused that initiative on reducing one-day stays and

reducing preventable admissions through our care management model that was deployed principally in our emergency departments and that has allowed us to not incur penalties we otherwise would have taken, and as a result, New York City, in general, has higher than the national average on preventable 30-day readmissions; we now have brought all of our hospitals, save one, to readmission rates which are at or below the national average -- the one hospital still above the national average is Coney Island Hospital, which has an average age of their patients is much greater than the rest of our system, largely because they're surrounded by nursing homes and so they get many elderly patients from the nursing homes and their readmission rates across the country tend to be higher.

We also focused on trying to grow in-patient capacity in select services, both to generate some additional revenue, but also to meet local patient and community needs, so there was focus on bariatric surgery and we now provide access to more than 1,000 bariatric patients each year; we have grown the cancer care centers at both Kings County Hospital and at Queens Hospital Center, and we have

focused on ensuring that those babies who need the highest level of neonatal intensive care actually receive that care within our own system, wherever possible, and Bellevue and Jacobi both provide those specialized services. Next slide.

On the ambulatory care front we did close six small satellite clinics with low patient volume; each of these clinics had fewer than 3,000 patient visits; they were principally child health clinics; it included one small dental clinic in Williamsburg. In selecting those clinics we took into account their proximity to other HHC sites, the level of utilization and the condition of the physical plant, which in many cases was very poor and would have required significant capital improvement or were located in NYCHA facilities where the plant itself really didn't lend itself to much upgrading in the environment.

We also moved to seek Federally-Qualified Health Center status for our six large diagnostic and treatment centers in order to garner enhanced reimbursement; we project that that should be worth somewhere between $26 and $30 million in increased revenue when completed; it's been a laborious and

complicated process, but we are now at the point where HRSA, which is the Federal agency that ultimately needs to approve FQHC status, has scheduled a site visit for the latter part of March.

We also, as part of "The Road Ahead," projected that we would look to transition inpatient, outpatient dialysis services to a joint venture model; this is something that we piloted at Elmhurst Hospital for a number of years and were able to provide excellent quality care without impeding access to any degree and to save money in the process, so we went through a competitive procurement process, ultimately selected the same entity that had been providing those services at Elmhurst and have begun to implement this initiative. Under the terms of that contract, access to care is guaranteed to all patients without regard to their insurance status, the same deal that we entered into at Elmhurst and the vendor entity has committed to expanding capacity within our system by about 30 percent, adding about 60 additional dialysis stations over the course of the next three years; those will be added to NCB, to Metropolitan and to Harlem Hospital; this is much needed additional capacity that we did not have the

capital funds to actually begin to expand and provide ourselves.

The transition of acute care that is inpatient dialysis to the vendor has been completed, we are about to now transition chronic dialysis, or outpatient dialysis to the vendor that does require final approval by the State Public Health and Planning Council that was on the schedule for their last meeting; the snow storm impeded their being able to take a vote, they didn't have a quorum on the committee that was considering this immediately before the Council; it's now scheduled for I think late March and that's the last step that would be required for them to be able to move forward on outpatient dialysis.

So the achievements to date -- we have effectively hit the combined target of $600 million; actually, as of the end of Fiscal 2013, on June 30th, [background comment] we had achieved $658 million, [background comment] so we over-achieved that target; we did it one year ahead of schedule. In the course of doing that, obviously payroll is 70 percent of our total costs, there's no way to achieve these levels of savings without reducing total workforce and we

did do that, though we did it mainly through attrition. We did manage to maintain virtually all of our service capacity and the quality of the services has been maintained or improved, indeed. Next slide.

As reflected on this slide, these are some of the award that HHC has received in recent years; it is quite an accomplishment and quite a tribute to our workforce across the system, that even as we were under these intense cross-containment pressures and undergoing all of this change, that they managed to not only maintain quality, but to improve it; we're particularly proud of the Eisenberg Award for Quality and Patient Safety, awarded by the National Quality Forum and the Joint Commission, a very prestigious national award. We've won the Pinnacle Safety Award in New York State twice, the Davies Award for using information technology to improve clinical care; again, is an award we won twice; there are only three other health systems in the country that have won that award twice, and a number of other awards, both on this slide and not on this slide, reflect the excellent work that all of

our staff have managed to do under these trying times. Next slide.

So even as we have been doing all of this, focused on trying to right the ship from a budgetary standpoint and secure HHC's fiscal future, we also are mindful that healthcare reform is fast changing the landscape under us, so we have worked hard to prepare the organization for those changes and to be able to deliver even better care going forward in that context. So as part of that we managed to achieve certification of all of our primary care sites, encompassing some 600 primary care providers as patient-centered medical homes. This NCQA designation was received at the highest level awarded, level three, and does entitle us to about $25 million enhanced primary care reimbursement going forward.

We also have worked very hard, and this is still a work in progress, but we're working on expanding primary care access and reducing waiting times; we're adding additional clinic hours in the evenings and on weekends; so far some of our sites have shown as much as 25 percent improvement in terms of access and reduced appointment waiting times.

We're continuing to use technology to create capacity and be more responsive to our patients, so we've made a very large investment recently in a new electronic medical record, which it will take a number of years to fully implement, as well as an improved appointment scheduling system, which ultimately will allow patients to schedule their own appointments electronically.

And then we've been working on developing care management and care coordination capabilities, those capabilities of an accountable care organization, since that's clearly the direction of healthcare reform. We did achieve accountable care designation from the Centers of Medicaid and Medicare Services and we are now participating in the Shared Savings Program for Medicare patients. And we also were the only entity in New York State designated as a health home in more than county; we are designated as a health home together with our health plan in the four most populous boroughs of New York City. Next slide.

So despite all of this progress, unfortunately future budget deficits do loom, as has been referenced by the Chair and in my opening

remarks. Our financial plan reflects large and growing projected budget gaps, and a very significant structural deficit which we will have to continue to struggle to remedy. At the current time we're showing a $430 million gap between expenses and revenues for Fiscal 2015 and that grows to about a $1.4 billion gap in 2018. [background comments]

Hurricane Sandy certainly has complicated the situation for us; there was a great deal of lost revenue, as we had to close major facilities for a number of months, there were exorbitant repair and mitigation costs associated with the damage done by that storm, and we have other threats that are likely to deepen the projected deficits even further that are not currently reflected in our financial plan; these include the outstanding labor agreements and for us, both the Teamsters and NYSNA, representing our nurses, have outstanding labor agreements that go back to the beginning of 2010 and there is currently binding arbitration over whether or not those unions would be awarded the pattern that was awarded to others for those two years, which is 4 percent and 4 percent. Assuming that that was done, the total retroactive liability for us, just on those two

contracts, is $350 million retroactively, and about $82 million prospectively; none of that is reflected in our financial plan, and there are additional potential labor liabilities going forward, because that doesn't cover the two additional years, including this fiscal year, where all of our unions are without resolved labor agreements. A 1 percent award in any one year amounts to about additional $30 million in personal costs going forward. And then we also have ongoing Federal budget cuts on the horizon to graduate medical education, which would affect us to outpatient clinical services, which would affect us; we estimate that if the proposed cuts actually go forward, that would be about another $60 million in revenue reductions to our system. So all in all, still a very daunting, a very challenging picture going forward.

That concludes my presentation, Mr. Chairman.

CHAIRPERSON JOHNSON: Thank you very much Mr. Aviles, I appreciate your thorough presentation. Before I announce the other council members and our Public Advocate who have arrived, I just wanna ask one thing; that that was a lot to digest, a lot of

numbers, and a lot of detail regarding each of the specificities that you spoke about; it would be helpful to also have all of that information as well broken down in the cost for the Committee and for the staff. So if you could please provide that to us, that would be great.

ALAN AVILES: We'll do that.

CHAIRPERSON JOHNSON: I wanna recognize some other council members that have joined us; before that I wanna recognize our Public Advocate, Letitia James, who is here, Chair of the Mental Health Committee, Council Member Cohen, Council Member Torres, and Council Member Maria del Carmen Arroyo for being here. So thank you all. I have some questions, but I wanna let the Public Advocate ask her questions first, because I'm sure she has a busy day ahead.

PUBLIC ADVOCATE JAMES: Thank you Mr. Chair. My first question is on the Medicaid waiver. Is HHC eligible to receive any of the Medicaid waiver money that… [interpose]

ALAN AVILES: Yes, we are.

PUBLIC ADVOCATE JAMES: And do you plan on applying for it?

ALAN AVILES: Yes, absolutely do. [interpose]

PUBLIC ADVOCATE JAMES: And do you believe that the Medicaid waiver will reduce your deficit?

ALAN AVILES: Well that is… we are hopeful that it will reduce [background comments] our deficit to some extent; however, unlike prior 1115 waivers that have been awarded without necessarily having a lot of stringent oversight as to how those dollars are expended and what results from that expenditure, this time around CMS is being very clear that these dollars must be applied to targeted initiatives that will produce certain outcomes. The overarching outcome is to reduce by 25 percent inpatient admissions over five years in New York State, so everyone who seeks some of the 1115 funding will have to submit their proposed projects, preferable in collaboration with other providers in the community and there will be performance targets that are set by the Federal Government; if they are not reached, the dollars will not be award, and much of that work requires significant additional

investment in order to make that transformation in the delivery system.

PUBLIC ADVOCATE JAMES: What will your application look like; what will you… you're seeking the funds for what purposes, specifically? [crosstalk]

ALAN AVILES: Well, I mean that is still a work in progress, because the State has not finalized with CMS the details of the 115 waiver, they have reached agreement on the broad framework; I think they have reached agreement on a whole set of a menu of various types of initiatives that they would find acceptable, but we need to see that final list; we have begun to think about some of the work that we're doing; obviously much of it relates to care coordination and care management so that we can produce both lower costs for the State and the Feds by avoiding emergency department visits and inpatient admissions, but also, produce a better result for our patients by, you know, increasing their health status so they don't require those intensive services.

PUBLIC ADVOCATE JAMES: Any possibility of the reopening of those outpatient clinics?

ALAN AVILES: Of the small… [crosstalk]

PUBLIC ADVOCATE JAMES: Yeah.

ALAN AVILES: child health clinics?

PUBLIC ADVOCATE JAMES: Yeah.

ALAN AVILES: I would say not, we have enough… these were principally child health clinics and as you know, the overwhelming low-income pediatric population we serve, even if they're undocumented, are eligible for coverage and so between our capacity and the capacity of community pediatricians, we're confident that those community needs are being met. In the aggregate, the total number of visits [background comment] that were eliminated through the closure of these small satellites is easily accommodated at our other sites and has been.

PUBLIC ADVOCATE JAMES: And in the 1115 application, would it include the possibility of reopening the peds unit at North Central in the Bronx?

ALAN AVILES: The peds unit… [background comment] you… you mean labor and delivery? [interpose]

PUBLIC ADVOCATE JAMES: The labor and delivery, excuse me.

ALAN AVILES: We already have determined and have indicated to the State Health Department that we will be reopening inpatient maternity services in the Bronx; it will take some time, they initially asked us to shoot for April 30th; I have been in direct conversations with Nirav Shah, the State Health Commissioner, to reassure him that we are moving forward to do exactly that, but that being able to identify and on-board the full complement of staff you need, not only for the inpatient maternity services, but also the neonatal intensive care unit which has to be there as well, will take us several months. So it will happen, but it won't happen by April 30th, but it will happen.

PUBLIC ADVOCATE JAMES: And last question is; as you know, my office prepared a letter and sent it to the State Department of Health with regard to the dialysis units and obviously we have opposed the privatizing of the dialysis clinics. I know that's been put on… it's been delayed; do you… can you tell me why it has been delayed; are you rethinking your proposal?

ALAN AVILES: The delay -- I mean this is something that was brought before our board 18 months ago… [interpose]

PUBLIC ADVOCATE JAMES: Yes.

ALAN AVILES: it was vetted -- many stakeholders voiced their opinion -- after due consideration, the board did approve our going forward with that; at this point, before… the vendor has already assumed inpatient acute care dialysis services across our system, but before they can assume the outpatient, chronic dialysis services, they need to have a Certificate of Need approved by the State Public Health and Planning Council, the State Health Department has reviewed everything and has recommended such approval; it was slated to be considered at the last meeting, but with the snow storm there was not a quorum, so they put it off to the next meeting.

PUBLIC ADVOCATE JAMES: Let me just say that the Office of Public Advocate, we are very much concerned about the privatization of the dialysis clinics, particularly because of the outcomes and a number of individuals have contacted my office regarding the fatality rate, and so obviously we're

very much concerned with respect to that privatization.

ALAN AVILES: Well we… you know obviously we care deeply about the quality of care rendered to our patients; we would not do this if we thought we were placing quality of care in jeopardy. I mean this is not… although most hospitals across the country have outsourced dialysis and have done so to large publicly-traded, for-profit companies that respond to quarterly earnings pressure and all the rest, we did not do that; this contract is with a local independent company that was actually created by two of our own nephrologists who used to work at Elmhurst Hospital; it is a company that actually has run chronic dialysis at Elmhurst Hospital since 2006. Their quality and their performance indicators are excellent and all of this is publicly transparent now, because the Federal Government in the last couple of years has required the reporting of all this quality data; we understand that some of their other sites may not perform quite as well as the Elmhurst site; it is because we insisted on a model where our nephrologists continue to oversee the treatment of care and the quality of care, we think

that is critically important; that's not necessarily done by others at other sites; that's the model we would follow going forward here.

PUBLIC ADVOCATE JAMES: I thank you, but we still remain concerned about the quality of care. Thank you.

ALAN AVILES: Understand.

CHAIRPERSON JOHNSON: Since we're on that issue, I mean I wanna come back to some of the broader issues that were talked about, but since we're on the dialysis issue, I just wanna ask a couple of questions and if other members wanna chime in on this, they can as well. As the Public Advocate stated, I think the entire Bronx delegation wrote a letter with regard to opposing the privatization of the dialysis centers, members whose districts were affected wrote a letter and I signed that letter as well with our concerns; I just have some questions on that. I know you spoke about the Elmhurst rates, but some critics have argued that Atlantic, the parent company of Big Apple, the outsourced company that dialysis would go to, has had a performance rate that is worse that HHC's has been. What has HHC's assessment been of privatized hospitals run by Big

Apple's patient care record in contrast to HHC's record?

ALAN AVILES: Well I think that you can't necessarily just make that comparison and come to a judgment. First off all, some of their sites are actually run for or in nursing homes; there is not question, but for example, mortality data will differ markedly, if you're talking about a general dialysis population or talking about a skilled nursing facility dialysis population, the average life expectancy for a general dialysis population is about 5 years, the average life expectancy for a dialysis patient at a skilled nursing facility is 6 to 8 months, so I think you really need to look at examples that really give you a sense of how would they do in our context. And quite frankly, I believe that HHC and its nephrologists and its primary care providers provide exceptional care to our patients, that's a critical part of this, it's not just what do the dialysis centers do, it's to what extent are they partnered with a system like ours that has a systematic approach to addressing the overall health needs of dialysis patients who often generally have diabetes, have hypertension; sometimes have

congestive heart failure, so you have to be addressing all of that as well. If you look at the Elmhurst model, which is this company, providing this service on a contractual basis, in partnership with our nephrologists at Elmhurst, they out-perform the majority of HHC's other sites and they uniformly out-perform national and State averages on the whole host of performance indicators that CMS tracks and makes publicly transparent.

CHAIRPERSON JOHNSON: So you in no way feel like the privatization of the dialysis centers in any way compromises HHC's core mission?

ALAN AVILES: We wouldn't be doing it if I felt that.

CHAIRPERSON JOHNSON: Okay. I have a few questions, then I'm gonna go to my colleagues that have signed up; if anyone else wants to ask a question, just let the Committee Counsel know. I know you spoke in great length about the lofty goal of reducing staff and consolidating services at facilities to save the hundreds of millions of dollars that have been saved thus far with minimal impact to access of care and quality of care and continuity of care; how has that been judged, because

what you said earlier, when you were going through the presentation, was that you've maintained most of service capacity, you didn't say all, you said most, so what parts have not been maintained that you feel has impacted quality of care or continuity in care?

ALAN AVILES: I don't know that it impacts quality of care or continuity of care, but obviously to the extent that those six small outpatient clinics represented capacity in their specific neighborhoods, that capacity is not there. It is… however, the need… the broader community need is met by the other facilities in relatively close proximity. We have seen some reduction in… not so much in capacity, but in utilization; this is true across the City now, because there is so much focus on reducing preventable admissions and one-day stays, so for this fiscal year we're down 5 percent in our inpatient admissions. We have not yet focused on what the appropriate response may be in right-sizing staff, in light of that reduced workload, in part because we're seeing great success, relatively speaking, under new health exchanges through our Metro Plus health plan and we are enrolling about 25 percent of all of those New Yorkers in the City who

are seeking coverage on the new health exchange are opting for Metro Plus, so we're hoping that that is going to increase the amount, the volume in utilization we see and that this excess capacity that we are beginning to see on the inpatient side will actually find volume that'll generate revenue and so that we will not have to reduce staffing in response to that reduced volume.

CHAIRPERSON JOHNSON: I have one more question before we go around to the other council members that are here. HHC, as was stated earlier, both in my opening statement and in yours, currently serves 37 percent of your population of people that do not have insurance, 478,000; if I read some of the reports correctly, you're projecting that the number will go down as people sign up, as you just said, through the exchanges and through the ACA; do you have any sense if HHC's number of 37 percent is typically higher, much higher than non-public hospitals across the City?

ALAN AVILES: It is extraordinarily high compared to non-public hospitals, even hospitals that are considered safety-net hospitals that often is because of the very high percentage of Medicaid

patients that they serve rather than the combination of Medicaid and uninsured patients. Even though HHC constitutes only 18 percent of all the hospital beds in New York City, 38 percent of the uninsured patients who need hospitalization find it in HHC facilities; 70 percent of all uninsured patients who receive outpatient services in a hospital receive those services within the HHC system. So we very disproportionately carry the burden, we view it as our obligation in our mission of caring for uninsured New Yorkers.

CHAIRPERSON JOHNSON: But why do you think that that number is going to go down; is there hard data that you guys have that says that because of the exchanges, because of the ACA you are still gonna have a significant undocumented population [background comment] that you'll serve at HHC facilities and hospitals; where does this number come from that you're projecting that it's gonna decrease significantly?

ALAN AVILES: Well we are projecting that a certain percentage of our uninsured will become eligible on the exchange or for Medicaid, since the Medicaid threshold for single adults has been raise.

However, you are absolutely right that we'll have to wait and see to what extent that becomes the case, because even though the number of uninsured in New York State as a whole has plateaued and begun to come down as the economy has improved; our uninsured numbers have continued to go up, and for us, that tells us that more and more other facilities, including voluntary facilities that are under tremendous cost-containment pressures, are channeling more of their uninsured to our front door. So about 60 to 70 percent of our uninsured we estimate are undocumented; they are not gonna get any help from the Affordable Care Act and they will continue to come to HHC for care.

CHAIRPERSON JOHNSON: So do you anticipate that the percentage of HHC patients who are uninsured will go up, your percentage will go up then?

ALAN AVILES: We are anticipating the percentage will go down, we just don't know by how much, because we don't know to what extent we will continue to be the magnet for more uninsured patients who may be getting their care now at some of the other voluntary hospitals, but as those voluntary

hospitals begin to suffer even more severe fiscal pressure, and some of them perhaps even close their doors, those patients will look to us to meet their needs.

CHAIRPERSON JOHNSON: Okay. We're gonna go to Council Member Barron, who has some questions.

COUNCIL MEMBER BARRON: Thank you Mr. Chair. Thank you for your testimony, there's lots in here and I'm certain that I'll probably have some other questions that I would like to pose to you after this hearing and I would love to be able to get a response. In terms of the 3,700 FTEs, what percentage of the total workforce is that… does that represent?

ALAN AVILES: When we started, the total workforce was about 39,000, so it is just over 9 percent.

COUNCIL MEMBER BARRON: And what job titles were most of those positions?

ALAN AVILES: Well 80 percent of the reductions occurred in three broad areas; they were clerical titles, they were environmental or housekeeping titles, and they were aide and orderly titles.

COUNCIL MEMBER BARRON: They were… the last category was what?

ALAN AVILES: Aides and orderlies.

COUNCIL MEMBER BARRON: Aides and orderlies. Do you have the percentage of aides and orderlies?

ALAN AVILES: Aides and orderlies is 21 percent, environmental housekeeping 36 percent, clerical 24 percent.

COUNCIL MEMBER BARRON: And I'm wondering how the 21 percent of aides and orderlies did not have an impact on the quality of care that was given. I know that nurses are very, very much overworked; I know that they have concerns about some of their job requirements where they have to lift patients and aides assist them in doing that and there's a whole request for certain equipment that will help them lift certain patients that are heavy patients. So I'm wondering how the quality of care for patients has not been impacted… [interpose]

ALAN AVILES: Yeah.

COUNCIL MEMBER BARRON: when… [crosstalk]

ALAN AVILES: So in…

COUNCIL MEMBER BARRON: 21 percent of those layoffs were aides. [crosstalk]

ALAN AVILES: in general, something I didn't address in my remarks; I mean, one thing we have tried to do; as I said, we've tried to engage our workforce in these changes and so over the course of the last 6 years we have been implementing a standardized process improvement approach, which we call "breakthrough," which is based upon a frontline team-based approach to removing waste and reengineering the way work is done to improve efficiency, which developed actually in the manufacturing industry decades ago and has been applied to healthcare only in recent years. That process through which we've done now more than 1,400 week-long rapid improvement events using frontline teams, which sometimes includes aides and orderlies, have looked for ways to redesign work so that it can be done more efficiently. So I mean, part of the reason we've been able to take attrition is because of the efficiency that we've achieved over recent years in going through that process, for sure. But you know, I'm not saying that this is not having an impact on our workforce; there is no question but

that our workforce is more stressed today than it was you know before we took these reductions and that our workforce is certainly working incredibly hard, because we're operating on a leaner model, there's no question about that.

COUNCIL MEMBER BARRON: And what is the patient-nurse ratio generally in HHC's, and does it differ from hospital to hospital?

ALAN AVILES: It generally differs from setting to setting, so the patient-nurse ratio will be different in the emergency department from what it is in the ICU, from what it is on a med-surg unit, from what it is on a rehab unit; it really depends upon the acuity of the patient, so in a regular med-surg unit it may be 1 to 8; in an ICU it is typically 1 to 2, for example.

COUNCIL MEMBER BARRON: And is it generally that ratio in all of your facilities or is it… [crosstalk]

ALAN AVILES: Well there is some variation and we actually are focused on trying to come up with a model that implements a more standardized approached in all settings and it can vary, you know from day to day, just depending upon

unexpected things like, you know, unexpected absences and the like. We do deploy a fairly large set of agency nurses who help us to make adjustments, both in terms of fluctuations in volume, which are both seasonal but can be daily, and in terms of fluctuation in the number of absences we may have at any given point.

COUNCIL MEMBER BARRON: And just two more brief questions. The Medicaid reimbursement rate; does that vary from hospital to hospital; is it the same for Kings County as it is for Bellevue or other hospitals? [interpose]

ALAN AVILES: The rates… in the final analysis, the rates, particularly on the acute care side, really are a function of the acuity and the types of patients that are seen in that facility -- a community hospital, like North Central Bronx, where patients are not necessarily admitted who have trauma because they're not a trauma center; that reimbursement will be lower than the reimbursement… [background comment] so the rates differ for acuity; our Chief Financial Officer is reminding me that the rates also differ based upon graduate medical education add-ons to the rate and also based upon

wage index, which is not uniform across all of New York City.

COUNCIL MEMBER BARRON: Okay. Now one last question… if I can find it… Do you have any recommendations… there's a Brooklyn developmental center in my district which is being closed because of the Olmstead Act, where we're not supposed to have confined persons in large settings, but they're supposed to be dispersed; it's a Federal requirement; do you anticipate that those numbers of people will in some ways need those services from HHC and how that would put another demand on the system?

ALAN AVILES: I'd have to look at that, I'm not familiar with that program or the… [interpose]

COUNCIL MEMBER BARRON: Okay.

ALAN AVILES: panoply of services that those individuals may need or how many we're talking about; we would have to really take a look at that.

COUNCIL MEMBER BARRON: Thank you.

CHAIRPERSON JOHNSON: So before we go on to other council members that have questions, I just wanna remind council members that we have six panels today of folks that have already signed up and I'm

sure more people that are in this room may sign up to speak; I know that you all have busy schedules and may not be able to stay the entire hearing, but I will be here to make sure everyone is listened to, and for the folks that signed up for panels after HHC, please be patient with us, because we have a lot of questions for HHC and I think they are hopefully questions that will be meaningful and informational to the folks that are here in the room today caring about the future of HHC. So with that I will go to Dr. Eugene. So we're not gonna put council members on the clock, but if folks can be mindful.

[crosstalk]

COUNCIL MEMBER EUGENE: Thank you… thank you Mr. Chair and I'm going to combine my questions and be very quick. The transfer or the sale of the dialysis services to Big Apple; what is going to be exactly -- transfer of lease agreement or transfer of permit or license? Is it going to be a transfer of license or is it going to be a lease agreement?

ALAN AVILES: It is… the space itself is being licensed to the vendor, which means that we have the ability to terminate that use of space on

much shorter notice than would be typical in an actual lease.

COUNCIL MEMBER EUGENE: So that means HHC will still have the license and they will be using the space; is that correct?

ALAN AVILES: Well there are two possible connotations to use of license here. There is… whether or not dialysis services is on our operating certificate, which is different; in fact, once the CON is granted for Big Apple Dialysis to assume outpatient chronic dialysis services, we would move to have chronic dialysis removed from our operating certificate, 'cause at that point we're contracting for that service from that entity and simultaneous with that, they would begin to occupy that space pursuant to a license agreement that allows them to occupy that space and they pay us, obviously, the equivalent of rent for that space.

COUNCIL MEMBER EUGENE: Thank you very much. In terms of services, will the services be the same or would there be any change in terms of providing services… [crosstalk]

ALAN AVILES: The services…

COUNCIL MEMBER EUGENE: providing services?

ALAN AVILES: The services, which will, again, be overseen by our nephrologists will be the services that are provided now; meaning that every patient who needs dialysis will receive as much dialysis as that patient needs, typically 4 hours, in order to ensure that they are being adequately dialysized, and to the patients there should not be a significant change apparent to them.

COUNCIL MEMBER EUGENE: I see. But since the services are going to be transferred to a new organization, a new entity, what do you have to secure the continuity of the good quality of services? Because one of the concerns… [interpose]

ALAN AVILES: All the services…

COUNCIL MEMBER EUGENE: one of the concerns of the nurses…

ALAN AVILES: Yeah.

COUNCIL MEMBER EUGENE: is the continuity of good quality services… [interpose]

ALAN AVILES: Sure.

COUNCIL MEMBER EUGENE: and also the safety of the patient…

ALAN AVILES: Sure.

COUNCIL MEMBER EUGENE: what do you have in place to guarantee that the services will [interpose]

ALAN AVILES: Sure.

COUNCIL MEMBER EUGENE: still be good quality services and that the patient will be safe?

ALAN AVILES: Well obviously, you know as I stated earlier, we are equally concerned to ensure that the quality of service delivery is there and that it is delivered in the safest possible way. Dialysis is one of the most heavily regulated healthcare services in the country; there are more than 700 performance metrics that all dialysis providers have to report to the Centers for Medicaid and Medicare Services and a certain number of those are actually publicly reported and available on the CMS website. Those performance metrics are also reported to us, not on a quarterly basis, as with CMS, but on a monthly basis, pursuant to our contract, and they are reviewed internally by us and will be reviewed by the Quality Assurance Committee of our board on a quarterly basis. So all of that, which is how we essentially ensure the quality of

services we're providing ourselves now will continue to get provided going forward.

COUNCIL MEMBER EUGENE: But in terms of Big Apple, did you conduct any survey; did you review any report related to their performance when… [interpose]

ALAN AVILES: Oh yes, of course. We looked at all of their performance data and more importantly, you now, our Chief Medical Officer and a nephrologist in the corporation reviewed some of this, in terms of the council that oversees work of this type. And as I alluded to before, we are maintaining the physician supervision and oversight of quality; this will be done by our own nephrologist. So that is how we will ensure that we, on a daily basis, are aware of the quality of care being rendered.

COUNCIL MEMBER EUGENE: This is my last question, Mr. Chair. In case the services are not the same; I mean the quality of services is not the same; what do you have in place to correct the situation? You never know.

ALAN AVILES: Yes, well they… I mean if we have any issue… and maintaining equivalent or

better quality of care is one of the contractual terms of obligation; if the data we're receiving reflects anything short of that, they will be given, at most, a 45-day window to correct that; otherwise the contract is subject to termination by us.

COUNCIL MEMBER EUGENE: Thank you Mr. Aviles; thank you Mr. Chair.

ALAN AVILES: Thank you. [crosstalk]

CHAIRPERSON JOHNSON: Thank you Dr. Eugene. Next up is Council Member Mendez.

COUNCIL MEMBER MENDEZ: Thank you Mr. Chair. President Aviles; please to see you again. Regarding the outsourcing of the dialysis work, can you tell me what was the… under HHC what was the staff to patient ratio and what is it under this other vendor?

ALAN AVILES: Well I don't know that off the top of my head, but we could certainly get that to you.

COUNCIL MEMBER MENDEZ: Okay. Thank you. Couple of questions; I'm just gonna go through them here. In Page 6 of your PowerPoint presentation you indicate that there was… is it correct that you

indicated… that's what I thought I heard… $9 million in savings from in-sourcing 140 IT jobs?

ALAN AVILES: Yes.

COUNCIL MEMBER MENDEZ: Can you explain that a little bit?

ALAN AVILES: Well much of our IT… we are a very technology-intensive environment, as you can imagine, so much of the healthcare equipment that is used today is bound together in way or another by an information technology infrastructure and of course we run business systems that are very IT heavy and we run an electronic medical report that is very sophisticated, and we're in the midst of preparing to implement a brand new electronic medical record. So we require a variety of IT skills and when you get to the high level of those skills, in the past we have often contracted with consultants to provide us with those skills. What we have done is systematically searched for individuals who either come to us with those skills or who come to us with a sufficient skill base that we can send them to then be certified at a higher level of skill and proficiency and use them as opposed to the consultants. The differential of the costs between directly employing and

contracting for those services is quite significant for 140 positions; the differential is $9 million.

COUNCIL MEMBER MENDEZ: And is all of HHC using electronic health records?

ALAN AVILES: Yes.

COUNCIL MEMBER MENDEZ: Thank you. On Page 7 of your PowerPoint presentation you indicated that 200 skilled nursing facility residents were discharged to community housing; you then added that you worked with HPD and NYCHA; could you explain that please?

ALAN AVILES: Well in connection with some of the housing opportunities -- for example, a building on 97th Street, which is providing affordable housing that is wheelchair accessible -- in order for some of our residents to actually be able to make that move into the community, the required Section 8 vouchers. And so we worked with HPD and NYCHA in order to make some of those vouchers available to these long-term residents of low acuity who could live in the community as long as they had an affordable option and particularly if it was right across the street from Metropolitan Hospital, which could provide support of medical services.

COUNCIL MEMBER MENDEZ: So this is permanent housing… [crosstalk]

ALAN AVILES: Yes. Yes.

COUNCIL MEMBER MENDEZ: and it's affordable through the Section 8 vouchers that NYCHA and HPD, who work with the Section 8 vouchers, work with you directly to get them located? So they're not necessarily in a NYCHA building… [crosstalk]

ALAN AVILES: No.

COUNCIL MEMBER MENDEZ: or in an HPD program building; it could be in a private building, but just that the voucher was secured?

ALAN AVILES: Let me have LaRay Brown respond to this, since she's been the lead on this. Why don't you go ahead.

LARAY BROWN: So council member, many of the two… [interpose]

CHAIRPERSON JOHNSON: Miss Brown, could you introduce yourself… [crosstalk]

LARAY BROWN: Oh I'm sorry.

CHAIRPERSON JOHNSON: on mic and what your title is?

LARAY BROWN: Sure. My name is LaRay Brown and I'm Senior Vice President for Corporate

Planning and Intergovernmental Relations. Sorry about that. So many of the 200 skilled nursing facility residents who were placed went to a combination of types of housing. Some actually went to public housing and because in fact, we have a long-standing agreement with NYCHA that there is a preference for HHC nursing homes -- in particular it was Coler-Goldwater -- for public housing and so many of the individuals met that criteria. In addition, we worked with various supportive housing providers throughout the city to identify housing opportunities for some of our nursing facility residents and that was successful. In addition, we worked with NYLAG, which is a legal service, to help individuals obtain either… essentially documentation or documents that they did not have prior to their admission to our nursing home or while they were in the nursing home, which then allowed them to have the benefit of resources that allowed them then to have tenancy in independent apartments and we also worked with families who, at a point in time during the resident's tenure in our nursing home may not have been ready to receive that resident post-discharge, but in our work with those families and providing

things like homecare through HHC's home health agency or through other community supports, the families were willing for that individual to return to their home or to live with the family. So we have a combination of strategies. The East 99th Street housing development that Mr. Aviles spoke about, that is a 175-unit apartment building that will be finished and be able to be rented out by this summer, and that project, as Mr. Aviles said, is being constructed with tax credits and other financing through HPD and HDC, and also working with NYCHA we were able to get the HUD… alphabet city… HUD's approval as project-based Section 8, so every one who will be a tenant in that building will also have rental support.

CHAIRPERSON JOHNSON: Thank you.

LARAY BROWN: You're welcome.

COUNCIL MEMBER MENDEZ: Thank you for explaining that. President Aviles, you also indicated in Page 8 of the PowerPoint that there was a $7 million savings this year for reimbursement opportunities, the optional… [crosstalk]

ALAN AVILES: Yeah, that relates to the billing for pharmacy services in our skilled nursing

facility which follows on a regulatory change that allowed us to actually bill separately for some of those pharmaceuticals, so we began to do that and that generated that revenue.

COUNCIL MEMBER MENDEZ: And so this was just limited to the billing in the nursing facilities or… [interpose]

ALAN AVILES: Oh there was actually a great deal of work done to optimize billing and collection generally across the system, so about a $100 million in total was secured over the course of this last year by addressing billing and collection and optimizing revenue.

COUNCIL MEMBER MENDEZ: Okay. I'm gonna wrap up. The six satellite clinics; could you tell us where they're located?

ALAN AVILES: Sure.

COUNCIL MEMBER MENDEZ: And you said they were closed for underutilization or was there other reasons?

ALAN AVILES: The six were -- in the Bronx it was the Glebe Child Health Clinic on Glebe Avenue, in Brooklyn it was Wyckoff Child Health Clinic on Wyckoff Street and the 5th Avenue Child

Health Clinic on 5th Avenue and the Howard Houses Child Health Clinic on East New York Avenue, and then in Queens, the Astoria Child Health Clinic on 31st Avenue and then, as I mentioned, there was a small dental clinic in Williamsburg on Graham Avenue that was also closed.

COUNCIL MEMBER MENDEZ: Thank you. And regarding your Sandy numbers here, you said that it went from $430 million in Fiscal Year 2015 to nearly $1.4 billion; is that just repairs and looking at… or was that loss of income through services and doing resiliency; could you…

ALAN AVILES: A good part of it is resiliency and mitigation going forward, particularly for Bellevue and Coney Island Hospital [background comment]. What? [background comment] Oh I'm sorry; I may have misunderstood your question; I thought you were referring to the Sandy numbers. You… you wanna respond to this, Marlene? Here. [background comment]

MARLENE ZURACK: Council member, the numbers that you were using… [interpose]

COUNCIL MEMBER MENDEZ: You're gonna have to identify yourself for the record, so.

MARLENE ZURACK: Hi, I'm Marlene Zurack, Senior Vice President for Finance, New York City Health and Hospitals Corporation. The numbers in the presentation to which you refer are the above-the-line budget gaps, not the Sandy number. The Sandy number is a couple of bullets down; I just wanna make that clear. So those were the above-the-line budget gap numbers, the $430 million growing to $1.4 billion. [background comment]

COUNCIL MEMBER MENDEZ: That's above line?

MARLENE ZURACK: Yeah.

COUNCIL MEMBER MENDEZ: And what were the actual Sandy losses?

ALAN AVILES: The Sandy losses, from the standpoint of costs associated with maintaining all of that staff while two major facilities were closed is in the ballpark of about $250 million, on top of that we had actual immediate emergency repair and permanent repair costs that were several hundreds of millions of dollars. On top of that we have an enormous amount of costs associated with the ultimate mitigation of the risks for, as I started to say, Coney Island and Bellevue; Coney in particular,

because that facility took water on the first floor and actually requires the rebuilding of the emergency department on an elevated platform in the parking lot and then the stacking of associated services, including imaging services, ICU services and other services that really need to be proximate to the emergency department. So that is a very significant ask to FEMA, which we are in the process of teeing up now.

COUNCIL MEMBER MENDEZ: I know that Bellevue was being brought back unit by unit, so all of the units at Bellevue are functioning… [interpose]

ALAN AVILES: Yes. Yes.

COUNCIL MEMBER MENDEZ: and also at Coney Island?

ALAN AVILES: All the units at Bellevue are fully operational; have been for quite some time. At Coney Island we still have I think one medical-surgical unit that has not yet been brought online…

ANTONIO MARTIN: It's operational now.

ALAN AVILES: Mr. Martin just told me it is now operational, so the last unit has now been brought back online.

COUNCIL MEMBER MENDEZ: Okay. Thank you very much. [interpose]

CHAIRPERSON JOHNSON: Thank you. And…

COUNCIL MEMBER MENDEZ: Thank you Mr. Chair.

CHAIRPERSON JOHNSON: and council members that are here, we're gonna go to Council Member Espinal and then Council Member Torres and we can go for a second round of questions as well. Council Member Espinal.

COUNCIL MEMBER ESPINAL: Thank you Mr. Chairman, good evening… uh oh, good afternoon. [laugh] I just have a question regards to the cancer care in your hospitals; I know you touched on talking about how there will be a growth at Kings County Hospital and Queens Hospital; can you touch a little bit more on that; is it increased in services; is that increased in capacity only for in-patient? Also, what would be your assessment of the quality of care in your hospitals?

ALAN AVILES: Let me ask our Chief Medical Officer to address both of those.

DR. ROSS WILSON: Thank you. My name is Ross Wilson, Chief Medical Officer at HHC. With

regard to the cancer services, at Queens Hospital Center we have a designated cancer center, multidisciplinary, which has been growing slowly and steadily and doing very good work and being very well-recognized by the national accrediting bodies. More recently, at Kings County Hospital, we've grown cancer surgery, particularly advanced cancer surgery involving the liver and the pancreas and we have increased the volume of patients there by threefold over the last two years with, again, outstanding results. We're augmenting that at Kings County with the additional new MRI scanner and as well, a linear accelerator for extra therapy. So those services are increasing and are very well regarded.

It's fair to say that at all of our acute sites we have very good cancer detection and screening and we provide cancer services everywhere, but for more sophisticated services that are required only rarely, obviously we do them at consolidated sites.

In regard to your second question -- how do we regard the quality of care? We regard the quality of care as excellent across HHC; as in any service, some days are better than others because

some days it snows or some days more people are sick or some days terrible things happen, but really, compared with all benchmarks, we do extraordinarily well with a very unpredictable workload with six major trauma centers and with such a high percentage of patients with behavioral health needs that come to our services and challenge our staff and our equipment every day. I think given the circumstances under which our staff work, they do an extraordinarily good job and we've been well-regarded by all of the measures.

I think finally to say, many measures of quality are now in the public domain; we are open about how well we do everywhere, we are open in our own website, we're open through CMS reporting and so sometimes it's up to others to judge how well we're doing because we're very clear about how we report. Thank you.

CHAIRPERSON JOHNSON: Council Member Torres.

COUNCIL MEMBER TORRES: Thank you Mr. Chairman and thank you President Aviles. I have a few questions about the closing of a highly-regarded and urgently needed maternity center at North Central

Bronx Hospital, it has implications from my district, I represent the Central Bronx, and I know it's slated for reopening, but I'm curious to know why did HHC decide to close it in the first place, and before making decisions about closing a service or privatizing a service; does HHC have a standard process of conferring with the community and conferring with institutional stakeholders? Those are my two questions for now.

ALAN AVILES: We had experienced a certain amount of destabilization for the obstetrical service in the North Bronx, which is actually run as a collaborative service between Jacobi and NCB and we were without a permanent director of OB services. During this time we actually lost an unusual number of senior attending obstetricians and during the summer; I remember this well because I was actually on vacation and I got a phone call from Dr. Wilson and some of our other leadership informing me that they had reached a conclusion that we could no longer safely deliver services at NCB because of the deficit particularly of senior attending obstetricians to cover all of the tours. So that was at that point that we made the decision that we would consolidate

services at Jacobi, wait for the new director of obstetrics to begin; we were still in the search process at that point, and then reconsider reopening in-patient maternity services. So ordinarily this is something that would have been discussed with our community advisory board, but because it was a matter of patient safety and some urgency that was done immediately once the conclusion had been reached that we could no longer feel confident that safe care could be rendered there.

COUNCIL MEMBER TORRES: Is there a timeframe for reopening it?

ALAN AVILES: The timeframe is as soon as possible, but the complete plan for reopening, including the staffing plan for the in-patient maternity services and the neonatal intensive care unit, which also needs to be reopened, won't be completed until sometime in March; we then need to do the on-boarding and recruiting of the entire complement of staff necessary for both of those services, you obviously can't turn it on until you have all of the staff in place to cover all of the tours seven days a week. You know I think that will take us several months to reach that point, so at

this point I would say we're probably looking at the summer, realistically.

COUNCIL MEMBER TORRES: I mean at what point will HHC have a plan or some outline of a plan available for public view?

ALAN AVILES: March.

COUNCIL MEMBER TORRES: March? Okay. And I guess the concern… there's also concerns that the maternity center's in danger of facing decertification by the Health Department at the State or… [crosstalk]

ALAN AVILES: I don't… I don't… I don't… I don't believe so; I mean it is typical for the State Health Department in a situation like this to provide, you know a timeline by which they would like you to make a decision as to whether or not you're reopening or you're looking to shut down a service; you know, it's a relatively arbitrary timeline, but I have had direct conversations with State Health Commissioner Nirav Shah about our intention of reopening and the fact that we will need to ask the State Health Department for an extension of time to do that and I've been assured that they will be completely responsive to that.

COUNCIL MEMBER TORRES: Do you know if the State Health Department would be willing to provide those assurances in writing to reassure the public?

ALAN AVILES: We will have to at some point, you know, formally make that request, which we'll do… [interpose]

COUNCIL MEMBER TORRES: 'Cause I know you're personally assured, but we… [interpose]

ALAN AVILES: No, as soon as we have the written plan, because they'll wanna see the written plan, we'll be able to actually make that request formally.

COUNCIL MEMBER TORRES: And you said that the original decision to close it, that you were no longer confident in your ability to… [interpose]

ALAN AVILES: Yeah.

COUNCIL MEMBER TORRES: safely deliver labor and delivery services, so if we reopen it, what assurance can you give us that we're not gonna repeat the same fate, that you're not longer confident in your ability to safely deliver these services?

ALAN AVILES: Let me ask Dr. Wilson to address that.

DR. ROSS WILSON: I think it's a very good question and it goes to the point that we are very focused on the quality and safety of our care, which has come up in several aspects of the discussion today and it shows that if we think that something is gonna happen which would compromise the care, that we would protect the patients and make the necessary decisions. And on this occasion we needed to make that decision because we couldn't retain senior staff and it was during a period of clinical leadership difficulty we were having at that time; we have subsequently replaced the chair of OB services in the North Bronx Network and he came onboard late in December; he is the person who's leading the development of the new plan. His ability to recruit and retain experienced and senior staff is key to this plan being successful; that's a mixture of OB staff, nursing staff, midwifery staff and anesthesia staff. With any service that we have, we are continuously watching all of the aspects that would make a difference to safety and quality and so if there was some extraordinary event that led to a concern about any of our services, we would always protect patients by diverting them somewhere else

rather than provide service that's not up to standard. We expect to build this plan carefully and deliberately and we don't want to reopen the service until we are really confident that we've got everything in place for it to be safe.

COUNCIL MEMBER TORRES: So just one last question; I just want, you know upon reopening, that you are assured that the beds will be safe and that we will have senior level staff able to deliver those services safely; that those are… if we have those assurances on record.

DR. ROSS WILSON: When we reopen this service, at that time we believe we will have in place all the safety requirements with staffing and equipment to provide a high level of care for women in the North Bronx.

COUNCIL MEMBER TORRES: 'Kay, thank you; I appreciate your testimony.

CHAIRPERSON JOHNSON: I wanna follow up on NCB as well. When do you plan on submitting HHC's plan to the State, by which date?

ALAN AVILES: We don't have a date certain, but it will be soon after we have the completed staffing and reopening plan, which we

expect to have completed in March, so you know, within a week or at most two of having that draft plan we should be in a position to submit, so somewhere between, you know the latter part of March; the very beginning of April.

CHAIRPERSON JOHNSON: And you've been assured by, as you said, the State Commissioner that they are not gonna decertify while this plan is submitted?

ALAN AVILES: Yes, it's clear that they appreciate our concerns about ensuring that we reopen these services thoughtfully and with the full staffing complement that's necessary and that we're confident we can render safe care and they will work with us to ensure that that's how it happen.

CHAIRPERSON JOHNSON: And just, again, to follow up on Council Member Torres; you may have just answered this, but I just wanna assure that you commit to preserving all beds in labor and delivery?

ALAN AVILES: Same capacity, yes.

CHAIRPERSON JOHNSON: Same capacity; no decrease?

ALAN AVILES: Correct.

CHAIRPERSON JOHNSON: Great. And I just wanna get back to how this decision was made; I'm told by folks that work at NCB or worked at NCB that… and the community was only given 72 hours notice, that was it, 72 hours and then out; is that correct?

ALAN AVILES: I'm not even sure that they were given 72 hours notice. As I said, you know, a decision was reached at a point in time that our clinical leadership was not, and our administrative leadership, were no longer comfortable that safe care could be rendered. As soon as… as soon as… [crosstalk]

CHAIRPERSON JOHNSON: So this is a… this is atypical?

ALAN AVILES: This is atypical, yes, absolutely.

CHAIRPERSON JOHNSON: And the community, I believe, was ensured in an early December meeting that there would be community consultation, planning meetings with the local community and the stakeholders involved moving forward and I just wanna understand why since I believe that early December date there has been no community meeting in January or February and we're almost in March and so it's I

think befuddling to me that outreach hasn't been done at this point.

ALAN AVILES: I'm not sure that there's been no communication or meetings during that entire period of time; I know I appeared before one of our very active advocacy organizations, before their board, which includes membership from some of the organizations that are particularly concerned, to discuss this personally myself, but remember that we needed to give our new director of OB services an opportunity to get in place to assess the situation before there was much to say of substance about, you know, how we would restart the services. We currently have a meeting scheduled, I believe, for the first week in March and we've already scheduled a second meeting for the first week in April with community stakeholders.

CHAIRPERSON JOHNSON: Well that's good to hear; I mean that may be news for some of the folks here I believe who told me they weren't aware of that, but I'm happy to hear that and I would hope that up until it's reopened and even after it's reopened that there will be a commitment from HHC to continue monthly meetings with the stakeholders and

community partners who are especially interested in this and have a real stake in this. Can HHC make that commitment?

ALAN AVILES: I…

ANTONIO MARTIN: Yes.

CHAIRPERSON JOHNSON: Can you say your name, sir?

ANTONIO MARTIN: Antonio Martin, Chief Operating Officer, HHC.

ALAN AVILES: He's in a better position to make a binding [laughter] long-term commitment.

CHAIRPERSON JOHNSON: Thank you. I'm gonna just ask a couple more questions and then we'll go and do another round. I wanna get back to dialysis for a moment, the privatization. I know that the February delay for the committee vote where a quorum wasn't present was because of a snow storm, but there was also a delay in January and in January when there was a delay, there supposedly additional information that HHC was seeking before there was a vote on this matter; what was that additional information that was being sought?

DR. ROSS WILSON: HHC was not seeking additional information, the State Department of

Health, the committee through the State Department of Health was seeking additional information about the quality of dialysis services performed both at HHC and by Atlantic Dialysis, and so HHC submitted information about our quality of services, Atlantic Dialysis submitted theirs to the Department of Health, and on the basis of those submissions; the Department of Health prepared a further submission to the committee for its consideration at the meeting, which was then postponed because of the absence of a quorum.

CHAIRPERSON JOHNSON: So what's been made clear today and in previous conversations with HHC is that the decision was made a year-and-a-half ago; this is the last formality in the process on the road to privatization with Atlantic and Big Apple and I would think from the questions from the Public Advocate and from Council Member Eugene and other folks that have weighed in today, and I share this concern, that there is really no going back, the decision's been made, the vote seems like a mere formality that will be adopted in the end of January, which to me, and I think many others, is incredibly

disappointing and potentially unnerves us in some way. You mentioned one way… [interpose]

ALAN AVILES: Can I… could I just respond to that, because I'm not sure it's entirely accurate. First of all, I would not characterize what the public health and planning council at the State does is a mere formality; the fact that they actually requested additional submissions going to the issue of all of the data that reflected quality I think speaks to how seriously they take any of these things that appear before them where they are the sort of final voice on approval or not. Secondarily, I mean given, you know, how much concern has been raised from different quarters, and although they are concerns that were raised previously and have been addressed, and although, as you heard, we don't believe that the concerns are well placed; it goes without saying that the current administration would be reviewing everything that has been put into public record at this point.

CHAIRPERSON JOHNSON: I don't say this in any way to mischaracterize anyone's intentions or to call in question their character and I don't know the folks that are part of the panel, I've never met any

of them that are gonna vote on this, but it's my understanding that some of the folks that have interest in Atlantic and Big Apple sit on that committee and have recused themselves from that vote.

[background comments, cheers, applause]

ALAN AVILES: That is… [interpose]

CHAIRPERSON JOHNSON: Is that correct?

MALE VOICE: Quiet please… quiet in the audience, please. Quiet in the audience.

CHAIRPERSON JOHNSON: Is that correct?

ALAN AVILES: I believe… one principal, I believe does… has sat on that committee; I mean from my perspective, it reflects the fact that he is held in high regard by the people in the profession; I mean this committee, if you look at the individuals who sit on it, this is… you know, this is a committee of folks, I think, who by and large have reputations that are impeccable and who run some of the most significant healthcare-related operations in our state.

CHAIRPERSON JOHNSON: I mean as we know in government and politics and in public policy concerns, sometimes perception and appearances can call into question certain actions and I think that…

I again am not… I've never met this gentleman; I don't know the least about his company… all I'm saying is that I know there have been concerns raised about the appearance of this and I am not an expert on dialysis centers or the delivery of that type of care, but I think it's important to mention here today, since it's been talked about in the past. The other question that I had to follow up on Council Member Dr. Eugene's concerns was; you mentioned in one way… the one way in which if there were problems with Atlantic, Big Apple, there could be suspension of physicians at Big Apple if that happened and then there's also a termination clause in the contract with them; what other means and mechanisms do you have to ensure their performance, besides the oversight from HHC and the termination clause in the contract, what other means are gonna be used to ensure that this is done in the most quality-safe way, up to standards at other facilities that are performed well?

ALAN AVILES: Well as I indicated before, the actual oversight of the delivery of care and the quality of care is going to be performed by our own nephrologist; I mean those folks who are responsible

for doing it now, when it's provided directly by us, will be responsible for overseeing its revision by Big Apple. So we certainly expect that they will hold the same high standards of quality performance, in terms of how they review all that. As I indicated earlier, a whole set of objective performance data will need to be submitted every month for review and ultimately will be reviewed on a quarterly basis, even by our board of directors in their quality assurance committee meeting.

CHAIRPERSON JOHNSON: One more question before I go to my colleagues, who may have additional questions from the committee. You said earlier that the Medicaid reimbursement rates depends on the graduate medical education at those particular facilities; will the realignment of affiliation agreements affect Medicaid reimbursements in any way?

ALAN AVILES: It should not; I mean by and large that realignment is not affecting our medical residency programs, affiliation agreements have two components, one can be service delivery when the physicians are actually employed by the affiliate, the other is purely the academic affiliation in relationship, which relates to the

residency programs and that hasn't been altered in any fundamental way.

CHAIRPERSON JOHNSON: Thank you. Council Member Mendez.

COUNCIL MEMBER MENDEZ: Thank you Chair. Earlier Council Member Barron was asking questions about the full-time employees and you said there were 39,000 approximately and then 3,700 were reduced; I'm assuming… is that through attrition or… [interpose]

ALAN AVILES: Mostly through attrition.

COUNCIL MEMBER MENDEZ: Okay. And what is, if any, the part-time numbers… part-time employees? [crosstalk]

ALAN AVILES: That… that number is full-time equivalent, so it takes both full-time and part-time and gives you a combined number of full-time equivalence.

COUNCIL MEMBER MENDEZ: Okay. Thank you.

CHAIRPERSON JOHNSON: Council Member Barron.

COUNCIL MEMBER BARRON: [background comment] My question is about employment, the workforce. As we talk about having the privatization

of the dialysis, what impact is that gonna have on the workforce?

ALAN AVILES: Well we made a commitment that we would not lay off any staff, so all of the staff who were performing dialysis will be redeployed elsewhere in our system, so no one loses their employment as a result of that contract.

COUNCIL MEMBER BARRON: And finally, just one comment. In your presentation; I think it's the last page… where is that? Well, it says achievements… achievements to date; perhaps you just wanna consider another label for that, because I don't think that reduction of a workforce by 3,700 is something that's a positive fact. [interpose]

ALAN AVILES: I agree with you.

CHAIRPERSON JOHNSON: Yeah, and I actually have a follow-up on that. You went over some of the makeup of those 3,700 workforce reductions; you covered 81 percent of which was from environmental, clerical, aides and orderlies; what bout the other 19 percent; what areas and how many layoffs were part of that versus attrition; is it a 100 percent attrition or the 19 percent, does that cover layoffs in any way?

ALAN AVILES: To the extent that we have, within the environmental hotel category which I gave, which was 36 percent, includes our trades, and so the layoffs were principally of the trades, so I forget the exact number, but the total workforce reduction there was about 350 and the majority of those were by layoff.

CHAIRPERSON JOHNSON: Thank you. I have a few more questions and then we have plenty of questions that we're not gonna be able to get to, given that I wanna give everyone that showed up here today the opportunity to speak and we have six panels left, which I will stay for each and every question that… or piece of testimony that is asked today.

I wanna talk a little bit about the closing of Goldwater; I know you said the facility was in major need of repair, it was from the 1930s and that is entirely understandable; I wanna understand how HHC handled the transfer of homeless patients to organizations and programs that transition homeless individuals to homes, if you could just describe that a little bit for me.

LARAY BROWN: LaRay Brown, Senior Vice President, Intergovernmental and Corporate Planning.

Everyone who was discharged from Coler-Goldwater was discharged into housing; there was no one that was homeless. The individuals who were identified as no longer needing skilled nursing care… the average stay in our skilled nursing facility for those individuals, was more than 7 years… [interpose]

CHAIRPERSON JOHNSON: I'm just confused, Miss Brown; I don't mean to cut you off; are you saying that none of the patients that were being served at Goldwater were chronically homeless or considered homeless; when they entered the facility, these were all people that had their own homes and… [interpose]

LARAY BROWN: Uh…

CHAIRPERSON JOHNSON: and ability to stay somewhere?

LARAY BROWN: I misunderstood your question. So some of the patients… most of our patients who go into our skilled nursing facilities come from the HHC system or other hospitals, or nursing homes. There are times when a patient has been admitted for acute care and when that person presented for the acute care, they may have been chronically homeless or they may have come from a

homeless shelter; then their acute medical need gets addressed and they may need post acute care or nursing home care and then they are referred to, as an example, Coler-Goldwater. During their stay at Coler-Goldwater they're not necessarily considered homeless anymore; however… [interpose]

CHAIRPERSON JOHNSON: Why not?

LARAY BROWN: Because the definition of a skilled nursing facility is called a residential healthcare facility, so the extent… [crosstalk]

CHAIRPERSON JOHNSON: But that's not permanent… that's not permanent housing.

LARAY BROWN: No, but to the extent that… in terms of the State regulations, they consider nursing homes as the person's home. However, individuals' needs change, so they may not need the level of 24-hour nursing care and when that is assessed or determined by the clinical staff of a nursing home, then that individual is prepared for community placement. Because many of our patients, particularly at Coler-Goldwater, are… many are undocumented immigrants, many have very low incomes; we have particular challenges in finding those individuals with appropriate and accessible housing.

I should also add that many individuals have mobility impairments. So what we did over the last two years was very much hone in in working with various organizations, including some consumer organizations, to help to prepare those patients or residents for community living and putting together very extensive support services plans, including the provision of home health care in combination then in working with housing providers.

CHAIRPERSON JOHNSON: I… that's very helpful; I have some more questions, so if you could stay… [interpose]

LARAY BROWN: Here?

CHAIRPERSON JOHNSON: Yes…

LARAY BROWN: Okay.

CHAIRPERSON JOHNSON: before you give up your seat. I ask this because, you know, HHC's mission that was spoken about earlier today is you serve some of the most vulnerable populations in New York City, a vast majority of whom do not get any services at any other facility besides an HHC facility; my concern and fear is that… and maybe it's misplaced; if it is, I would love to just be corrected and understand further what the operations

and plans are, but my fear is, is that when homeless people are being cared for at an HHC facility like Goldwater, which was shut down, what is HHC's relationship with homeless service providers, the major ones across the city; what happens after they leave the facility to track where they go back in the healthcare system; are they readmitted in other HHC facilities; are there caseworkers that are assigned; what is the follow-up so that the chronic homelessness doesn't continue and they don't continue to reenter the system without getting help that they need?

LARAY BROWN: So the State regulations actually require a minimal of, after you discharge someone from a nursing home, a minimum of 30 days in which you must monitor to make sure that that placement is successful. So that's one of the things that we did. But we've gone beyond that, in that we are continuing to monitor the successful community tenure of individuals who have been placed in community settings and, as I mentioned, an important element of their community placement is connecting those individuals with HHC's home care program, as well as connecting those individuals with the nearest

HHC hospital or community health center, depending on where their housing is.

There also, over the last year, the State has required that people being considered for or placed or discharged from nursing homes actually become enrolled in managed care. So as part of the discharge plan, we have to work with that resident, the individual, as to whether they will… which long-term managed care plan they would sign up with… [interpose]

CHAIRPERSON JOHNSON: But not all… [interpose]

LARAY BROWN: You know, to assure that…

CHAIRPERSON JOHNSON: Sure.

LARAY BROWN: their post discharge services are continued.

CHAIRPERSON JOHNSON: I understand and that's… that's great, but not all homeless individuals are people that are gonna require nursing homes.

LARAY BROWN: Well I'm only an… I thought your question was very specific to what we did, vis-à-vis Coler-Goldwater… [interpose]

CHAIRPERSON JOHNSON: Got it.

LARAY BROWN: and that's my… that's where my answer is.

CHAIRPERSON JOHNSON: And are you tracking whether these patients are utilizing services at the Henry J. Carter facility?

LARAY BROWN: No. Okay. Henry J. Carter, in fact, is a replacement facility for Goldwater, so Henry J. Carter includes 200 long-term acute care hospital beds and 164 skilled nursing facility beds. So the individuals who were placed in housing in the community are not the same individuals who are continuing to get their long… their chronic hospital care and their nursing home care at our new Henry J. facility.

CHAIRPERSON JOHNSON: But you would know if they came back?

LARAY BROWN: Oh yes, we would… [interpose]

CHAIRPERSON JOHNSON: It's tracked through electronic records. [interpose]

LARAY BROWN: Yeah. Well and more than likely though, individuals, if their community tenure was not successful, they would likely be admitted first to an acute care facility.

CHAIRPERSON JOHNSON: What other impacts do you believe the decommissioning of Goldwater has had on the patients that were served by Goldwater?

LARAY BROWN: Well those patients who were not discharged, many of those individuals either were transferred to our Coler facility, which is on the other end of Roosevelt Island, for their continued skilled nursing care and then other individuals were… basically their long-term hospital care or their skilled nursing care is being continued at Henry J. Carter.

CHAIRPERSON JOHNSON: And what is the current homeless population that is being served by HHC; do you… is that tracked by HHC?

ALAN AVILES: We do not track that in the aggregate…

CHAIRPERSON JOHNSON: Is there a reason why?

ALAN AVILES: Well because we don't necessarily know the status and because patients don't necessarily feel comfortable giving us that information, they may offer up an address that is a relative's address or even a non-existent address and

it's only after the fact that we may discover that they are in fact homeless… (CROSS-TALK)

CHAIRPERSON JOHNSON: Well I'd like to have a, hopefully, constructive conversation if there is a better way to handle that with you, whether there's a voluntary question that could be asked and people could choose not to answer it, so that we in some way could track the homeless population and see its fluctuations in any way and what those aggregate numbers are and figure out, with coordination with DHS and some of the non-profit providers if we could be doing anything better to handle that population.

ALAN AVILES: Sure.

CHAIRPERSON JOHNSON: One more question and then I'm happy to see if the two remaining council members that are here have any questions and then we can go to the panel and I think we'll have a lot of follow-up questions in writing that we weren't able to get to today, but I really appreciate you spending this amount of time answering our questions.

I know you talked about that the Federally Qualified Health Centers are going through an approval process right now with the Federal Government and that there is a site visit that is

gonna take place sometime soon that has been scheduled; HHC has six potential FQHC's; is that correct?

ALAN AVILES: Yes.

CHAIRPERSON JOHNSON: Six. Okay. [intercept, background comment]

ALAN AVILES: Well it has six sites that will be… [crosstalk]

CHAIRPERSON JOHNSON: Six sites.

ALAN AVILES: under one FQHC umbrella, yes. [crosstalk]

CHAIRPERSON JOHNSON: Only one, but the five other you're hoping to become FQHC's?

ALAN AVILES: There is one umbrella FQHC… [crosstalk]

CHAIRPERSON JOHNSON: Got it, I understand.

ALAN AVILES: there's a multi-site FQHC; those sites initially are the six diagnostic and treatment centers that we run.

CHAIRPERSON JOHNSON: And the visit that is set to happen from the Federal Government coming here to look at those sites to see if they qualify,

is… are the additional five facilities all gonna be looked at during that site visit?

ALAN AVILES: They are… [interpose]

CHAIRPERSON JOHNSON: So it's not gonna be done in a piecemeal way?

ALAN AVILES: The site visit is intended to encompass a range of different requirements, some of which is determined on the submission of paperwork, but some of which is accomplished by their actually being on-site and asking questions of staff and completely understanding the governance model. One of the complexities in our doing this is that it is only relatively recently that the Federal Government has recognized and approached the FQHCs that essentially allows for a sort of partnership or joint venture with a hospital system like ours, 'cause we are not looking to simply divest ourselves of these diagnostic and treatment centers; we wanna take advantage of the revenue opportunities that FQHCs can garner; we wanna meet the Federal requirements that do impose upon us additional obligations, but we wanna keep them bound to us as part of an integrated delivery system for which we are ultimately responsible… [interpose]

CHAIRPERSON JOHNSON: That's good to hear.

ALAN AVILES: Yeah.

CHAIRPERSON JOHNSON: Absolutely. Council Member del Arroyo.

COUNCIL MEMBER ARROYO: Maria Arroyo.

CHAIRPERSON JOHNSON: Maria. Maria.

COUNCIL MEMBER ARROYO: Yeah. Hi you all…

ALAN AVILES: Hi.

COUNCIL MEMBER ARROYO: nice to see you. So when the visit happens, where is it going to take place?

ALAN AVILES: They're coming first… [interpose]

COUNCIL MEMBER ARROYO: I don't know if the Chair was able to drill down on that question.

ALAN AVILES: Oh. The way… [crosstalk]

COUNCIL MEMBER ARROYO: One application, one H… one FQHC; where is the central office; where is the actual visit going to be executed?

ALAN AVILES: They're coming initially to Gouverneur, but they are planning on visiting the other sites. Do we have a full itinerary?

[background comments] Hm? [background comment] You have a schedule? We'll share that schedule with you.

COUNCIL MEMBER ARROYO: Okay. [background comment] Thank you. Thank you Mr. Chair.

CHAIRPERSON JOHNSON: Thank you Maria. Council Member Mendez; you have anymore questions before this panel departs?

COUNCIL MEMBER MENDEZ: Yes. The Chair was asking about the individuals from the skilled nursing home that were being put in these other locations and they were being tracked at least for a minimum of 30 days and they may be ending up in other HHC facilities; are their electronic health records going with them and are all of these electronic health records readable at all these different facilities?

ALAN AVILES: Well one of the reasons why we are transitioning to a new electronic medical record is the system we currently have does not readily allow us to view the medical record across the entire system in each different setting, so that will be corrected by the implementation of new electronic medical record, but there are ways for us

to… there are ways for individuals at one of our facilities to access the electronic medical record in a different facility or even a different network and we can grant that access, and then there are typically printed summaries that follow patients when we want to ensure that critical information is going with those patients.

COUNCIL MEMBER MENDEZ: When you say the entire network or enti… what does that mean?

ALAN AVILES: Uh…

COUNCIL MEMBER MENDEZ: Like currently how many HHC facilities are able to read all of the electronic health records?

ALAN AVILES: If we grant them specific access, they all can do that; as I said, it is very cumbersome because although we have one electronic medical record, we were an early adopter, more than 20 years ago we began to install these and way back then they decided to install them in a decentralized way, so we have six different databases that align mostly with our different networks and you know, if you're within that network, like the North Bronx Network or the Queens Health Network, you can access all of the records within that network, but if you

need to access the records of a different network, then we need to provide you with special access for you to be able to bring that up on a different screen with a different, you know, login identification and the like.

COUNCIL MEMBER MENDEZ: Okay. And how time-consuming is it to grant access?

ALAN AVILES: I mean it doesn't happen at the snap of a finger; I mean we routinely do provide that, but it's one of the major advantages of implementing a new electronic medical record which will provide seamless access across the entire system and across all settings.

COUNCIL MEMBER MENDEZ: And anticipated when entire access or upgrading so they're all using the same or can access all the electronic health records; when do you think that would be?

ALAN AVILES: Well the full implementation is gonna take several years; however, we have implemented, for those patients who are our most complex patients, who really do require care coordination across settings, not only within our own system, but out in the community, we have acquired a software application that is specifically for the

purposes of care management so certain key clinical data can be exchanged and so that the treatment plan for that patient can be viewed by providers that are in different settings, whether within our system or in the community.

COUNCIL MEMBER MENDEZ: Thank you very much. Thank you Mr. Chair.

CHAIRPERSON JOHNSON: I have one final very quick question. This, "The Road Ahead" plan was contracted out to Deloitte, a private company; is that correct?

ALAN AVILES: No, we… [interpose]

CHAIRPERSON JOHNSON: No?

ALAN AVILES: we contracted with Deloitte in order for them to provide us with analytical support and actually crunching numbers and going through a whole variety of different scenarios, some of which we rejected to see… [interpose]

CHAIRPERSON JOHNSON: So they made some recommendations?

ALAN AVILES: They… along the way they did make recommendations, yes.

CHAIRPERSON JOHNSON: And the contract was for $4 million?

ALAN AVILES: Do you remember what… [background comments] something like that… [background comments] that's the ballpark, I think… [interpose]

CHAIRPERSON JOHNSON: Yeah. Yeah. And was it paid for HHC or was it paid by the State or some other entity?

ALAN AVILES: By HHC.

CHAIRPERSON JOHNSON: By HHC. Thank you very, very much President Aviles for being here, Dr. Wilson and Mr. Martin; I really appreciate your time today, as well as the other folks who spent time with us from HHC. And just so folks that are gonna continue to stay know, that we have someone, the Director of Intergovernmental Affairs is gonna stay and be here for the entirety of the hearing, so you will have someone here taking down your concerns and if we don't have answers to your questions, we as the Council and this Committee on Health will make sure that your questions are answered and we will submit them to the appropriate people to make sure they are answered. So thank you all very, very much.

And if folks wanna have a conversation with each other, it would be very, very helpful if

you could step out into the hallway and close the door so that we can continue to proceed. [background comment] So… [background comment] we're gonna go on the clock, right? Yeah. We're gonna go on the clock for this… [background comment] we'll do three minutes.

Our first panel are gonna be folks from NYSNA, and it is Anne Bove -- I apologize if I mispronounce your name -- Miss Kwashi… Mr. Kwashi and Leon Bell. If you could all come up. [background comments] We're gonna take… you can go whatever order you would like to go in and if, when you turn your microphone on, you could please give us your name for the record and also your affiliation. Is someone not… did someone have to leave? [background comments] Oh here he comes. Okay, great. [background comments] Turn the mic on.

ANNE BOVE: Thank you. Hi, my name is Anne Bove; I'm President of HHC Executive Council, which is the union arm of NYSNA. I'm here basically today because we're concerned about the privatization issue. We are pleased to see that large numbers of New Yorkers are signing up for insurance for care at HHC including many young people, but no matter, we

still service people regardless, just simply regardless, regardless of ability to pay, regardless of place of origin, and obviously we're maintaining that system in terms of that mission statement that's within the system.

Privatization undercuts that quality. At the very time that we are told that access to care should be growing, privatization threatens the quality that we are giving with regards to that access to care. The example I have for you today is on how privatization is the wrong prescription regarding renal dialysis.

HHC wants to sell its dialysis clinics -- the equipment, the supplies, drugs, care services -- for end-state renal failure patients to a for-profit agency, as has been discussed, Big Apple Dialysis. This for-profit will use the clinic space and site of four HHC facilities under terms of a service agreement to treat HHC patients and others. This is part of "The Road Ahead," which is supposed to have a projected 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 Department of Health, Big Apple was asked to describe its experience or track record in providing patient care at other facilities. And that's really the question in hand -- there was no information given by Big Apple to establish just exactly what is their quality of care. The big concern we have is that the Big Apple in their associated clinics have a 24 percent higher mortality rate than the four HHC facilities that are being sold, and this is for the time period covering 2009 to 2012. To put it very simply, Big Apple patients have a shorter life expectancy than those treated by HHC.

HHC has a fine record of care provided to dialysis patients, especially those four facilities that are in question right now, which are Harlem, Metropolitan, Lincoln, and Kings County. We at NYSNA are proud of the services provided there. Our dialysis nurses are highly skilled and very committed.

Basically, it's bad news of course for the patients at Big Apple affiliated system that HHC, in essence, is going to give away that quality care established to this private agency. Problems that

have been brought to our attention regarding the services provided include high rates of infections at catheterization points, and HHC actually had to reeducate those personnel from those private agencies to work to decrease those infection rates. There is documentation in terms of cherry picking patients with good insurance. An internal investigation of system of infections at one of the Bronx facilities showed that there was a failure to report patient care problems to the doctors, ultimately giving poor patient outcomes.

Many of the people who have given us reports are not here today because they feel intimidated and are very afraid of being disciplined or just simply afraid. What I know certain is that the process by which privatization has been carried out at HHC is not acceptable and is quite shameful in presentation. [bell] New York City can do better and we urge you to bring privatization of dialysis to a halt and to investigate this issue further. And one final thing… [interpose]

CHAIRPERSON JOHNSON: Sure.

ANNE BOVE: if a private agency can make money, why can't we?

CHAIRPERSON JOHNSON: Thank you very much. If we could restart the clock, please. [background comment] Yes sir, if you could just introduce yourself.

DAVID KOSHY: Yes. Good afternoon Health Committee members; my name is David Koshy [phonetic] and I currently work as an RN in the Chronic Dialysis Unit at Harlem Hospital. Thank you for allowing me to speak to you about the care we provide to our patients.

In an average week I dialyze anywhere from 15 to 20 patients; what I'm sharing with you today is an expression of other Harlem Hospital dialysis nurses, as I spoke to 10 fellow RNs in preparation for today.

From the moment patients arrive we are responsible for the review of the medical histories and an assessment of our patients' health by looking at their enter weight gain, vital signs and the access site. We check the access site for infection to see if the access site is functioning properly. After a thorough assessment we provide patient education and begin the dialysis process. We continue to monitor patients throughout the dialysis

process. When they are finished with the treatment we reassess the patients and provide additional patient education; only then is the patient discharged and sent home. We are also responsible for making sure the machines are thoroughly cleaned to prevent any cross infections between patients.

It is critical to safe and effective dialysis to have RNs treat chronic dialysis patients, because patients can become unstable very quickly. As most of our patients have other core morbidities, such as diabetes, hypertension and coronary issues. RNs have the professional expertise necessary to quickly assess the symptoms and respond appropriately and effectively. For example, my skill sets come from a background as a nurse in a medical-surg unit; I'm aware when a patient begins to exhibit signs of acute medical distress.

My colleagues and I are experienced, knowledgeable nurses who have a proven track record of providing excellent health care for our chronic dialysis patients at Harlem Hospital. My colleagues and our patients are concerned about the quality of care our patients will receive if chronic dialysis service is sent elsewhere; in particular, to a for-

profit model of care that largely removes nurses and other clinical staff from dialysis care.

We will move onto other RN assignments, but the move will be costly in terms of quality of care and outcomes. Why interfere with such proven quality of care? We ask Health Hospitals Corporation; Department of Health to let us continue to provide our patients with the best quality of care. Thank you for hearing our concerns.

CHAIRPERSON JOHNSON: Thank you very much, sir. If you could just give some greater explanation on the access that you were talking about.

DAVID KOSHY: Okay. When I say access site, usually most of the patients, they… we access with catheters; they have an access site usually on their arms or usually at the chest, the upper right side of the chest; that's what I mean by… it's how we connect the patients from the machines to their bodies. Okay? It’s a simple way… [crosstalk]

CHAIRPERSON JOHNSON: Thank you very much. Thank you. Yes, sir, if you could just give us your name and if the sergeant… thank you very much sergeant at arms.

LEON BELL: Yeah, my name is Leon Bell; I'm Director of Political and Policy at the New York State Nurses Association. I wanna apologize up front; there was a bit of a snafu with my testimony today; I sent the wrong document in by email, so I will try to forward a formal copy and I'm gonna have to wing it a little bit here today.

I think for us at NYSNA, one of the key issues in… when we talk about HHC and "The Road Ahead" in general terms, is that the City of New York, in particular, and the State of New York, more broadly, are in the throws right now of a pretty intense healthcare crisis. Anyone that follows the press, even in the slightly bit, is keenly aware of this and one of the concerns that we have in this whole process is that this crisis, from our perspective, is a result of a really long-running series of policy failures. We have been pursuing, in the City and at the State level, a policy based on privatization on market models, on for-profit models that are basically raping and pillaging the system, tearing money out of the system and leaving patients basically to fend for themselves. And the upshot of that, if you look around the City of New York, if you

look in Brooklyn in particular, the upshot of that is that we have… at the same time, that on the East Side of Manhattan you have six or seven beds per 1,000 population, in Queens and in Brooklyn you have two beds per 1,000 population and yet we're told that we're over-bedded. And for us the issue here is that we are failing a failed corporate model that has brought us to this point and rather than change course, what we heard today from HHC, clothed in a lot of, you know, well-meaning and well-intentioned language about fulfilling their mission statement, but ultimately what we heard from HHC was a warmed-up version of the corporatization of the public hospital system. "The Road Ahead" is nothing more than a process of privatization, corporatization and conversion to this for-profit model that has failed us and we at HHC, we at NYSNA and many of our union allies at NYSNA really believe that it's time to abandon "The Road Ahead" and move in an entirely different direction. We have to address income disparities, we have to address healthcare disparities and inequalities and the way to do that is to take HHC in a new direction as a leading force for forcefully addressing the underlying problems,

forcefully responding to community health needs, rather than under a corporatized model responding to the needs of the bottom line and profit models and competitive models that are all focused on patients as sources of revenue.

So from our perspective what we need to be looking at is revamping the entire system, abandoning "The Road Ahead" and moving to a… [bell] HHC as a vanguard in transforming our healthcare system into a system that is focused on meeting human healthcare needs as its first priority.

CHAIRPERSON JOHNSON: Thank you very much Mr. Bell. And thank you all for your testimony today.

Our next panel is going to consist of Carmen Charles, Barbara Edmonds and Ralph Palladino. [background comments] Is it just gonna be the two of you? [background comments] Oh no, here she comes. Great. You can go in whatever order you'd like, just please give us your name before you start to speak. [background comment] You may have to turn the mic on.

CARMEN CHARLES: My name is Carmen Charles; I'm the President of Local 420, District

Council 37. Good afternoon Chairman Johnson and members of the Committee; good afternoon to everyone in the room. I know I have three minutes, so I'm gonna speak very fast.

In my remarks there's a slideshow from the Health and Hospital Corporation website that captures the overall mandate of the Corporation; patient first is its core, supported by five revolving principles -- prudent resource management, teamwork, safety for all, continued refinement to learning and the achievement of excellence.

Four years ago we were presented with a bleak financial picture of HHC's future that threatens this model. The Corporation faced challenges pertaining to healthcare reform and increased patient load with decreases in State and Federal healthcare reimbursement subsidy, the increases in the cost of administrating patient care to an uninsured and under-insured population, expenses exceeded revenue for HHC. Faced with this challenge, Kimberly Comer [phonetic] McLean [phonetic] and Deloitte Consulting LLP were hired to review HHC current operations, looking for cost-saving ways to strengthen the organization for a

sustainable future with patient first still at the HHC's core.

Today we are here to discuss "The Road Ahead" plan. "The Road Ahead" projected a $305 million savings over the next four to five years from five categories -- administrative shared services, affiliation alignment, acute care realignment, ambulatory realignment and long-term care realignment. Overnight, overnight alignment and realignment became substitute words for outsourcing and privatization -- doing more with less -- less mean, less people. This certainly aligns with one of HHC's revolving principles -- prudent resource management, bit it weakens the other four principles.

After a careful examination of HHC records, Local 420 has come to the conclusion that the public is being grossly misled by HHC's presentation of cost containment. To date there are five outsourcing initiatives -- Sodexo Dietary, Sodexo Laundry, Crothall Environmental Services, Johnson Control Plant Maintenance and Atlantic Dialysis Operations -- without a trace of the impact that privatization is having on the system. HHC reported Calvary mentioned the loss of jobs and the

increased safety risk to Local 420 and to union members, when they are asked to do more and more with less -- less people [bell] less supplies.

Please indulge me, Chairman Johnson, I want you to hear this point. [interpose]

CHAIRPERSON JOHNSON: You can proceed.

CARMEN CHARLES: It is time for the public, it is time to restore the public in public health care by working together to find cost-saving initiatives. When we examine HHC's proposed budget and financial plan, it's $1.5 billion projected deficit for the year 2014 is half of its professional service contract and other operating expenditures combined. Therein lies the foundation of where the discussion can start. Why is HHC not maximizing their staff? Let them do the work and stop paying consultants to tell us how we can do the job. I find it grossly insulting to think that a 10-year housekeeping aide, Wanda, with HHC for years, cannot provide savings. This institutional knowledge that is free if consulted is wasting when we rely on outside consultants. Lets do more with less, more inclusive consultation with labor, providing more acceptable services by adhering to HHC revolving

principles of teamwork, continued refinement through learning and the achievement of excellence with less outside for-profit consultants and less… [interpose]

CHAIRPERSON JOHNSON: If you could please…

CARMEN CHARLES: me… [interpose]

CHAIRPERSON JOHNSON: if you could please wrap up Miss Charles.

CARMEN CHARLES: and less masking of services. Thank you for indulging me today and I sincerely hope that we can move forward on the road ahead as partners as we strive to continue strengthening the strongest public healthcare system in America. Thank you.

CHAIRPERSON JOHNSON: Thank you very much.

RALPH PALLADINO: Ralph Palladino, Clerical Administrative Employees Local 1549, representing roughly 16,000 workers of the City of New York, about 5,000 at HHC, as well as Metro Plus HMO. Our jobs at HHC include financial counseling, patient registration, billing, patient accounts, communications, interpreter services, information admitting, and signing up the uninsured for health

insurance, among other things. I am also a patient at Bellevue Hospital and I've worked and been a patient at Bellevue for 35 years.

HHC is my choice in terms of health care, I think it's excellent, the quality of care is wonderful; there are problems though, and the problems stem from, in part, the continuation of what was stated before, the corporatization, privatization, for-profitization style healthcare. "The Road Ahead" was developed when HHC was basically held at gunpoint, I believe, by the former city administration -- in order to get funding you had to do certain things -- privatize, downsize and get new technology, very often just for using technology sake.

The plan was undemocratic and it was non-inclusive. It did not involve in a real way the community advisory boards, the unions involved, the area policy community boards and I don't know of any needs assessment done of any community in New York by that plan that led to that plan. It's about finances, not about health care, pure and simple.

Under the plan, private contractors in… you've heard about the reduction in clericals;

private contractors right now have… roughly 7-10 percent of the workforce in clerical are from private contractors. They're not civil servants, they are not trained, because our contract says we must be trained -- they don't take a test -- quality is suffering because of that -- absenteeism control is suffering because of that. As a patient I can give you firsthand accounts from dealing with phones, to being told that I have to call six months in advance to get my primary care appointment; at one time that was the case; now I have to call 90 days in advance -- still the same amount of time though; if I want in May because of the new system technology, Sorian, which by the way, the employees don't like, it is cumbersome, and also in terms of the patients, it forces patients to keep calling back to get the appointments they want, which I had to do just recently to get the appointment I want and at certain days in May. I used to have to call, as I said, six months in advance, but I find six months in advance to be an advantage, strangely as it may seem, and sadly to say, I might add.

The staffing shortages have forced HHC to consolidate certain things; I had to go get my [bell]

inoculation in a clinic outside the clinic, which made me stay in the hospital longer. In terms of recommendations, if you don't mind, quickly, HHC needs to be a central component of the advancement and the extension of health services, especially the community health clinics, cost effectiveness and quality. CMS is gonna come out with rulings and HHC should get its proper share because of the amount of people we see who are uninsured and the City Council should weigh in that and do it right away. Review HHC's private contracting. Right now the City Council has no review; it's very sad to say. Add trained quality staff in order to take care of the additional workload and meet demands. And finally, and most important, be all-inclusive and more democratic in the healthcare planning process. Thank you. And welcome aboard, by the way.

CHAIRPERSON JOHNSON: Thank you Mr. Palladino. Miss Edmonds.

BARBARA EDMONDS: Thank you. Thank you Council Member Johnson and the members of the Health Committee for giving me this opportunity to testify on behalf of DC 37 and our 120,000 workers and 18,000 that work in HHC. I'm also here on behalf of the

Municipal Labor Unions that you'll also be hearing from, so I'll try to be brief and not reiterate and just kinda give you the highlight of some of my testimony. I wanted to try to put a face on some of the things that you've heard from the prior speakers and some of the folks that you'll hear before me, but I think the important thing to think about when we look at "The Road Ahead" is that we are talking about people, we're talking human beings, folks in the community and workers and administrators, but most importantly the patients and the community. We face, since 2009, nearly 3,800 cuts of employees, and as you know in District Council 37 we represent clerical, nurses aides, laborers, engineers, folks who were on the frontline, who were critical in fact in making sure that during Hurricane Sandy and before that, 9/11, that we were able to continue the type of work that we needed to.

So just to touch on a few things -- when we look at the laundry and linen services, which were a part of "The Road Ahead" plan, and when we also look at the outsourcing of plant maintenance or the environmental services, there are a couple of common themes. When we talk about linen we're talking about

that worker that has to go in day in and day out and make sure that that linen is properly cleaned, despite major reductions of nearly 100 entry-level good-paying jobs since 2009. And we're talking also, when we go into the plant maintenance and management area, major reductions in staff, nearly a cut of 30 percent of the personnel -- electricians, carpenters, plumbers, painters, metal workers, and the members we represent, nearly a 100 plus laborers and other titles. And when we talk about those workers, some of those who have been laid off cannot pay their mortgages, some of them have in fact been evicted, so we're talking about a plan that has had a real impact on the lives of the members and the community; many of them are constituents in your districts.

When we look at Cook Chill and there's some debates about how we can calculate whether Cook Chill was really included in "The Road Ahead," but we'll give you some documentation on that, versus breakthrough. We're talking about folks in our long-term care facilities who have to provide the meals very quickly and are now using a new system and when you look at the rating, and I know Carmen Charles speaks frequently about this, the ratings that are

used in terms of the satisfaction scores at these facilities in terms of the quality of the food; as you can imagine, there's real concerns about the diversity of that food, whether it's hot enough, and those things come up in the scores.

When we look at the long-term care realignment in Henry J. Carter and at the [bell] other hospitals, we see cuts dramatically in our respiratory, in our activity therapists, in our aide titles and throughout this process the common theme has been cuts in services; increased use of agency personnel. We would urge you to look at the recommendations, many of them have been outlined already and many of them are outlined and I will finally close with looking again at our "Public Health Care Under the Knife" report; we want to work with HHC to make this corporation a road to a positive change for all of us, for all of the stakeholders and most importantly for the patients and the community and we look very forward to working with you and your committee and anyone else in the community to improve services and make HHC thrive instead of just surviving for years to come. Thank you so much and we'd be happy to answer any questions

or send them to you, since we have a very long list of folks you have to listen to. [crosstalk]

CHAIRPERSON JOHNSON: Thank you Miss Charles, Mr. Palladino and Miss Edmonds. Under the knife; that really gets to it. [laughter] Thank you for a good title [background comment] and we look forward to working with you as well. If you have any further questions, please submit them to us.

BARBARA EDMONDS: Thank you.

CHAIRPERSON JOHNSON: Our next panel is gonna be Dr. Frank Proscia and Samrina Kahlon. [background comments] If folks wanna have conversations, if they could please step outside so we can continue to proceed. We still have a lot of speakers left. [background comments] You may proceed. Please introduce yourself and turn the mic on.

DR. SAMRINA KAHLON: Dr. Samrina Kahlon, Committee of Residents and Interns, Regional Vice President. Can I start?

CHAIRPERSON JOHNSON: Absolutely.

DR. SAMRINA KAHLON: Okay. Good afternoon Chairman Johnson and the members of the Committee. I'm Dr. Samrina Kahlon, Emergency

Medicine Fellow at Metropolitan Hospital and the Regional Vice President of Committee of Residents and Interns, the labor union that represents about 2,000 resident physicians within HHC's system. We wanna thank you for this opportunity.

"The Road Ahead" clearly identified challenges confronting the world's largest public healthcare system; the proposed solution was imperfect and too similar to the top down cost-control efforts we see elsewhere in the corporate world. Moving forward we need to innovate, not just amputate.

Today HHC has an opportunity to focus on quality improvement and patient safety to get some of the fundamental questions of controlling costs long-term. More and more public healthcare programs, like Medicare; Medicaid, are adopting the principles of value-based purchasing, whereas reimbursement will be determined not just by the number of procedures, but on clinical processes and patient satisfaction -- this is where all the health care is moving; the genie's out of the bottle. 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.

My union, the Committee of Interns and Residents, has our own track record of labor management partnership with hospitals in here in New York to make meaningful changes in the same quality indicators that reimbursements will be tied to moving forward. So we have begun to establish this level of partnership with HHC.

The House Staff Safety Council has been operating at individual hospitals within the HHC system. Now we have formed a newly HHC-wide Quality Improvement Council and a Patient Safety Council, which is about to begin. We formed these councils with a good will that our administration will support us and out of a recognition that house staff have a unique understanding of the systems in which we practice and therefore are uniquely positioned to have a high impact in the ways we treat our patients to reduce errors and cost.

I have seen the effects of House Staff Safety Councils in my hospital -- by using huddles every two hours we have decreased the amount of time patients spend in the ER, we have reduced the dwell

time and we have decreased the walkout rates by 30 percent.

HHC has a golden opportunity to not just deal with its year to year operating deficit, 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 HHC-wide House Staff Quality Improvement Councils and Patient Safety Councils. HHC should use it as a model of other labor management [bell] partnerships to engage their frontline providers of providing a quality improvement care. Fundamentally, HHC should recognize the value of resident physicians. [background comment] As our mission aligns with their mission, they should use us, use our perspectives and use our expertise. Our common goal is to provide the best high 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 followed through; they should. These partnerships and the work of building the culture of quality improvement and healthcare innovations are good not

just for HHC, but for our patients and everyone else. Thank you.

CHAIRPERSON JOHNSON: Thank you very much. Dr. Proscia.

DR. FRANK PROSCIA: Thank you very much. Good afternoon Chairman Johnson and members of the Health Committee. My name is Dr. Frank Proscia and I am President of Doctors Council SEIU. Our union represents doctors in the metro area and in states throughout the country; this includes the attending doctors in HHC hospitals and facilities. In 2013, our doctors at HHC facilities served more than 1.5 million patients, approximately 40 percent of whom were uninsured.

To truly get HHC to be a provider of choice and not the last resort, we must work together to not just survive, but to thrive in the years ahead; there an no longer be business as usual. With all the changes occurring in health care, including ACOs, PCMH, FQHCs, 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 the health care and the impact on our patients. Our doctors work in HHC because they are dedicated to public health care. The 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. 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 doctors in addressing quality improvement. Second, we are doing surveys of 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 at Harlem Hospital, census volume of patients at Gouverneur DNTC and waiting times to see primary care physicians at Jacobi.

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

This can be a dawn of a new day for our public healthcare 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 an empowering frontline clinicians who take care of our patients, but also involving the patients from the communities we serve and the other healthcare workers as part of the patient care delivery team.

I would also like to add that Doctors Council SEIU stands united with our community [bell] and union allies in calling for a reopening of labor and delivery services at NCBH. The community needs these services. After extensive advocacy from our union and the coalition, HHC committed to reopen this by April 30th, though we heard otherwise today. 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 in the community served deserve no less. Thank you very much for your time today.

CHAIRPERSON JOHNSON: Thank you both very, very much; I appreciate your testimony and I have it with me. If we have any questions we'll let you know; if you have any questions for us, feel free to submit it to us. [background comments]

Next up we're gonna have Anthony Feliciano, Lois Rakoff, and I apologize if I pronounce your name incorrectly, Agnes Akrakan… [background comment] Abraham… [background comments] I'm sorry. I guess that's sort of Abraham. You may proceed in whatever order you'd like to go in; if you could please give your name and your affiliation once you start speaking. Whoever wants to go can go first.

ANTHONY FELICIANO: Okay. My name is Anthony Feliciano; I'm the Director for the Commission on the Public's Health System. Thank you for the opportunity to testify in front of you today.

CPHS has been a supporter for the Health Care Safety Net for health care services for everyone, particularly low-income, medically

underserved immigrants and communities of color, especially for the HHC system, which is a vital safety-net resource for all New Yorkers.

You're gonna probably hear a lot of the concerns, and you've heard already a lot of the concerns regarding "The Road Ahead," including steep expenditure reductions; movement to privatize important patient care services. Even though the closing of vital health services like labor and delivery services at NCB is not part of "The Road Ahead," it is indicative of some of the pattern and the structure issues that have been going on with HHC.

You also already heard about some of the flaw analysis that came from Deloitte and the sweeping infrastructural changes, but I wanted to focus really on discussing some of the main areas to be observed and imperative to be addressed, and one of them is ensuring and monitoring that HHC creates a mechanism for more community and labor involvement in the decision-making process. This could be done by making sure that HHC renews, sustains and creates new collaborations, expands the role powers of the function of the community advisory boards… and I'll

be short there… develop adequate planning calls when considering changes to healthcare services. It would like to be seen in the future that HHC does the following in all its facilities -- convene community members to seek input on any changes to healthcare services in the community; once a change has been decided upon, a communication plan to be developed to give hospital staff, patients and community members adequate notice of impending changes and to explain the reasoning behind it. And thirdly, work with the community advisory board at each facility and setting up community meetings to gather feedback from community residents and expanding relationships with local organization.

The other area will be, quickly, identify HHC board members. We have an ongoing commitment to the mission of the Public Health System and also in patient care and expanding accessibility. There is a need to reform the current agency board structure; it needs more diversification. One of the things that we'd like to recommend -- we know that there's a spot for the chair of the board; we know that's a mayor selection, but if the Council can actually push for actually having them have a dual title as an advisor

to the mayor, which board has stipend. Bloomberg actually discontinued this, but it was a practice that it was before and so we're hoping the Council can ask the mayor to do that again.

And some of the other areas is ensuring that HHC preserves and expands access to quality healthcare services. First and foremost -- 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 privatizing many services is troubling; the worst is the contract, obviously with the dialysis, [bell] and as you heard before, there's been an approval for other places. But one thing that the Council can look at is monitoring… once some of these dialysis services are going forward, they're saying that there's a nephrologist… two or three staff people looking over it; it is a very large healthcare service and so really, monitoring it is important and particularly if they can just stop the privatization piece.

And other places we were talking about is redoing the consolidation of selected specialty care services to one network per borough. Forcing

patients to travel longer distance outside of their community for services, such a rehabilitation, orthopedics, does not make sense and just adds hardship.

The other area is supporting evidence-based best practices. 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 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.

A very big piece of this is reducing the very long waiting times. I know we heard from Aviles around this issue, but a plan needs to be in place to ensure that.

The other area is evaluating resources, including undertaking the review of "The Road Ahead," which you all doing already, holding accountable all the HHC affiliates, the physician groups, PAGNY, NYU Hospital and Mount Sinai Hospital, accountable, transparent and leadership and function to be improved.

As part of the budget CPH has always had issues with NYU's use of Bellevue as to cover to demonstrate they are supposedly providing care to the poor and the uninsured. There are very good NYU doctors that care about their patients, regardless of who they are and where they're from, however the reality of 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.

The other area is reviewing the quality in patient and hospital staff engagement of current HHC programs and functioning.

I will just add that it is important to have labor and communities involved in decision-making process. Many times there are crises that occur, but some of it is very preventable. Some of it, in relation to even North Central Bronx, where there could've been something done ahead of time. Thank you.

CHAIRPERSON JOHNSON: Thank you very much. Miss Rakoff.

LOIS RAKOFF: Thank you. I'm Vice Chair of the Community Advisory Board of Bellevue Hospital Center and this is what I presented… [interpose]

CHAIRPERSON JOHNSON: Just one… Lois, I'm sorry; just for the record, Lois Rakoff; I just wanna make sure… 'cause everything gets transcribed. So go ahead, proceed. [crosstalk]

LOIS RAKOFF: R a k o f f. Okay… [crosstalk]

CHAIRPERSON JOHNSON: It's okay.

LOIS RAKOFF: It's okay… and I'd like to thank Council Member Corey Johnson and particularly Rosie Mendez, Council Member Rosie Mendez, who plays a hands-on integral part at Bellevue Hospital; she is involved with mostly everything, every day. Now this is a wish list that -- I'm not representing CB2 or CB6, although what you read might confuse you -- this is a wish list that was combined with the Bellevue administration and the CAB and there's… I'll just read them fast and you'll have the description. What we need are: neurointerventional radiology bi-plane C replacements, we need ophthalmology victrectomy equipment replacements, we need EP lab hemodynamic and reporting system replacements -- this is for

budget and I know that we're having budget next month, but I want you to get this in. We also need radiology ultrasound machine replacement; we also need ICU critical patient transport monitors.

Now the President of the United States and also diplomats of the UN come to Bellevue; we are the flagship hospital in New York City; we also have weathered the storm of Hurricane Sandy beautifully and we also have the World Trade Center Health Center at Bellevue, particularly for pediatrics. And I urge the Committee to look into improving the budget for Bellevue. And since I have like a little bit of time, some of the things that we're looking at, the CAB are looking at at banning Styrofoam products, increasing the height of children going on the MTA, because when they go to their clinics, the little children who are now growing bigger with good health, they have to pay and yet they could be 4 or 5 years old. We're looking at a sprinkler system at Bellevue; it has not been completed; I hear it's 2020, and I'd like to invite everyone, including Corey, and I know Rosie will come; everyone to Wednesday, this Wednesday we have a CAB meeting, a

full board meeting, 6:00 in the Rose Room at Bellevue and March 28th we have a legisla… [interpose]

CHAIRPERSON JOHNSON: And food is always served.

LOIS RAKOFF: What… and food is always served… [crosstalk]

CHAIRPERSON JOHNSON: Food is always served. Yes.

LOIS RAKOFF: And particularly March 28th at 10:30 we have a legislative breakfast [bell] at Bellevue.

CHAIRPERSON JOHNSON: Thank you very much Lois. You may proceed.

AGNES ABRAHAM: Thank you. Good afternoon Chairperson Johnson; my name is Agnes Abraham and I'm the Chairperson of Health and Hospitals Corporation's Council of Municipal Advisory Board and also the Chairperson of Kings County Hospital Center.

I sit before you this afternoon to concur with "The Road Ahead" as presented by President Aviles and his team. While I may not agree wholeheartedly with some aspects of the restructuring -- for example, 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.

Given the mission of HHC and the closings and threats of closing of hospitals in key contiguous zones served by HHC, makes HHC virtually impossible to continue to perform its future 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 Council Members for your support in appropriating funds to assist the Corporation in funding its operations. However, you will agree, I am sure, that if a projected loss of $465 million in 2015, as it gets 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 HHC hospitals, especially Kings County Hospital Center. Twenty-nine years ago I suffered a

severe ruptured appendix and was rushed to Kings County Hospital emergency room, 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 wheelchair with a very poor outlook on life; thank god for the care of the health professionals at Kings, the rehab unit, led by Drs. Bill, 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, I am a patient getting the care that I spoke earlier about. Fifty years [bell] after the Civil Rights Act was signed, I find it very disturbing and I can get very distraught about the state of the financial health of HHC. Health care is a civil right and I urge you to do all in your power, get some cojones and deal with HHC as it's supposed to be dealt with, the public deserves a public healthcare system that delivers and HHC does. With all its flaws, it does us proud. Thank you.

[applause]

CHAIRPERSON JOHNSON: Thank you very much, and thank you for really holding back and not

saying how you really feel; [background comments, laughter] I appreciate that… [interpose]

AGNES ABRAHAM: I'm from Brooklyn.

CHAIRPERSON JOHNSON: I can tell. And I wanna thank you all who testified -- Miss Abraham, Miss Rakoff and Mr. Feliciano -- for your service, for your public service and looking out for the healthcare needs of people across our city, so thank you all.

Next we're gonna have Sandra Thomas, Fay Muir and Eileen Markey. [background comments] Is it just two of you; did someone have to… oh, okay, great, wonderful. So does Miss Thomas wanna go first? [background comments] Or someone else can.

SANDRA THOMAS: Okay. I just would like to… [interpose]

CHAIRPERSON JOHNSON: If you could just please introduce yourself and your affiliation.

SANDRA THOMAS: Okay. My name is Sandra Thomas and I am a member of the Northwest community. I'm here about the North Central Hospital and the closing the reopening. I've always been a member, always… lived in the Bronx all my life; North Bronx Hospital, I've had children there, I had

grandchildren there; I'm looking to have great-grandchildren there. For them to take midwives and staff out of that hospital and our community that is poor; we have minority, we have immigrants here; we can't afford what they're doing to us, our children are our future. I have a son that I gave birth to 22 years there; he's in college now to become a doctor…

CHAIRPERSON JOHNSON: Uhm.

SANDRA THOMAS: I want him to be a doctor in his community -- give back… I was taught… give back in home; home is where it starts, give at home and then go to other countries or whatever. I wanna see North Central Hospital there when my son graduates as a doctor and I'm asking you, City councilmen, please make sure that HHC keeps their promise to our community that they will not close this hospital down, that they will not allow me to have my great-grandkids in a ambulance, in the front door of a hospital or in an emergency room. They promised that they would open; they're taking their time; the date is April the 30th; they cannot produce. But the State is saying that they will take the beds away; we need North Central Hospital, we really need it. Thank you for listening.

CHAIRPERSON JOHNSON: Thank you very much; congratulations to you and your son, I'm sure you're proud of him and I think we heard a commitment today, as what I perceived as one, from HHC to do all they can to make sure that it is reopened and I asked them to provide a date and their plan on how it's gonna happen and I was told… and we will follow up on this… that the State Commissioner of Health has said that they are not gonna decertify those beds; they're gonna work with HHC to reopen the labor and delivery services there, and I will do my best, as I know the rest of the Committee will, to ensure that that happens.

SANDRA THOMAS: I just wanna let you know, I'm 61 years and I've watched hospitals close. I watched them close.

CHAIRPERSON JOHNSON: I understand. I live… [crosstalk]

SANDRA THOMAS: Okay. Thank you.

CHAIRPERSON JOHNSON: three blocks from St. Vincent's Hospital and I watched it close.

SANDRA THOMAS: Thank you.

CHAIRPERSON JOHNSON: Next up. Thank you very much.

FAY MUIR: My name is Fay Muir; I'm a resident of Norwood for 35 years [background comment] and I serve on the Community Advisory Board of North Central Bronx Hospital. I have had occasion to receive health services from both North Central Bronx, Jacobi Medical Center, as well as Montefiore Hospital. My personal experience has been that the treatment I received at NCB is far superior and any number of my neighbors, friends and colleagues echo that comment, even though they are not able to be here because of the time this hearing is scheduled.

From my point of view as a patient, I get the feeling that the larger facilities… in those larger facilities my personhood is devalued and I become more like one of the cogs that keep the wheel turning. What brings me here today is concern over the closing of labor and delivery services at NCB and the way in which this occurred without notice to the public or even to the staff members.

I would like to say that I listened to Mr. Aviles say that the CAB was consulted -- well, I was at the meeting where we were told that it was closed; at least that was my understanding, and when I asked a question about staff training and staff

recruitment I was, you know, cut off and told that they had already hired two people. So I can't understand why it is that many, many months ago they could hire two people on the spot and yet they can't find enough staff to open up now.

In addition, although the promise has been made that this is temporary, I question whether this should have happened at all and indeed, whether that promise is a commitment.

At a meeting with our community on December 12th, HHC officials committed to the reopen of services by April 30th and now they're saying that they need more time to reopen the services. If they cannot make that deadline, the State Department of Health will force the removal of those maternity beds, which will make the service even harder to bring back. NCB is renowned especially for its labor and delivery services and it accounts for almost half of its business. To me, removing those services sounds like a death note for the hospital and it will be just a matter of time before NCB will not be able to continue its valuable services to the poor, marginalized and underserved population. Clearly there is something deeply flawed with HHC's strategic

planning process if it has allowed for the closing and delay of reopening such a vital [bell] health service, the only one of its kind in the Northwest Bronx; [background comment] this would be a great loss indeed to the entire HHC system. My first great-grandson was born at NCB seven short months ago -- one of their many success stories; he was born with an emergency C-Section and both mom and baby are doing well. Having him born at NCB enabled me to visit every day to offer my assistance my family needed, which would not have been possible to do had they been at Jacobi. Personally, I had a recent operation at Jacobi and my family had difficulty coming to visit and one friend had her visit thwarted because the driving directions she received were confusing and she had to turn back. If people who are well have difficulty making their way from our neighborhood to Jacobi, how much more difficult will patients find it, in particular, expectant mothers could be caught in the cross-town traffic, plus the unbelievably volatile weather lately compounds the difficulty. Many neighborhoods in the Northwest Bronx, because of their large percentage of poor minority residents, including many undocumented and

homeless people, will be unable to get the health services they need without NCB.

It is because of my community's experience with the loss of labor and delivery services at NCB that I'm deeply concerned that HHC has developed this strategic plan with no input from the community whatsoever. HHC did not host a public meeting where details about its plan could be shared and feedback from the community provided.

The plan calls for an extraordinary number of layoffs and downsizing of hospital staff, as well as for the consolidation of specialty care services. We have already been hurt by being forced to travel farther for maternity services that were consolidated into an already overcrowded and under-staffed facility at Jacobi. This cannot stand, HHC must prevent more cuts or reductions in health services and programs. Communities like ours need programs like NCB's Midwifer Services that were a citywide model of evidence-based best practices that have been shown to improve health outcomes.

As a member of the Community Advisory Board of NCB, I do as much advocacy work for them as possible; NCB's Community Advisory Board, as well as

its in-house liaison were consolidated with Jacobi; a number of CAB members have suffered because of the economic hardship they experience in our community, people with families who work more than one job find it difficult to participate, especially when that calls for travel… [crosstalk]

CHAIRPERSON JOHNSON: If you could please… if you could please wrap up.

FAY MUIR: Jacobi. One more sentence. Consolidation to cut corners has cost our community's ability to give input as well as critical services; it's essential that HHC administration and our house liaison visit NCB to engage the Advisory Board more comprehensively. I hope to see the wonderful health care services given by NCB expanded and enhanced. Thank you.

CHAIRPERSON JOHNSON: Thank you very much.

EILEEN MARKEY: Good afternoon; my name's Eileen Markey; I'm consolidating my testimony in the interest of time, but I really hope that you and your… rest of your absent committee read all the copies, 'cause I spent a lot of time thinking and writing it… [interpose]

CHAIRPERSON JOHNSON: We… by the way, we will make sure that your testimony gets to every committee member.

EILEEN MARKEY: Thank you. I live in Norwood, in the Bronx; unlike many of the people who've spoken today, I'm not an expert on public health or HHC; I'm simply a Bronx woman who gave birth at an excellent hospital. That excellent hospital, NCB, is no longer supporting women as they bring life into the world. I'm here first as a proud citizen of New York City and then as a heartbroken one. Overnight thousands of women, overwhelmingly immigrant, poor and working class women of color, were robbed of a safe, supportive and accessible place to begin our families. There was no warning, no input, no notification, even for the alleged Advisory Board, as Fay has testified.

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 a lot of photographs of our babies

who were born well and safely at an excellent hospital; in response, HHC has given us ostecation [phonetic], shifting stories, an ever-receding reopening date; a mishmash of misinformation.

I agree with the recommendations of everyone else who's spoken for strengthening accountability and transparency, both in regards to this particular NCB issue and the much broader ones regarding "The Road Ahead" program.

What's important to note is that this wasn't just any hospital; NCB was a gem; that maternity ward was a gem. 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 pregnancy test until the day I walked out of the hospital with my son, I received the highest level of skilled, humane, woman-centered care. 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, underestimated; as patients, men or women, in so many healthcare settings we're used to being treated as numbers, as units, as annoyances; North Central Bronx was the

opposite of all 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 [bell] was directly linked to the midwife model of care and the ethic pervasive at a ward where midwives are in charge, not guests… it's very, very brief… I looked forward to those appointments… [crosstalk]

CHAIRPERSON JOHNSON: Take your time.

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

CHAIRPERSON JOHNSON: Thank you very much Miss Markey. And thank you all. I can just tell you that… I believe you all were here during HHC's presentation and when they answered our questions and I think you saw that there was a deep concern among a wide variety of council members who are seeking to restore the labor and delivery unit as soon as possible and I can give you my assurance the entire Bronx delegation, eight or nine members' assurance, and members on this committee who aren't in the Bronx, that we all wanna see it reopened and restored as soon as possible. So we will stay on the issue; we appreciate your advocacy and I really appreciate you being patient and taking the time to be here today and I'll make sure that your testimony is put in all of the Health Committee members' mailboxes so they have time to review it as well. Thank you.

And next up we have two more left. We have Mindy Friedman and Sascha Murillo. If you could turn the mic on. Proceed. Yeah.

MINDY FRIEDMAN: Good afternoon Chairperson Johnson and 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.

I have shortened my testimony in the interest of time, but please accept my full written testimony.

In October of 2012 the City Council held an Oversight Hearing regarding the accessibility of healthcare 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. In accessibility is the result of architectural and communication barriers, in accessible equipment and provider bias, and the resulting disparities are well documented. Studies have shown that individuals with disabilities are far less likely to access healthcare services than individuals without disabilities.

With the help of ICS, a few New York City healthcare facilities, including HHC facilities, have begun to make accessibility improvements for women with disabilities who seek a full range of health services. Last year, in the wake of the Oversight

Hearing, the City Council allotted $2.5 million in Fiscal Years 2013-2014 and $2.5 million in Fiscal Years 2014-2015 towards making accessibility improvements at all HHC facilities. We again applaud the City Council for prioritizing these changes, which will help hundreds of thousands of New Yorkers with disabilities to access critical healthcare services. All New York City hospitals are required to ensure accessibility for their patients and HHC facilities have an especially critical role to play.

The funding provided by the City Council is a first step towards enabling HHC facilities to become accessible to the most underserved people with disabilities in New York City. It is essential that the City Council and HHC continue to prioritize access to healthcare for people with disabilities. We ask that the City Council follow through on its commitment to fund accessibility changes at HHC facilities in the coming fiscal years.

We also ask that HHC continues its commitment to coming into compliance with federal, state and local antidiscrimination laws.

Once again, we thank HHC and the City Council for their ongoing efforts to make healthcare accessible to all New Yorkers. Thank you.

CHAIRPERSON JOHNSON: Thank you very much. And I just was asking the Committee Counsel -- this is a concern for me; it's something that I had known about and it's something I care deeply about and I believe HHC also is doing their best, though more could be done to make sure that all of their facilities are accessible to people who are differently abled in any way. So I look forward to working with you all and other advocates and HHC to make sure that these steps are taken so that everyone can receive quality healthcare without not having access, both, you know, physically… you know, structurally not having access, so thank you very much.

MINDY FRIEDMAN: Thank you.

SASCHA MURILLO: Alright. 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. I would like to thank you, Health Committee Chair, for convening this

hearing to examine HHC'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 for low-income and uninsured New Yorkers. And so you know, I'm here to speak mostly on behalf of the coalition to save North Central Bronx Hospital and to bring back labor and delivery services and we feel that what HHC has done at North Central Bronx Hospital demonstrates sort of the consequences of HHC's current modus operandi across the system.

So on August 12th, 2013, HHC suspended labor and delivery services at NCBH and they transferred staff and patients to Jacobi Medical Center with only three days notices. The community, including residents, labor; health advocates, we were all strongly opposed to the loss of a vital and treasured service. Further, the community was frustrated by the lack of transparency with which the initial decision to suspend services was made and the lack of effort on the part of HHC to seek community input.

So as a result of the suspension, pregnant women previously served by NCBH must now

travel upwards of an hour to Jacobi Medical Center to deliver their babies and this poses additional threats to the well-being of the mother and child. I have spoken to women in NCBH's prenatal clinics who are angry and disappointed about not being able to deliver their babies in their community hospital. Staff nurses and physicians have expressed concerns about overcrowding in the maternity floors at Jacobi and additionally, mothers who utilized pediatric services at NCBH are now scared that the suspension of maternity services signals that the whole hospital may be under threat of closure.

So we've heard today that HHC reps have made public statements regarding their intention to reopen maternity services, but I'd like to remind everyone that the New York State Department of Health had initially set a deadline of December 9th and that they granted them an extension to April 30th and now HHC is seeking another extension. But still, regardless, they still risk decertification under the current regulations of its maternity and neonatal beds and services from its operating certificate. So it's imperative that HHC act now to work with

residents, labor and policy experts to bring back this crucial service.

We recommend that HHC, one, work with the growing coalition of community and labor groups of which we are a part and thank you Council Member Johnson, you met with us, I believe, several members of us, so we thank you for that. And two, we would like HHC to expand the role and power of the community advisory board and require that they monitor HHC's progress in returning maternity services to NCBH. Three, ensure that HHC preserve and expand access to high-quality maternity [bell] care in the North Bronx… I'm almost finished… [interpose]

CHAIRPERSON JOHNSON: You… you can… you can contin… [interpose]

SASCHA MURILLO: Okay.

CHAIRPERSON JOHNSON: you can continue your testimony in full.

SASCHA MURILLO: Okay, great. And that they support the return of a robust midwifery program at NCBH; you've heard several times today that this is an evidence-based best practice that has been

shown to improve health outcomes, which is especially important in the Bronx.

And finally, we ask that HHC implement planning protocols, including a communication plan for notifying staff and community members of upcoming changes, a process for gathering community input and a detailed timeline for any future changes.

These recommendations don't just apply to NCBH and they can be applied across HHC, and so we hope that HHC, as they consider sweeping changes to the public hospital system will preserve access 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 healthcare services in the North Bronx and across New York City. I thank the members of the Health Committee for listening to my testimony. Thank you.

CHAIRPERSON JOHNSON: And you may, again, submit your testimony so that we can ensure that all committee members receive it, especially members where NCB is being affected. So I appreciate you all for being incredibly patient, both staff from HHC who stayed for the entirety of the meeting to all the advocates in the room and organized labor and

everyone that came out today on this very important issue. Once again, we're gonna have preliminary budget hearings in March and you all are welcome to come back and speak specifically about the budget and the year ahead and I look forward to working with all of you. I just want again… want to thank the committee staff, Dan and Crystal and Crilhien, who did an incredible job preparing for today's meeting and I look forward to working with you all. Thank you very much. This meeting is adjourned.

[gavel]

[applause]

C E R T I F I C A T E

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

Date _____ _March 7, 2014 _____