NYC Health

Testimony

of

Oxiris Barbot, MD
First Deputy Commissioner
New York City Department of Health and Mental Hygiene

before the

New York City Council Committee on Health

on

Intro 974

December 9, 2015
250 Broadway – Committee Room
New York City

Good morning Chairman Johnson and members of the Committee. I am Dr. Oxiris Barbot, First Deputy Commissioner at the New York City Department of Health and Mental Hygiene. On behalf of Commissioner Bassett, I want to thank you for the opportunity to testify on the topic of community health planning.

The mission of the Department of Health and Mental Hygiene is to improve the health of all New Yorkers. As in many large cities, the health of New York's residents is addressed through a comprehensive system of partnerships across the health care, public health, and non-health sectors. The Department has a major role as a facilitator in uniting and maintaining information in this system, and helping to steer the system toward achieving health equity and improving population health. We have extensive population health, health care system and health planning expertise. Our agency works tirelessly to analyze the systems that deliver health care services in New York City, recommend best practices and coordinate the complex system of stakeholders to help all New Yorkers receive affordable high-quality health services.

Many of the health issues facing New Yorkers, including obesity, type 2 diabetes, hypertension, and maternal mortality, disproportionally affect communities of color. In 2014, to better coordinate health planning involving under-served populations, the Department launched the Center for Health Equity. The Center is focused on advancing the Department's framing of health as a racial justice issue, investing in key neighborhoods, building partnerships that advance racial and social justice, and making injustice visible through data and storytelling. These approaches allow the Department to better address the root causes of health inequities. The Center does this work in collaboration with all health department divisions and the central coordination of our Policy, Planning and Strategic Data Use unit. Improving health equity requires government policymakers, health professionals, researchers, and community groups to work together, and the Department plays a critical role in bringing these stakeholders to the table.

Earlier this year, the Department was funded by the administration to launch the Neighborhood Health Hub initiative. Community-based organizations, providers of medical, dental and mental health services, and other City agencies will be co-located under one roof in underutilized Department buildings in high-need neighborhoods. The goals of the Hubs will be to build on neighborhood assets and identify resource gaps to improve population health, address root causes of health inequity, including the physical environment, structural racism, housing and employment, and close service gaps and reduce redundancy by bringing community groups together to facilitate neighborhood health planning. Center for Health Equity staff will coordinate the work of Hub partners and assist in navigating community members to the appropriate health and social services. The Hubs will be located in Bedford, Brownsville, and Bushwick, in Brooklyn; Central Harlem and East Harlem in Manhattan; and Morrisania and Tremont in the Bronx. We are excited to share that new partners will be moving into the Bedford, East Harlem and Morrisania Hub sites in the early part of 2016.

Additionally, the Department is partnering with the Fund for Public Health in New York, the United Hospital Fund and the New York Academy of Medicine to facilitate the New York City Population Health Improvement Program (PHIP). The PHIP promotes health equity as well as the "Triple Aim" of better care, lower health care costs and better health outcomes for New

Yorkers. Through the PHIP, we engage community members and cross-sector leaders in strategic health planning in order to increase investment in public health interventions that prevent disease and improve health equity. The PHIP partnership also supports the local transition to value-based health care and advanced primary care. A critical part of the PHIP is the Steering Committee, which consists of representatives of multiple sectors including healthcare systems, health services payers, education, academia and economic development. Membership includes the Department, CUNY School of Public Health, Fund for Public Health in New York, Greater New York Hospital Association, NYC Health + Hospitals, Hispanic Federation, HealthFirst, Jewish Association Serving the Aging, Metro New York Health Care for All Campaign, New York Academy of Medicine, Public Health Solutions, Partnership for a Healthier NYC and the United Hospital Fund. The Steering Committee meets quarterly, and recommends priorities and multi-sector strategies relevant to meeting the health needs of subpopulations that disproportionately experience adverse health outcomes. PHIP activities are planned through 2017, and we believe that this existing infrastructure can be used to continue comprehensive health planning citywide.

The Department is also a key stakeholder in the New York State Delivery System Reform Incentive Payment Program commonly referred to as DSRIP. We offer guidance and support to each of the eleven New York City Performer Provider Systems in planning projects to create patient-centered medical homes, integrate behavioral health services with primary care, and implement community-oriented and evidence-based interventions on asthma, HIV, and tobacco cessation. The Department's Division of Prevention and Primary Care was created in 2014 to advance improving access to and the quality of primary care and prevention efforts throughout New York City, with a focus on population health. This Division is tasked with supporting and promoting primary care, and has been assisting over 16,000 clinical providers and their organizations with the adoption of information systems including electronic health records, quality improvement, and practice change to improve the delivery of preventive services and coordinate care for patients with chronic conditions. Since 2010, even before PHIP and DSRIP, we have provided technical assistance to hundreds of community-based primary care practices to improve their ability to manage chronic diseases and connect with community-based resources. These activities have been ongoing as part of practice transformation activities across the state and country, including Patient Centered Medical Homes and Medicaid Health Homes.

The Department's work also focuses on devising and implementing policy, program and research interventions that maximize coverage and reduce barriers to health care access for underserved populations. We have a team of Certified Application Counselors (CAC), who work throughout the year to identify uninsured New Yorkers, educate them about their health insurance options and provide assistance signing them up for coverage through the New York State of Health Marketplace. This team also helps link New Yorkers to appropriate and affordable health care services. In addition to our CAC outreach, during the Marketplace open enrollment periods we launch a citywide public awareness campaign – GetCovered! – to increase enrollment into health insurance and promote use of in-person enrollment assistance.

Recognizing that immigrants can face additional barriers in accessing health insurance coverage and care, we co-chaired the Mayor's Task Force on Immigrant Health Care Access. As part of this work, we are working closely with the Mayor's Office of Immigrant Affairs and

other City agencies to lead the development of a health care access program for immigrants who are excluded from federal and state support that will begin in the Spring of 2016 as a pilot program. This program will allow New York City to provide more coordinated primary and preventive care to those foreign-born New Yorkers who cannot access insurance, even under the Affordable Care Act.

The coordination of citywide mental health and substance use services is another important role of the Department. Our Division of Mental Hygiene is the Local Governmental Unit that has statutory authority and responsibility for oversight and management, quality improvement and fiscal oversight of the local behavioral health system. New York State Mental Hygiene Law requires the Department to develop an annual Local Services Plan, with input from stakeholders including hospitals, community mental health centers, consumer groups, advocates, community-based organizations, local correctional facilities and other local criminal justice agencies. We also organize the New York City Regional Planning Consortium, which identifies and addresses issues stemming from the transition to Medicaid Managed Behavioral Health Care, for which we have legislative authority for joint oversight with the state. The Regional Planning Consortium monitors service access and capacity, system stability and improvement, and service quality, efficiency, and efficacy. Additionally, as part of ThriveNYC, we facilitate the Mental Health Council which provides guidance for implementation of behavioral health initiatives across City government.

Regarding Intro. 974, the Department routinely analyzes the existing landscape of the City's health care resources. This analysis includes the existing universe of federally qualified health centers and other safety net providers, primary care capacity and health professional shortage areas. Through the Community Health Survey we analyze the status of New Yorkers' health using a series of indicators and monitor access to care through questions related to unmet medical and mental health needs, insurance and primary care coverage. This information is crucial to the development of the Department's health plans, such as ThriveNYC and Take Care New York 2020, and is used to make recommendations to key stakeholders where efforts might be directed in order to address disparities in access to care. We support the intent of Intro 974 and look forward to discussing details such as availability of data, the inclusion of mental health and substance use services, and additional resources required with you further.

Thank you again for the opportunity to testify. I am happy to answer any questions.

For The Record

TESTIMONY OF

THE UNITED FEDERATION OF TEACHERS

BEFORE THE CITY COUNCIL

COMMITTEE ON HEALTH

REGARDING COMMUNITY HEALTH PLANNING

DECEMBER 9, 2015

Good afternoon Chairman Johnson and members of the Committee on Heath. My name is Anne Goldman, and I am vice president for the non-Department of Education members of the United Federation of Teachers (UFT). On behalf of our union's 200,000 members, including more than 5,000 nurses, I want to thank you for this opportunity to offer testimony today. I plan to spotlight some of the fine work we're doing, as well as provide some recommendations on how we can move forward on community schools.

Our union has a wealth of knowledge and experience when it comes to building and developing health initiatives that work seamlessly within complex governmental structures. What's more, we operate a robust suite of mental health services and programs. Our work ranges from providing patients with medical care through our nurses' chapter to providing students with medical, dental, vision and mental health supports through our New York City Community Learning Schools Initiative.

Our city has the opportunity to improve access to primary and preventative care in our school communities. We believe the future of health care can be found in school-based health centers. We're in the process of opening two such centers this year, and foresee children from neighboring schools coming to them for much-needed care.

These centers are part of our push to align services from city agencies as well as non-governmental organizations and private partners to address the needs of a child in a holistic manner. As part of that push, we must provide more mental health services to our communities. All the schools that applied to our Community Learning School Initiative emphasized the need for mental health services. Given Mayor Bill de Blasio's emphasis on this critical issue, we strongly advise that the new Office of Community Health Planning make sure these programs are offered to all students.

<u>UFT Nurses Chapter</u>

Nurses are the backbone of our health care system. From the neonatal unit to hospice, a nurse's expertise is more important than ever.

Established nearly 40 year ago, the Federation of Nurses/UFT represents 5,000 nurses here in the metropolitan area. Our members are registered nurses and licensed practical nurses at two private hospitals - Brooklyn's Lutheran Medical Center and Staten Island University Hospital - and two

health care agencies, the Visiting Nurse Service and Jewish Home Healthcare. We also represent several hundred health care professionals in Guildnet.

All of our nurses are distinguished "professionals" in every sense of the word. They have received specialized education and training, and they use their skills to initiate life-saving measures every day. What's more, they use their experience and critical thinking skills to develop and implement care plans for home-based clients.

We trust our nurses to give the best in patient care. And, as their representatives, the safety of our members is among our top priorities. Because of the specialized nature of their jobs, we ensure that they have input in policy development and the management of the care they provide.

School-Based Health Care Professionals

In schools, thousands of UFT members work every day to provide students with critical health care services. Our social workers, psychologists, and guidance counselors are all uniquely trained to address the social well-being of our students. They assess a student, work with teachers and parents to learn the full scope of issues either in school or at home, and then develop comprehensive counseling plans.

Occupational and physical therapists are also a vital part of the equation, helping students develop or regain physical and emotional health. They also develop therapeutic plans to address student needs and work with teachers, parents, and doctors to ensure implementation of those treatments. Many times that program includes teaching vocational and homemaker skills, daily life skills, and social skills. Their goal: to promote student independence and productivity. These roles are particularly important in our District 75 schools.

Beyond these titles, it's also important to note that the UFT represents teachers based in New York City hospitals. They provide educational services to seriously ill children who require long-term hospitalization, or students with special needs. Their bedside work coincides with strong collaborations between school personnel, hospital caregivers, and administration.

School-Based Health Care Services

Locating health and mental health services within school buildings is a proven formula for improving the overall health and wellness of our students. Within community schools, students, and sometimes their families, receive care for a range of illnesses including asthma and diabetes. They may receive dental care, checkups, vision and hearing tests, mental or behavioral health care, substance abuse counseling and health and nutrition education.

It's a smart and practical place to deliver these services because our schools are essentially community "hubs." Many of these school-based health services are offered through partnerships between the school and community or health organizations. The UFT continues to recommend an increase in funding to expand and enhance these services; an increase is necessary to ensure

that these school-based health clinics can provide the skilled nursing services for students with disabilities and those with other serious health issues.

The New York City Community Learning Schools Initiative

The UFT's NYC Community Learning Schools Initiative facilitates partnerships between schools and non-profits, businesses, and government. As with the mayor's community schools program, this initiative helps public schools develop support services with the goal of improving student achievement. The underlying principle is to address the health, safety and social service needs of students and communities and thus create a better learning environment.

Launched in 2012 by the UFT in collaboration with the New York City Council, the Partnership for New York City and Trinity Wall Street, the Initiative began with six demonstration schools. We're proud to say we now support 25 schools this school year. Our model works to seamlessly integrate services into a school's daily operations. These services include medical and dental programs, social services, and mental health, and food and nutrition programs. We believe, based on research and evidence, that close collaboration among schools, neighbors and service organizations leads to increased student success and strengthens entire communities, making them more stable and desirable places to live.

One of our key goals, and a priority for students in all our schools, is to ensure that our children have their eyes checked and that eyeglasses, or any other visual aids, are supplied as needed. According to the American Optometric Association, as much as 80 percent of a child's learning is done visually, making uncorrected vision a true detriment to success in school.

The NYC Community Learning Schools Initiative has made a conscious effort to improve the vision of students in our Community Learning Schools. These efforts have been possible through collaboration with organizations such as Lutheran Family Health Services, Montefiore, SUNY Optometry and One Sight. The need is so great, however, that we require further support to ensure that no child struggles because of poor vision.

Member Assistance Program

As part of the UFT's commitment to improving the lives of its members, we provide the Member Assistance Program to help support those who are having difficulties. MAP, as we call it, provides free short-term counseling. Our staff's professionally-trained counselors assist with family/marital problems, financial and legal difficulties, stress and substance abuse. The program also provides members with outside resources and referrals to find solutions to a wide range of personal and work-related problems. The services provided are confidential, professional, supportive and independent. These programs have been such success that other unions have requested our assistance in neighboring school districts. For example, after the Sandy Hook Elementary School massacre in Connecticut, we were called in to help.

Positive Learning Collaborative

Another aspect of our work students vis à vis mental health is our Positive Learning Collaborative (PLC), a partnership between the UFT and the city Department of Education. The PLC emerged from the realization that the existing school disciplinary practices were having a drastic impact on our most vulnerable students: children with learning disabilities, and those from high-poverty neighborhoods, many of whom are children of color.

As experienced educators, we understand the toll that poverty, trauma and stress take on our students. The PLC holistic approach supports the creation of a supportive climate through the use of a multi-tiered framework that focuses on reflective and restorative practices while developing the systems needed for sustainability.

Restorative practices are successful when implemented school-wide and integrated into the fabric of the school community. When the school culture is infused with restorative strategies, the level of support allows for issues to be addressed quickly in a caring and thoughtful manner. We believe that embedding restorative practices in elementary schools can have a broad transformative impact on school culture and society at large. Young students are most receptive to new patterns of how to relate to others. The earlier we start, we have found, the better.

Recommendations

We believe that our diverse and wide-ranging expertise makes our union a unique and powerful partner for the City Council as it develops the Office of Community Health Planning. By having a seat at the table, the UFT can help Council maximize the new office's effectiveness.

What's more, with more schools now on the front lines of health care delivery, especially under the community schools model that Mayor de Blasio hopes to expand, the UFT's unique expertise in working with government and private sector agencies can help guide the Office of Community Health Planning.

More specifically, the UFT can help connect schools with needed services and ensure that those services are seamlessly integrated into a school's daily operations. We can help streamline services between the Department of Health and the Community Learning Schools. In that same vein, we would encourage this department to work with our nurses to connect them to schools with District Public Health Centers, which are underutilized.

Thank you again for your support of our members and our projects. We look forward to working with you and the Office of Community Health Planning in the future.

FOR THE RECORD

PROTECT OUR HEALTH
SAVE OUR HOSPITALS

cphs*
*putting the public back in public health

WE SUPPORT INTRO 973-A

PROTECT OUR HEALTH – SAVE OUR HOSPITALS is a grassroots campaign led by community based organizations, advocates, and unions calling to preserve hospital and health services for all New Yorkers, regardless of race, ethnicity, immigration status, language spoken, gender, sexual orientation, disability, neighborhood, diagnosis or ability to pay. The following undersigned organizations join us in this endeavor to support health care decision making powers returning into the hands of the communities where it belongs. We support the following:

1. Intro 973-A, to amend the New York City Charter, in relation to establishing an office of comprehensive community heath planning and an interagency coordinating council on health.

2. Public Hearings and other public opportunities to discuss the importance of passage of Intro 973-A and meaningful community engagement. These local bodies should be empowered to assess community health care needs, including working with stakeholders to establish criteria on:

    - Accountability and planning based on community health needs and conditions that impact people's well-being (i.e. housing, food access, environment, other social determinants of health), as formulated by the community and in conjunction with health care professionals.
    - Identify inequities in access and quality of care, and formulate plans to correct such deficiencies.
    - More transparency; representation and engagement; equitable governance and decision-making

3. Sustaining the coordination of the interagency coordinating council with funding and support by at least one paid staff person

In New York City, our healthcare system is in the midst of an ongoing crisis and reforms to its delivery of health care services (i.e. DSRIP). Against the backdrop of historical inequities in access to quality health care services – especially in low-income, immigrant and communities of color – we have seen:

1. New York City Hospitals close, merge and purchase physician practices at an alarming rate, on average two hospitals a year over the past ten years have closed. For the most part, private development has take over hospital property leaving communities without critical emergency room and other hospital services. In the past three years, at least 17 community hospitals in the New York City area have joined larger systems. The pace of acquisition is not sustainable. The consolidation trend has been justified by so-called 'reform' efforts to reduce waste and reward value instead of volume, but these monopolizing forces are contributing to a rise in costs and more importantly, impacting access and quality of health care.

2. New York City and New York State failed to replace critical life-saving services provided by these closed facilities creating health care disaster zones in low-income, immigrant communities and communities of color. There are already vast health care inequities leading to dangerous overcrowding of facilities in neighboring communities.

For more information or how to get involved, please contact Anthony Feliciano or Josh Starcher, at ProtectOurHealthNow@gmail.com (c) 646-325-5317 or (w) 212-246-0803

SIGN-ON AGREEMENT

PROTECT OUR HEALTH – SAVE OUR HOSPITALS

Participating organizations signing on are asked to help develop and adopt agenda items and strategies in support of direct advocacy, organizing, and preparation of any policy recommendations. This can happen in the following ways (**check all that apply**):

- ■ Discuss and publicize the bill amongst your members/contacts.
- ■ Organize volunteers to collect signatures (if necessary).
- ■ Participate in regular face-to face meetings and/or telephone conference calls.
- ■ Provide "People Power"- for example, participate in work-groups, conduct research, host presentations, and recruit/identify volunteers for various tasks or actions.
- ■ Provide "Money Power"- Financial/Pro-bono support for the advocacy efforts. This is based on an organization's size, budget and ability, and can range from making copies to hosting meetings to helping this effort.

****

I have read and agree with the campaign to support Intro 973 and the various ways to support the efforts of the campaign.

Signature: Anne Bove', RN

Print Name: Anne Bove', RN

Organization: NYSNA / CPHS

City/State Zipcode: Woodside, New York 11377

Address: 48-53 45th Street Apt. A5; Woodside, NY 11377

Phone/ Email: 917-696-0660 / annbov1@aol.com

Please sign and return to NYSNA at Fax: 212-785-0429 or ProtectOurHealthNow@gmail.com

FOR THE RECORD

GREATER NEW YORK HOSPITAL ASSOCIATION

555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

December
Eight
2015

Council Member Corey Johnson
Chair, Committee on Health
250 Broadway
Suite 1804
New York, NY 10007

Dear Council Member Johnson:

Greater New York Hospital Association (GNYHA) represents more than 135 member hospitals and health systems, both public and not-for-profit, in New York State, the majority of which are in New York City. On behalf of our members, I am writing to oppose Intro. 973-A, which would create two City health planning entities: the Office of Comprehensive Community Health Planning (OCCHP) and the Interagency Coordinating Council on Health (ICCH).

The proposed legislation would encroach on New York State (NYS) jurisdiction and authority; the bill would impose a local health planning process that is duplicative of existing State health planning and health care reform processes and activities. Furthermore, New York State already has the Public Health and Health Planning Council (PHHPC) that is responsible for health planning throughout the State, including a Certificate of Need process for changes in hospital services.

The State processes currently underway include enacting the Medicaid Redesign Team (MRT) reform recommendations; establishing value-based purchasing in NYS, which is designed to improve quality in the Medicaid program; implementing the State Health Improvement Plan, which is designed to advance primary care and coordinated care throughout the State, including in NYC; and operating Public Health Improvement Plan (PHIP) regional entities created throughout the State—and operated by the NYC Department of Health and Mental Hygiene here in the City—designed to support population health improvement and enhance primary care.

Each of these initiatives have various committees and workgroups comprising various stakeholders who are dedicated to obtaining input and discussing health care reform and redesign issues. All of these committees include many of the same organizations contemplated to be part of the ICCH that would be established by the proposed legislation. In total, there are more than 20 multi-stakeholder committees and work groups associated with these initiatives that are dedicated to discussing aspects of health care reform and health system redesign. Examples of some of the committees and workgroups that have been convened over the last two years include:

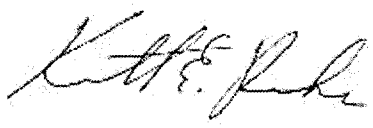
- Workforce Flexibility and Change of Scope of Practice Work Group

- Social Determinants of Health and Community-Based Organizations Committee
- Advocacy and Patient Engagement
- Clinical Advisory Group
- Regulatory Impact Group
- Integrated Care Work Group
- Workforce Work Group
- Transparency, Evaluation, and Health Information Technology Workgroup
- Behavioral Health Work Group
- State Health Innovation Plan Council
- Supportive Housing Work Group
- Basic Benefit Review Work Group
- Behavioral Health Reform Work Group
- Health Disparities Work Group
- Health Systems Redesign: Brooklyn Work Group
- Managed Long Term Care Implementation and Waiver Redesign Work Group
- Medical Malpractice Reform Work Group
- Payment Reform and Quality Measurement Work Group
- Program Streamlining and State/Local Responsibilities Work Group
- Social Determinants of Health Work Group

Clearly, creating a new health planning structure for the City would be duplicative of all of these efforts. GNYHA members are already highly regulated by the State and Federal governments, including on all of the issues that would be discussed under the proposed legislation. In addition, establishing a health planning process that does not include the State agencies with jurisdiction on these issues would be counterproductive, confusing, and time-consuming. City resources would be better utilized by continuing to engage in these existing health reform processes and discussions, rather than trying to duplicate these very same ongoing and dynamic discussions with the same participants.

For these reasons GNYHA, on behalf of its members, opposes City Council Intro. 973-A.

Sincerely,



Kenneth E. Raske
President
GNYHA

cc: Speaker Melissa Mark-Viverito
Members of the Committee on Health

Leon Bell

To: Leon Bell
Subject: RE: Crain's Health Pulse - Today's News Monday, November 30, 2015

Crain's Health Pulse
Today's News Monday, November 30, 2015

NYU Langone's bulging bottom line

NYU Langone generated a $229 million gain from operations for its 2015 fiscal year ended Aug. 31. Expanded ambulatory services boosted revenue, leading to a 6.6% increase in operating profit. Net patient service revenue rose 20%, to $2.5 billion, partly a reflection of the system's recovery from Superstorm Sandy. Management also attributed the surge in revenue to growth in demand for ambulatory surgery, cardiac catheterization and electrophysiology and in cancer and musculoskeletal center visits. NYU Langone also got rate increases for inpatient and outpatient services, according to unaudited financial statements posted online last week. During fiscal 2015, the system made a major push into Brooklyn. It opened a freestanding ED in Cobble Hill last October that helped boost ED visits 52%, to 62,911. Amid an 8% increase in discharges, to 34,732, operating expenses rose 12%, to $2.4 billion. Operating margins fell slightly to a still-robust 8.8%, from 9.2% in the prior year. The hospital disclosed its $190 million commitment to NYU Lutheran during the next five years—a $50 million grant and $140 million in loans—for investment in capital projects and administrative systems, including a new electronic health record. NYU Langone said it is considering hospital affiliations outside Manhattan, but "no letters of intent or other binding documents have been executed."

NYC Health + Hospitals has heavy first-quarter loss

As a new chief financial officer takes the reins, NYC Health + Hospitals has a massive first-quarter loss in fiscal 2016: $263.6 million.

The loss was related to the timing of supplemental Medicaid payments, a health system spokesman told *Modern Healthcare* last week. That category of funding includes Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) payments.
The operating loss was almost nine times the size of the red ink during the same period in 2014, according to unaudited financial statementsposted last week. It was also greater than the network's $58.1 million year-end loss for fiscal 2015, which ended June 30, according to financial statements.

After nonoperating items, including investments and $33 million spent on interest, the 11-hospital system lost $293.3 million in the first quarter of fiscal 2016.

Plachikkat Anantharam was named chief financial officer last week and will be charged with helping to restore financial stability to the network, which had a $4.9 billion net deficit as of Sept. 30.

In April, Dr. Ram Raju, NYC Health + Hospitals' president and chief executive, outlined a number of goals to meet by 2020. He aims to improve the patient experience at its hospitals and clinics to increase market share at the system and at MetroPlus. The insurer earned $107 million in operating income in fiscal 2015.

"In order to continue carrying out our mission, we need financial stability," Raju said. "To secure that financial stability, we need to grow our patient base and serve more New Yorkers."

In the first quarter, the system reported $1.2 billion in net patient service revenue, down 7.4% from the same period last year. Appropriations from the city were up 42.6%, to $67.7 million. Premium revenue from the system's insurance products ticked down 1.1%, to $609.2 million. Grants revenue was less than one-third of the 2014 total, at $32.2 million, which is related to the delayed payments. Total operating revenue shrank to $1.9 billion, down 7.2%.

Total operating expenses rose 4.1%, to $2.2 billion, in the first quarter. Costs from the category that includes salaries and wages were $692.3 million, up 1.5% from the prior-year period.

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

Testimony of the New York State Nurses Association
In Support of Intro 973 A and Intro 974
December 9, 2015

The New York State Nurses Association is the union representative of more than 37,000 registered nurses throughout New York State. In the City of New York we represent 20,000 nurses in the NY City Health and Hospitals system and in the private hospital sector.

Intro 973 A would amend the City Charter to create an Office of Comprehensive Community Health Planning in the executive office of the Mayor and an Interagency Coordinating Council.

The Office of Comprehensive Community Health Planning will consist of a Director appointed by the Mayor and will be empowered to coordinate the activities of the various City departments in identifying local health care needs and developing plans and recommendations for addressing identified needs on a systematic basis.

The Interagency Coordinating Council will serve as an advisory body to assist the operations of the Office of Comprehensive Community Health Planning in formulating its health planning. It will be composed of a wide cross section of stakeholders, including representatives of the heads of the various agencies that deal with health care issues, representatives of various health care providers (hospitals, FQHCs, primary care, ambulatory care and other providers), representatives of front line health care workers, health care advocacy organizations and local community and patient representatives.

The two bodies will work together to conduct comprehensive city-wide and local community health needs assessments, including not only an assessment of unmet needs but also of the extent and availability of the services being provided by the existing networks of public and private health care providers.

Based on the health care needs assessments, the bodies are required to develop a comprehensive plan and recommendations on how best to address these identified local community needs.

The legislation requires these bodies to specifically address not only the availability and scope of existing health services, but also to consider such other key factors as the social and economic determinants of health, disparities in the availability and quality of care, and the cultural, language and other barriers needs to accessing care of specific populations or local communities.

The legislation would also expand the role of the City in setting policy and formulating planning to systematically analyze the existing health care delivery networks of public and private health care providers and to coordinate the distribution and allocation of health care resources by existing hospital systems and other providers in a manner that is responsive to community needs.

The legislation would also create a more transparent and open process in setting health care policy and designing health care services than is currently the case. The proposed legislation would require regular public hearings and the consideration of input and recommendations of the public and health care advocates in the formulation of community needs assessments and the development of health plans.

Intro 974 would complement the health planning provisions set forth in Intro 973A by requiring the establishment of a public and easily accessible database outlining available health care services and identifying deficiencies in the distribution and available services.

NYSNA strongly supports enactment of Intro 973A and Intro 974.

The current structure and problems in the health care delivery system

The provision of health care in New York City is dominated by a patchwork of private hospitals systems, the NY City Health and Hospitals system, private physicians in group or individual practices, myriad non-profit primary care providers, and various corporate entities (pharmacies, diagnostic and treatments centers, specialty practices, surgery centers, etc.), most of which are operated as for-profit businesses.

Within this structure, large segments of the health care industry are primarily motivated by the organization need to generate incomes and profits. The corporate and for-profit providers are legally required to maximize investor returns. The non-profit and public hospital systems and other non-profit providers are increasingly forced through competitive pressures and financial concerns to act in a similar fashion.

State and federal policy initiatives such as DSRIP, MRT, payment reform, and the Affordable Care Act encourage increasing consolidation into large integrated systems, the imposition of market oriented reimbursement formulas and a reliance on market competition in an effort to improve health care delivery and reduce health care costs.

These structures and policies are well intentioned efforts to improve the delivery of care, but they also exacerbate contradictions between the needs of local communities and the allocation and distribution of health care services and resources.

The contradictions in the health care system are apparent in the ongoing process of closures of hospitals, reductions of services, intensified competition for market share among well-insured and more affluent populations, the dearth of health care services in low income communities, the flow of resources and services to communities that are already saturated with providers, and

an increasing focus on providing services that offer the highest economic rate of return at the expense of communities and populations that are money losers for the providers.

The need for systematic and robust local health needs assessment and planning

The proposed legislation offers an opportunity for the City of New York to more effectively assert its interest in protecting the health and promoting a fairer distribution of services based on established local needs.

The development of comprehensive community health needs assessments and planning to address identified local needs provides the opportunity for the City to more effectively assert local interests and to encourage greater cooperation and coordination in the local operations of all segments of the local health care industry.

The state of New York has asserted the authority to regulate health care services at the local level under the "preemption" doctrine and sets the legal and regulatory parameters for the provision of care. Within this framework, the City is relegated to conducting public health initiatives and providing direct financing for health programs to fill gaps in the availability of care or to address particular health care problems.

The City, however, has the ability and the right to more actively and systematically assert moral and political authority in determining the structure of health care services at the local level and to directly influence both state policy and the activities of local hospital networks and other private and public providers of health care services.

The proposed legislation creates the structures for the City and its people to have a greater say in how necessary health care services are being provided.

Creating a more democratic and transparent decision making process

One of the greatest flaws in the current health care delivery system is the lack of public and local influence and input in decision making about vital local health care services.

Concrete decisions about the location, scope and nature of health care services are currently largely made by private non-profit and for-profit corporate boards and executives behind closed doors and based upon institutional interests and financial considerations.

The decision to close a hospital, to reduce or relocate community health services, to choose the site and nature of new services, to change the way services are delivered, to determine how services are provided, to monitor and control the quality of services, and other critical decisions are generally decided upon by these private entities with little or no local or community input.

These decisions are then forwarded to the State DOH or other administrative bodies for approval. In most cases the approval of these private decisions by the state occurs without any input or knowledge of local communities that will be impacted by the decisions. Some of these decisions are subject to Certificate of Need review, but the public role in the review process is

limited to the opportunity of provide a short comment and this only after the DOH has already conducted its review and made its decision on the matter. In short, the public and affected local communities are effectively left with no voice in decisions that will directly affect their health care services and health needs.

The proposed legislation will greatly enhance the ability of local populations and communities to have a say in vital health care matters. The formation of local needs assessments and action plans will be conducted in a more open manner and the public will have a greater role in formulating local health planning than is currently provided by the State and by the private providers of care.

Addressing disparities and inequality in the local health care system

We assume that the state DOH and other agencies that regulate local health care services are well intentioned and seek to improve health outcomes. We also assume that most hospitals and other providers of care are genuinely interested in providing the best possible care to our communities.

We believe, however, that the state of New York is not able to fully and fairly integrate the full range of local community needs into its health care regulation and policy. Its responsibility is to oversee the entire state health system and its financial obligations for health care, but it cannot and does not look at the system from a local and community perspective.

Moreover, the prevalence of private providers competing with each other for market share and revenues creates a dynamic in which resources are disproportionately directed to geographic areas, populations and patients that will produce the revenues that they need to operate. This dynamic also leads to a concomitant tendency to avoid services, service "lines" and patient populations that operate at a loss.

The result of these dynamic is an increasing threat of two-tiered health care in which the affluent and well insured receive qualitatively and quantitatively superior services, while the uninsured, low income and other communities have less access and a lower quality of care.

This is evident in the widespread practice of "VIP" or "red carpet" treatment of well-insured patients, the tendency to provide ambulatory and specialty care "pavilions" and the creation of "luxury" units with catered meals and other perks for those who are able to pay. Patients who are not well insured or able to pay are relegated to long wait times in emergency rooms, assignment to crowded units with hallway beds, and other disparate treatment that occurs on a daily basis.

The two-tiered nature of the health care system is also clearly evident in the distribution of services. Certain neighborhoods are oversaturated with hospital, specialty and primary care services, while whole swathes of the City are virtually health care deserts with little in the way of primary care and reliant on precarious safety net hospitals for what care they do receive.

The proposed legislation provides the City with an opportunity to address the inequality and disparities in local health care services in a more systematic manner and to complement and correct deficiencies in state policy and private provider networks.

Roles of the State and City in health care policy and planning

The proposed legislation does not constitute an illegal assertion of regulatory power or impinge upon the jurisdiction of the state. It also does not assert improper or direct control over the operations of private health care providers.

The legislation instead requires the city to frame its policy and planning needs in a more transparent and democratic manner that brings local communities, health care workers and advocates into the decision making process.

The needs assessments, plans and recommendations that come out of this process will constitute a comprehensive counterweight to the state and private providers to inform and influence their decision making. The local planning process will not impose decision upon the other agents, but will create the possibility of a more collaborative and open process in which the interests of patients and local communities can be asserted as a factor in the allocation, distribution and quality of health care services.

Conclusion

We urge the council to adopt Intro 973A and Intro 974.

Presented by:
Leon Bell
Director Political Affairs and Public Policy
New York State Nurses Association

PROTECT OUR HEALTH
SAVE OUR HOSPITALS

cphs*

*putting the public back in public health

Commission on the Public's Health System Testimony on Dec 9th, 2015, 250 Broadway, 16th Fl
Support for Intro 973A and Intro 974
Need for Health Equity in New York
Anthony Feliciano, Director

Good Morning, my name is Anthony Feliciano, and I am the Director at the Commission on the Public's Health System (CPHS), a member of The People's Budget Coalition for Public Health (PBC) and co-lead with New York State Nurses Association for the PROTECT OUR HEALTH – SAVE OUR HOSPITALS campaign. PBC is a coalition of approximately two dozen grassroots-level community groups across New York City, and their trade union and social service allies. It was founded in 2007 as a project of the Commission on the Public's Health System in New York City, and is now jointly coordinated by us along with the Federation of Protestant Welfare Agencies (FPWA). PROTECT OUR HEALTH – SAVE OUR HOSPITALS is a grassroots campaign led by community based organizations, advocates, and unions calling to preserve hospital and health services for all New Yorkers, regardless of race, ethnicity, immigration status, language spoken, gender, sexual orientation, disability, age, neighborhood, diagnosis or ability to pay. I am here to support Intro 973A.

CPHS and many other community and union allies have worked with Council Member Corey Johnson's office on creating the opportunity for local New York city communities to play a bigger role in health planning, especially low-income, immigrants and communities of color, and other groups who have historically been excluded from the decision-making process and have been disproportionately and adversely impacted by those decisions (for example. the closing of hospitals).

"Community," "planning" and "policy development" are key words that have power. We understand the importance of that power in working toward addressing health inequities and promoting healthy communities. Improving the health and well-being of a community is no simple task. It takes long-term policy strategies for sustaining change in systems and environments. And it takes the necessary community and organizational infrastructure for carrying out those strategies. In short, there is a need for comprehensive health planning for identifying, developing, sustaining, and evaluating public health efforts, one that can help it manage internal and external challenges and create the mandate for real, meaningful, community engagement.

We emphasize that a successful and comprehensive health care system is the result of a formula that includes access, quality, services, fairness and community. If one element is missing, the formula fails. As advocates, we often have many criticisms of the way that the government is handling a particular situation. We shouldn't allow our dissatisfaction with specific approaches to overshadow the fact that the government is still a crucial player in fixing health care. It is therefore essential to consistently articulate a positive role for government, even as we point out the inherent failings. Some of those failings have been:

- The current system violates human and civil rights. This health care system and its priorities have led to the closing of facilities in medically underserved communities that are typically low income, immigrant and communities of color.
- Continuation of the irresponsible diminution of vital safety-net services for underserved low income and communities of color
- Direct decision-making power not being shared with communities.
- Lack of state Investment in true safety-net providers and fairness in the distribution of dollars (charity care) to safety-net providers like NYC Health and Hospitals.

- State so called "independent" commissions, which have not been representative of low-income, immigrants nor communities of color, have not prioritized community needs nor thoughtful health care planning (i.e. The Commission on Health Care Facilities in the 21st Century- a.k.a. Berger/Hospital Closing Commission in 2007). The structure and criteria of the Berger Commission exacerbated an already bad situation. The Commission was set up to consider the bottom line over human needs, and consequently its decisions endangered already underserved communities. At that time the public had little, if any, voice in its process. According to a study done by Opportunity Agenda, a partner of CPHS during the fights against the Berger Commission, only 19% of residents were aware of its work, while a full 77% believed that closings would be "a bad thing." The Commission's lack of respect for our state's most vulnerable populations and the attempt to stifle potential critics was troubling and still is with the newest Medicaid Waiver. However, advocacy and organizing efforts have always ensured that our voices were heard and some things could have been far worst if it had not been the case.
- State and Federal policies (DSRIP, MRT, payment reform, ACA insurance mechanisms, etc.) encouraging or mandating consolidation of health care into large systems
- Market oriented reimbursement schemes and competitive mechanisms that prioritize revenue enhancement and cost cutting, and decisions made by private corporate health care providers about health care being overseen by the State DOH and other regulatory bodies, have had little or no input from affected patients, communities, and front line providers of health care.
- The Affordable Care Act (ACA) added new requirements that mandate hospitals to conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy at least once every three years. Prior to the new ACA mandate on hospitals, conducting a CHNA was merely optional. CPHS has throughout the years documented and worked with community organizations to advocate for community input and engagement in past CHNAs, but we have seen very little improvement in hospitals' responsiveness to community participation.

Major parts of the healthcare industry are also to blame. Large segments of the healthcare industry are dominated by private, for-profit corporations and partnerships, practice groups, etc. that are primarily motivated by the desire to generate income and profit. Decisions regarding health care resource allocation and distribution and the way in which services are delivered in our communities are made by the CEOs and Boards of these powerful networks with little or no transparency, public input or involvement by affected communities.

The decision making process can no longer remain the exclusive prerogative of corporate executive and state bureaucrats. For that reason, the city has to step up and become a crucial player in helping to fix this inequity. The challenge that community health planning addresses is that of making the healthcare system more accountable to average residents in their communities. The policy rationale for this is that of bringing private interests in healthcare delivery into better alignment with public interests. Currently, the city may not be able to address all these inequities, have powers over private/voluntary hospitals and over hospital consolidations, mergers and closings. Intro 973 can provide opportunity for the city and communities to address the unbalanced power dynamics and critically contribute to the solution.

I would like to state we support provisions in the bill focused on developing community health assessments. If done right, the community health assessment assures that city agencies that focus on issues and people (i.e. housing, homelessness, food insecurity, environment, LGBTG, people with disabilities, seniors, and immigrants) could better coordinate, collaborate, and share information on how local resources are directed toward activities and interventions that address critical and timely public health needs.

There are many benefits for the City Council and the Mayor to be found by passing Intro 973 as part of the concept of smart community health planning, solidarity and good government. Some of these benefits are:

- Providing systematic and comprehensive assertion of-home rule in the design and delivery of care that meets local needs as identified by local communities.
- Assuming an active role in challenging wasteful and counterproductive competition between health care providers and big systems.
- Creating local planning bodies to serve as a counter-balance to the power of private health care providers/hospital systems and of the state DOH by asserting local needs and interests in the structure of the health care system and the delivery of services.
- Living up to the talks about a "tale of two cities". We need more representatives of community interests including a role to health care workers, community healthcare advocacy groups, and local populations. This only makes things better for greater transparency, representation and engagement for local populations in the governance and decision-making process around vital health services.
- Support for District Needs Statements developed annually by local community boards. Many times, the boards lack the additional support, knowledge, or resources necessary to develop a more comprehensive assessment of local health needs.

CPHS also would like to recommend:

- An Interagency Council on Comprehensive Community Health Planning will need to operationalize respect for the community so that the community becomes vested in the partnership in which responsibility for improving the health of the community is shared. It must become aware of their community's concerns, and demonstrate the willingness to be accountable to them in how they use resources. Respect is shown too by recognition of the validity of community judgments even when they differ from more rigorous professional judgments.
- An interagency Council on Comprehensive Community Health Planning must recognize and operationalize a set of imperatives involving the sharing of information, which is personally meaningful to each participant in each of the roles played by each stakeholder in the membership. Communities and community organizations are vital contributors to the resources and capacity of a public health system.
- Modifying the bill to include minimum staffing requirements of the bodies and a minimum funding mechanism similar to that utilized by the Independent Budget Office – a percentage of the city budget is automatically allocated to fund the IBO operations. This is highly critical for sustainment and commitment from the City.

Health is central to opportunity. Too frequently, inequalities and problems with our current system cause losses in time, money and ultimately, health which threaten our economic security. Our current Mayor and many New Yorkers agree that everyone deserves an equal chance in life. But the reality is that many don't have that opportunity. A community's right to self-determination is a basic human right that helps motivate for community health action. Without care, health is jeopardized. Without good health and access to health care, people can't support their families or contribute fully to our society. We need a health care system that works for everyone. Too many New Yorkers are left out or left with substandard care, and often the determining factor is income, race, immigration status, gender, mobility, or language proficiency. Because maintaining good health is central to opportunity, it is an insult to our basic values that an unfair system prevents entire communities from getting the care they need. The goal of all health care planning and policy, therefore, should be the creation of a system that works for all New Yorkers. And if, as evidence indicates, entire groups of people are being left out or left behind, remedying that situation should be one of our highest priorities.

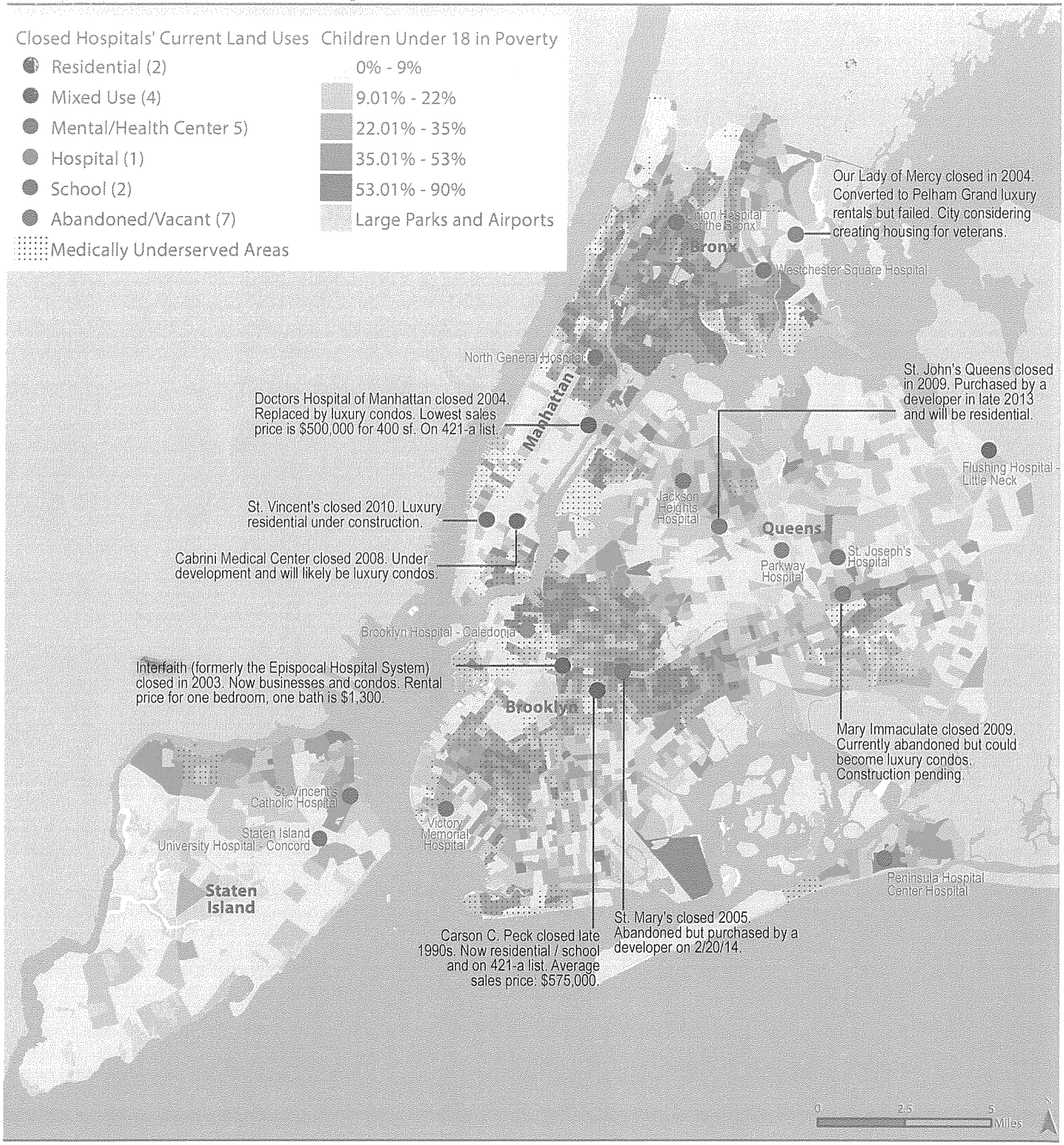
Thank you!

45 Clinton Street, New York, NY 10002 *

Work: 212-246-0803 * Cell: 646-325-5317 * afeliciano@cphsnyc.org www.cphsnyc.org

New York City Hospitals Closed 1995-2012 Converted or to be Converted to Market Rate Residential

PROTECT OUR HEALTH
SAVE OUR HOSPITALS



One closed hospital's address is unknown and could not be mapped.

Sources: NYC DCP, NYC DPR, NJDEP, NYS CSCIC, CPHS, 2007-2011 American Community Survey, 2008 Institutional Cost Reports (ICR), US Dept of Health and Human Services. 7/30/14.

cphs*
*Putting the public back in public health

SAVI
Spatial Analysis and Visualization Initiative

PROTECT OUR HEALTH
SAVE OUR HOSPITALS

cphs*
*putting the public back in public health

WE SUPPORT INTRO 973-A

PROTECT OUR HEALTH – SAVE OUR HOSPITALS is a grassroots campaign led by community based organizations, advocates, and unions calling to preserve hospital and health services for all New Yorkers, regardless of race, ethnicity, immigration status, language spoken, gender, sexual orientation, disability, neighborhood, diagnosis or ability to pay. The following undersigned organizations join us in this endeavor to support health care decision making powers returning into the hands of the communities where it belongs. We support the following:

1. Intro 973-A, to amend the New York City Charter, in relation to establishing an office of comprehensive community heath planning and an interagency coordinating council on health.

2. Public Hearings and other public opportunities to discuss the importance of passage of Intro 973-A and meaningful community engagement. These local bodies should be empowered to assess community health care needs, including working with stakeholders to establish criteria on:

    - Accountability and planning based on community health needs and conditions that impact people's well-being (i.e. housing, food access, environment, other social determinants of health), as formulated by the community and in conjunction with health care professionals.
    - Identify inequities in access and quality of care, and formulate plans to correct such deficiencies.
    - More transparency; representation and engagement; equitable governance and decision-making

3. Sustaining the coordination of the interagency coordinating council with funding and support by at least one paid staff person

In New York City, our healthcare system is in the midst of an ongoing crisis and reforms to its delivery of health care services (i.e. DSRIP). Against the backdrop of historical inequities in access to quality health care services – especially in low-income, immigrant and communities of color – we have seen:

1. New York City Hospitals close, merge and purchase physician practices at an alarming rate, on average two hospitals a year over the past ten years have closed. For the most part, private development has take over hospital property leaving communities without critical emergency room and other hospital services. In the past three years, at least 17 community hospitals in the New York City area have joined larger systems. The pace of acquisition is not sustainable. The consolidation trend has been justified by so-called 'reform' efforts to reduce waste and reward value instead of volume, but these monopolizing forces are contributing to a rise in costs and more importantly, impacting access and quality of health care.

2. New York City and New York State failed to replace critical life-saving services provided by these closed facilities creating health care disaster zones in low-income, immigrant communities and communities of color. There are already vast health care inequities leading to dangerous overcrowding of facilities in neighboring communities.

For more information or how to get involved, please contact Anthony Feliciano or Josh Starcher,
at ProtectOurHealthNow@gmail.com (c) 646-325-5317 or (w) 212-246-0803

Supporters of Intro 973-A

APICHA
Brooklyn Coalition for Health Equity for Women and Families
Commission on the Public's Health System
Doctor's Council-SEIU
DC 37-AFSCME
Fort Green SNAP
Health People Inc
Legislative Committee of the Bellevue Hospital CAB
Make the Road New York
Metro Health Care For All
New York Immigration Coalition
New York Lawyers for the Public Interest
New York State Nurses Association
People's Budget Coalition for Public Health
Rekindling Reform

Planned Parenthood®
Care. No matter what.

26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

Planned Parenthood of New York City

Planned Parenthood of New York City
Testimony on Int. 973 & Int. 974

Good morning. I am Julienne Verdi, Director of Government Relations at Planned Parenthood of New York City (PPNYC). I am pleased to be here today to provide testimony in support of Proposed Int. #973-A & Int. 974. Planned Parenthood of New York City thanks the Chair of the New York City Council Committee on Health, the Honorable Council Member Corey Johnson, for his leadership in convening this hearing. We'd also like to thank Speaker Melissa Mark-Viverito, the Committee on Health and the entire City Council for their dedication to issues of health equity, and we welcome the opportunity to discuss ways we can improve health care access for all New Yorkers.

As a sexual and reproductive health care provider, we see nearly 50,000 patients annually in our five health centers located in all five boroughs of New York City. PPNYC provides sexual and reproductive health services including birth control; emergency contraception; gynecological care (including cervical and breast cancer screenings); colposcopy; male reproductive health exams; testing, counseling, and treatment for sexually transmitted infections; the HPV vaccine; HIV testing and counseling; pregnancy testing, options counseling (including adoption) and abortion. As a trusted safety net provider in New York City we understand firsthand the structural inequities that affect a person's access to quality health care.

Proposed Intro. #973-A would amend the New York City Charter, in relation to establishing an office of comprehensive community heath planning and an interagency coordinating council on health. Currently, there is no agency or organization in New York City that provides a comprehensive overview of the community health services available. Further, there are no systematic efforts for widespread collaboration between different city agencies that impact and provide health services and not-for-profit and other community health care providers throughout the City. Community health planning has the potential to provide the data and analysis that can connect the needs of the community to the services that can be provided to them. PPNYC is in support of improving coordination between community providers and city agencies with the shared goal of reducing disparities, maximizing resources, and improving health outcomes. PPNYC is in favor of an agency that will be representative of community interests and give a role to health care workers, community based providers, community healthcare advocacy groups, and local populations in decision-making processes.

There are many factors leading to disparate health incomes in New York City, including but not limited to: race, ethnicity, immigration status, sexual orientation, geographic location, health insurance enrollment, housing and food insecurity and other socio-economic factors. As a safety net provider, PPNYC understands the socio-economic barriers that often impact a person's access to healthcare and work to address them through all aspects of care.

We are proud of the strides New York State has made in implementing the Affordable Care Act (ACA) surpassing its goal with over a million residents signed up. Since 2000, PPNYC has provided on-site public insurance enrollment assistance to all our clients who are in need. In response to the opportunities that the ACA provides, we have ensured that all of our entitlement staff are now Certified Application Counselors and offer one to one counseling and enrollment in both the public and private insurance programs on the NY State of Health portal. Over the years, we have assisted thousands of our clients in obtaining Medicaid coverage and are thrilled to now be able to offer the range of Qualified Health Plans to those eligible. Our Certified Application Counselors represent the recognition that to maximize access,

Planned Parenthood®
Care. No matter what.

26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

Planned Parenthood of New York City

there has to be easy, on-site insurance enrollment services provided together with health care services. We encourage that on-site enrollment services such as these be supported and promoted by the community health planning agency. In addition, PPNYC urges New York City to maintain support of safety net providers so that we can continue to provide care regardless of a patient's ability to pay.

Despite the gains from the ACA, many New Yorkers still remain ineligible for coverage. Ensuring care for all New Yorkers, without regard of immigration status is imperative from both a human rights and public health stance. PPNYC is proud of its work to provide culturally competent care to all, no matter what, regardless of immigration status or ability to pay. We look forward to working together to make New York City a national model for health care access for all people. At a moment where access to health care coverage is significantly expanding in New York, we appeal to the Council to prioritize the voices and needs of New Yorkers that too frequently have been left out of our health care system.

There are large parts of New York City with few, if any, health care providers and these communities experience widespread unmet healthcare needs. PPNYC is committed to ensuring that we are adequately addressing the health needs of all New Yorkers. We are keenly aware that health demographics and disparities often shift in our ever-changing city. As such, the health care facilities map as outlined in Proposed Intro. #974, could be an important tool in assessing health care needs by zip code so that city agencies and providers like PPNYC, can best tailor their outreach and other services to the unique needs of New Yorkers and reduce disparities.

We urge the City Council to pass Intro. #974 and further recommend the following additions to the proposed interactive map to more fully address the range of health care issues affecting New Yorkers. Firstly, the bill requires that the interactive map display the location of every voluntary non-profit and publically sponsored diagnostic and treatment center "that provides primary health care services." Sexual and reproductive health services are part of basic, preventive care and therefore, should be included in the map. It is essential that these services sit side by side with all other aspects of primary care and also be adequately included and represented in the community health care planning agency. Many of PPNYC's patients enter the health care system, for the first time, through our services and a significant percentage of them only utilize sexual and reproductive health care as their primary source of care.

PPNYC further recommends that HIV prevalence (people living with HIV/AIDS) and sexually transmitted disease (specifically Syphilis, Hepatitis C, Gonorrhea and Chlamydia) rates for geographic regions smaller than a borough be provided for targeted disease prevention and health promotion. These and other diseases are associated with demographic co-factors such as age, education, incomes and other characteristics that are now listed in Intro. 974. We also recommend that the map provide percent of the population with less than a high school education as this is also associated with poor health literacy, service utilization, and outcomes. Finally, we recommend that age-adjusted rates for pregnancy outcomes (births, spontaneous and induced terminations) for regions smaller than a borough be provided because these are associated with maternal and infant health outcomes, and are critical to best determine health promotion efforts, the need for health services, and risks for sexually transmitted diseases. HIV prevalence, sexually transmitted disease rates and age-adjusted rates for pregnancy outcomes should be aggregated in a way to protect confidentiality.

Planned Parenthood of New York City applauds the City Council's commitment to increasing access to health and urges the Council to pass Proposed Intro. No 973-A and 974. We further urge that any community health planning agency and mapping recognizes sexual and reproductive health care services

Planned Parenthood®
Care. No matter what.

26 Bleecker Street
New York, NY 10012
p: 212.274.7200 · f: 212.274.7276
www.ppnyc.org

Planned Parenthood of New York City

as basic, preventive care, and places them side by side with all other aspects of primary care. We look forward to working closely with the City during potential implementation. Thank you for the opportunity to testify on this important issue and I would be happy to take any questions or provide additional information.

###

Since 1916, Planned Parenthood of New York City (PPNYC) has been an advocate for and provider of reproductive health services and education for New Yorkers. Through a threefold mission of clinical services, education, and advocacy, PPNYC is bringing better health and more fulfilling lives to each new generation of New Yorkers. As a voice for sexual and reproductive health equity, PPNYC supports legislation and policies to ensure that all New Yorkers—and, in fact, people around the world—will have access to the full range of reproductive health care services and information.

FOR THE RECORD

LEGISLATIVE MEMO:

WE SUPPORT

DC 37

December 8, 2015

DC 37 represents 18,000 members in the NYC Health and Hospitals, 5,000 members in the NYC Department of Health, and thousands more in the social service agencies including Human Resources Administration, Department of Homeless Services and Administration for Children's Services. All of these agencies would benefit from the interagency coordination called for in the bill.

Coordination and health planning would allow the city to better leverage the resources of employees who provide direct or indirect health care services. Health planning would allow the clients and patients to be served more effectively, and would improve health outcomes. Ultimately this will create savings for the City of New York which can be reinvested.

District Council 37 supports Intro 973 A.

Political Action and Legislation Department
Wanda Williams
Director

Albany Address:
150 State Street, 5th floor
Albany, NY 12207-1682
Tel: (518) 436-0665
Fax: (518) 436-1066

FOR THE RECORD

CALLEN LORDE
COMMUNITY HEALTH CENTER

Wednesday December 9th, 2015

Int. 973-A – Creating the Office of Comprehensive Community Health Planning (OCCHP)

Int. 974 – Creating a Health Facilities Map

Written Testimony on behalf of Callen-Lorde Community Health Center

---

Chairman Johnson and Members of the NYC Council Health Committee:

Callen-Lorde Community Health Center provides sensitive, quality health care and related services targeted to New York's LGBT communities regardless of ability to pay. Our grassroots heritage dates back over 40 years, and today we operate two health centers in Chelsea, one on West 18th Street and one on West 17th Street, and are building a new facility in partnership with BOOM!Health in the Bronx. Callen-Lorde provides a wide range of services to the community, including STI and HIV/AIDS prevention and treatment, care for the uninsured, dental care, women's health services, transgender health services, an on-site pharmacy and mental health services. In 2014, Callen-Lorde provided care to over 15,000 patients from all five boroughs and diverse backgrounds. Approximately 21% of our patients are transgender or are of gender non-conforming experience, 28% of our patients are uninsured, and 25% receive Medicaid benefits.

As a healthcare organization that serves residents of all five boroughs, representing a wide range of demographics, Callen-Lorde and its staff are aware of the difficulties in finding affordable, competent, and consistent healthcare. Callen-Lorde also recognizes that the diverse and disaggregated health care system in New York City can often be confusing for patients. This is especially true for disadvantaged populations and those who require special care and attention. Despite our best efforts, many New Yorkers who need care the most often slip through the cracks of our current system.

In recognition of these issues, Callen-Lorde enthusiastically supports Int. 0973-A and Int. 974 for the creation of an Office of Comprehensive Community Health Planning (OCCHP), an Interagency Coordinating Council on Health (ICCH), and an official NYC Healthcare Facilities Map.

Regarding Int. 973-A, the interagency coordination of NYC's healthcare system that could be implemented by OCCHP and ICCH would be a huge step forward to strengthen the healthcare services provided in this city. Increased coordination

and support for community health centers like Callen-Lorde will strengthen the safety net already in place for vulnerable populations.

OCCHP would recognize and identify the dire needs of NYC's uninsured, LGBT, HIV-positive and homeless populations, among many others, who require consistent and culturally sensitive care, despite location or type of care provider. Healthcare providers specializing in care for those with little or no insurance coverage are few and far between. The OCCHP would seek to identify existing providers and make their whereabouts easier for the public to understand, while also aiming to fill gaps in communities that lack care through future planning. Additionally, as many lower income residents may be enrolled in other public benefit programs, this bill would improve the process for city agencies to coordinate care and services for recipients.

The bill also requires the OCCHP to create and update a comprehensive health care services plan and a health system assessment. These two reports will prove extremely valuable in continuing to fine-tune the city's health care system and will aid community health providers like Callen-Lorde in achieving our mission of identifying and serving those New Yorkers most in need.

Regarding Int. 974, a Healthcare Facilities Map would be a vital resource for New Yorkers, tourists and visitors seeking hospital services and different healthcare options. As a FQHC, Callen-Lorde strongly endorses a universal and easy to use portal for those seeking a variety of healthcare services throughout the city.

For those unfamiliar with the health care system and the options available, finding a health care provider can be a daunting experience. Even for people who have taken advantage of the facilities available, it can be difficult to choose a new provider in a new neighborhood or for a different type of service. Not only will this map make it easier for patients to access the system, but it will also allow the community and policy-makers to better assess the needs of the community and where improvements need to be made.

Callen-Lorde thanks the Health Committee for reviewing Int. 973-A and Int. 974 and endorses their passage.

Sincerely,

Wendy Stark
Executive Director

DOCTORS DC COUNCIL
a national affiliate of SEIU

A United Voice for Doctors, Our Patients, & the Communities We Serve

National Office
50 Broadway
11th Floor Suite 1101
New York, NY 10004
P: 212.532.7690
F: 212.481.4137
info@doctorscouncil.org
www.doctorscouncil.org

Testimony of Matthews Hurley, M.D.,
First Vice-President of Doctors Council SEIU
Before the New York City Council Health Committee

December 9, 2015

Good Afternoon Chairman Johnson and members of the Health Committee. My name is Dr. Matthews Hurley and I am First Vice President of Doctors Council SEIU which represents thousands of doctors in the Metropolitan area, including in every NYC Health + Hospitals facility, the New York City Department of Health and Mental Hygiene, correctional facilities including Rikers Island, and other New York City agencies. Thank you for the opportunity to testify today.

Doctors Council SEIU is here today in support of Intro 973a related to establishing an office of comprehensive community health planning

Since Doctors Council was founded, we have always emphasized that we are strongest when we stand with and for our patients and are working to meet the broad range of needs that impact their health. The delivery of quality care to New Yorkers, especially in underserved communities, requires the input and meaningful engagement of the best experts and resources that we have—the patients and their families, as well as the doctors and other health care delivery team members who are on the front lines.

Communities across New York City are experiencing a rapidly shifting medical landscape – for example recent hospital closures and consolidations. Moreover, the complexity and rapid pace of DSRIP implementation poses challenges to providers, advocates and government officials.

The involvement of the community, local stakeholders and medical providers provides transparency in what can sometimes be a daunting system and can go a long way to increasing healthcare access.

We believe that comprehensive community health planning that looks at everything from coordination of services to cultural competencies to funding – and more - can help remove barriers to or disparities in health care, especially in low-income, medically underserved, immigrant and communities of color.

Front line medical workers are eager to be part of the community health planning process. Doctors Council SEIU has made great strides in front line medical worker engagement in the NYC Health + Hospitals system and we hope to continue that trend. We are pleased to see that Intro 973 includes attending physicians and dentists. In including us, we can enable the knowledge and experience of thousands of clinicians in problem-solving efforts to improve the clinical quality, safety, patient experience, and efficiency for the people of our communities.

In fact, a White Paper produced by Doctors Council in 2014 entitled "Putting Patients First Through Doctor, Patient and Community Engagement" echoes these very sentiments.

An office of comprehensive community health planning is a significant undertaking. We hope that the creation of the office will be backed by the financial resources necessary to ensure its success and sustainability.

Thank you for the opportunity to testify in support of Intro 973a. I would be happy to answer any questions.

HEALTH PEOPLE
Community Preventive Health Institute
552 Southern Boulevard ♥ Bronx, New York 10455 ♥ Phone: 718/585.8585 Fax: 718/585.5041 ♥ www.healthpeople.org
Chris Norwood, Executive Director

Disparities, Challenges and Reform in NYC

Comments on Comprehensive Community Planning Bill 973A

I would like to compliment Council Member Corey Johnson office and the City Council for a very thoughtful much needed bill and the serious effort to tailor this bill around the community needs.

Health care services and resources are unevenly and unequally distributed, with excess and unneeded services available in more affluent communities and inadequate or non-existing services in poorer communities. During the last administration, Community based organizations, especially in the "other Boroughs" experienced drastic funding cuts in many program services they provided to the community. One of the worst examples is AIDS: the last administration took so much federal AIDS support money, commonly known as Ryan White funding, out of the Bronx and Brooklyn and reallocated this funding to Manhattan, which ended up with almost 60% of this funding even though the majority of HIV/AIDS cases are now in the Bronx and Brooklyn. Sixty (60) programs in the Bronx and Brooklyn were forced to close. The Bronx was left without food pantries, without nutritional services, and without one of the family support programs that were designed to give the extra support to parents who were usually single mothers. But Manhattan got five (5) family support programs for parents with AIDS! Every effort to speak with the last Administration—and even protest—was put forth in order to convince them to put the funding back. These efforts failed to change this terrible situation—which is a clear example of why we need Comprehensive Health Planning.

Meanwhile, we see populations from the re-entry to those in drug treatment concentrated in the same neighborhoods over and over again—yet without a fair share of resources to stabilize and help these populations. This can only be possible if it is well coordinated and funded.

- Modify bill to include minimum staffing of the bodies
- Modify bill to create a minimum funding mechanism similar to that utilized by the Independent Budget Office – a percentage of city budget is automatically allocated to fund the IBO operations

GMHC

FIGHT AIDS. LOVE LIFE.

NEW YORK CITY COUNCIL COMMITTEE ON HEALTH

Contact: Michael Czaczkes,
michaelc@gmhc.org / 212-367-1185

Good morning, my name is Michael Czaczkes and I am the Director of Policy and Public Affairs at the Gay Men's Health Crisis (GMHC). Founded in 1982, GMHC is the world's first AIDS service organization. In 2014, we served 9,336 clients across New York City, distributed more than 80,000 hot meals in our dining hall, and tested more than 2,600 individuals.

Today, I will be testifying in support of Intro 973-2015, sponsored by Council Member Corey Johnson, which would create an office of Comprehensive Community Health Planning.

First, this office would develop and coordinate access to culturally competent health care. The need for acceptance and cultural capacity in HIV care is critical. Walk through the door of a Ryan White provider clinic and you will find a cross-section of communities hardest hit by HIV and AIDS, which includes people of color, substance users, and transgender women. Entering HIV care often marks the first time an individual has ever had a primary care physician. Providers who understand how to work with underserved populations are essential to ensuring positive health outcomes.

Second, support for initiatives to expand and enhance primary care is vital for those living with HIV. HIV specialists need to provide the full spectrum of primary care to patients and primary care physicians need a better grasp of the impact HIV care has on routine healthcare. Patients whose HIV is under control might feel they don't need to see a doctor regularly, but adherence is about more than just taking antiretroviral treatments regularly; it's also about receiving regular primary care to help ensure patients with HIV infection live long and healthy lives.

Third, integrating planning efforts from the federal, state and local agencies will support implementation of the White House HIV and AIDS Strategy; the Governor's Ending the Epidemic Blueprint; and the work the Mayor, Speaker and City Council are all doing to end the epidemic. Ending HIV and AIDS will require a new level of coordination and collaboration at all levels to government to ensure that resources are allocated in the most efficient manner possible to address a full range of prevention, care, and social service needs

Finally, better coordination of health service delivery for those living with HIV and AIDS will provide an expanded form of medical case management. In turn, this will ensure linkage to care in a timely manner. At GMHC's David Geffen Center for HIV Prevention and Health Education, we test approximately 2,600 people every year. Clients who test positive for HIV are immediately linked to care by a GMHC staff member, who walks them to Mt. Sinai Hospital's Comprehensive Health Program-Downtown. The client is then assigned a GMHC staffer to ensure sustained linkage to effective care. This is how we're able to achieve the 90% viral suppression rate for clients who test positive at GMHC, over twice the viral suppression rate statewide, and over 3.5 times the viral suppression rate nationwide.

Testimony of Amr Moursi
Chairman, Department of Pediatric Dentistry, New York University College of Dentistry
before
New York City Council Committee on Health

December 9, 2015

Good afternoon Chairman Johnson and members of the City Council Committee on Health. I am Amr Moursi, the Chairman of the Department of Pediatric Dentistry at the New York University (NYU) College of Dentistry. I appreciate the opportunity to testify before you today as you consider legislation to improve coordination of health care providers throughout New York City.

The NYU College of Dentistry provides dental care and education to thousands of New Yorkers regardless of their ability to pay. As the number of qualified dentists who accept Medicaid shrinks, NYU provides a crucial service to low-income families and children seeking critical dental care. We are able to provide this care through two popular programs in New York City.

The first is the Smiling Faces, Going Places Mobile Dental Van that has provided oral health care and dental education to over 2,000 children annually through visits to daycares, public schools, and health fairs throughout all five boroughs over the past 15 years. The mobile dental van addresses the lack of quality dental care for low-income children in New York City, providing necessary preventative care such as fluoride treatments and sealants as well as restorative care such as fillings. We thank the City Council for continuing to support the van program and partnering with NYU to ensure crucial dental services are provided to underserved children.

Another way we provide dental services to New Yorkers is through our dental clinics, including our pediatric dental clinic. Located on 1st Avenue, the clinics saw over 300,000 patients visits in 2014, including nearly 10,000 children from all five boroughs. With dental decay being the most common chronic diseases in children, more common than asthma, it is critical to increase both access and utilization of care.

The NYU College of Dentistry supports the legislation being discussed in today's hearing. However, we feel that the legislation would be strengthened by the inclusion of dental services, as they are a vital part of an individual's overall health. Research shows that, for example, children with poor oral health have poor nutrition, poor sleep and perform poorly in school. Adults with poor oral health have a higher risk of diabetes, heart disease and complicated pregnancies.

Due to the important role dental health plays in overall health, it is to the City's benefit to include dental services in the scope of health care needs examined by the proposed Office of Comprehensive Community Health Planning for inclusion in the proposed Comprehensive Health Care Services Plan and Health Care Assessment Report. Furthermore, it is appropriate for a representative from a dental services provider to serve as a member of the proposed Interagency Coordinating Council on Health. Finally, dental service providers should be consulted by the proposed Interagency Coordinating Council on Health to ensure the current availability of dental services for all NYC residents is accurately captured and addressed pursuant to the objectives of the proposed legislation.

In addition, including dental services in the City Council's proposed interactive New York City map of health services would allow New Yorkers to easily identify where they can address their oral health needs. Listing city-contracted dental services, such as the ones NYU provides through our clinics and van program, will increase awareness of access to dental services and eliminate one more barrier to equal access of healthcare across the city.

We hope that any legislation being discussed here today take into consideration the services and expertise that the NYU College of Dentistry, and other dental provider across the city, can provide to the people of New York City.

Thank you again for the opportunity to testify.

GREATER NEW YORK HOSPITAL ASSOCIATION
555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

December
Eight
2 0 1 5

Council Member Corey Johnson
Chair, Committee on Health
250 Broadway
Suite 1804
New York, NY 10007

Dear Council Member Johnson:

Greater New York Hospital Association (GNYHA) represents more than 135 member hospitals and health systems, both public and not-for-profit, in New York State, the majority of which are in New York City. On behalf of our members, I am writing to oppose Intro. 973-A, which would create two City health planning entities: the Office of Comprehensive Community Health Planning (OCCHP) and the Interagency Coordinating Council on Health (ICCH).

The proposed legislation would encroach on New York State (NYS) jurisdiction and authority; the bill would impose a local health planning process that is duplicative of existing State health planning and health care reform processes and activities. Furthermore, New York State already has the Public Health and Health Planning Council (PHHPC) that is responsible for health planning throughout the State, including a Certificate of Need process for changes in hospital services.

The State processes currently underway include enacting the Medicaid Redesign Team (MRT) reform recommendations; establishing value-based purchasing in NYS, which is designed to improve quality in the Medicaid program; implementing the State Health Improvement Plan, which is designed to advance primary care and coordinated care throughout the State, including in NYC; and operating Public Health Improvement Plan (PHIP) regional entities created throughout the State—and operated by the NYC Department of Health and Mental Hygiene here in the City—designed to support population health improvement and enhance primary care.

Each of these initiatives have various committees and workgroups comprising various stakeholders who are dedicated to obtaining input and discussing health care reform and redesign issues. All of these committees include many of the same organizations contemplated to be part of the ICCH that would be established by the proposed legislation. In total, there are more than 20 multi-stakeholder committees and work groups associated with these initiatives that are dedicated to discussing aspects of health care reform and health system redesign. Examples of some of the committees and workgroups that have been convened over the last two years include:

- Workforce Flexibility and Change of Scope of Practice Work Group

- Social Determinants of Health and Community-Based Organizations Committee
- Advocacy and Patient Engagement
- Clinical Advisory Group
- Regulatory Impact Group
- Integrated Care Work Group
- Workforce Work Group
- Transparency, Evaluation, and Health Information Technology Workgroup
- Behavioral Health Work Group
- State Health Innovation Plan Council
- Supportive Housing Work Group
- Basic Benefit Review Work Group
- Behavioral Health Reform Work Group
- Health Disparities Work Group
- Health Systems Redesign: Brooklyn Work Group
- Managed Long Term Care Implementation and Waiver Redesign Work Group
- Medical Malpractice Reform Work Group
- Payment Reform and Quality Measurement Work Group
- Program Streamlining and State/Local Responsibilities Work Group
- Social Determinants of Health Work Group

Clearly, creating a new health planning structure for the City would be duplicative of all of these efforts. GNYHA members are already highly regulated by the State and Federal governments, including on all of the issues that would be discussed under the proposed legislation. In addition, establishing a health planning process that does not include the State agencies with jurisdiction on these issues would be counterproductive, confusing, and time-consuming. City resources would be better utilized by continuing to engage in these existing health reform processes and discussions, rather than trying to duplicate these very same ongoing and dynamic discussions with the same participants.

For these reasons GNYHA, on behalf of its members, opposes City Council Intro. 973-A.

Sincerely,

Kenneth E. Raske
President
GNYHA

cc: Speaker Melissa Mark-Viverito
Members of the Committee on Health

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973A-974 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Carmen Santana

Address: 872 Woodward Ave

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Amr Moursi

Address: 345 E. 24th St. NY NY 10010

I represent: NYU College of Dentistry

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973A Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Latisha Gibbs

Address: 552 Southern Blvd

I represent: Health People / People Budget Coalition

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anne Goldman

Address: 399 Main St

I represent: UFT

Address: 50 Bdway NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Michael Czaczkes

Address: 500 4th Ave 3H 11215

I represent: GMHC

Address: 446 W 33rd St 10001

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973 + 974 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Julienne Vercli

Address: 7A Franklin Ln SI NY 10306

I represent: Planned Parenthood of NYC

Address: 26 Bleecker Street NY NY 10012

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 974 Res. No. _____

☑ in favor ☐ in opposition

Date: 12/9/15

(PLEASE PRINT)

Name: Oxiris Barbot

Address: 4209 28th Street LIC

I represent: NYC DOHMH

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973A Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Dr. Matthews Hurley

Address: _____

I represent: Doctors Council SEIU

Address: 50 BWAY, 11th Fl NY, NY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 873 Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Leonard Kodpera

Address: 310 W 86th St

I represent: Self

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973-4 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Robert FAPLUG

Address: 151 W 74 #2C

I represent: Rekindling Reform

Address: 155 W 72nd 10023

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: FAY MUIR

Address: 286 RESERVOIR PLACE

I represent: BRONX NY 10467

Address: NW BRONX COMMUNITY & CLERGY

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0973 Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Debra Lesane

Address: 3512 Church Avenue Bklyn

I represent: Caribbean Womens Health Assoc

Address: 3512 Church Ave Bklyn

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973 Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anthony Feliciano

Address: CPHS

I represent: CPHS

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973-A Res. No. _____

☒ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Anthony Feliciano

Address: 841 BWAY

I represent: CPHS

Address: 841 BWA

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973 Res. No. _____

☐ in favor ☒ in opposition

Date: _____

(PLEASE PRINT)

Name: Deborah Leuwers

Address: City Hall

I represent: Mayor

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: J Wessler

Address: 84 Charles St

I represent: —

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973+974 Res. No. _____

☒ in favor ☐ in opposition

Date: 12-9-15

(PLEASE PRINT)

Name: NYU DENTAL SCHOOL

Address: 25 WEST 4TH ST, NY, NY

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 973A & 974 Res. No. _____

☒ in favor ☐ in opposition

Date: 12/9/15

(PLEASE PRINT)

Name: Leon Bell

Address: 131 W. 33rd St. NY NY

I represent: New York State Nurses Assoc.

Address: Same

Please complete this card and return to the Sergeant-at-Arms