CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HEALTH

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March 23, 2015
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HELD AT: Committee Room - City Hall

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

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Rosie Mendez
Mathieu Eugene
Peter A. Koo
James G. Van Bramer
Inez D. Barron
Robert E. Cornegy, Jr.
Rafael L. Espinal, Jr.

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

Dr. Barbara Sampson
Chief Medical Examiner
Office of the Chief Medical Examiner

Dina Maniotis
Executive Deputy Commissioner
Administration
Office of the Chief Medical Examiner

Florence Hutner
General Counsel
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Frank De Paolo
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NYC Department of Health and Mental Hygiene

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Assistant Director, DC37
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Anne Bovay [sp?]
New York State Nurses Association

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First Vice President
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Alana Leviton
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Citizen's Committee for Children

Courtney Bryan
Director of Criminal Justice Operations
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Community Healthcare Association of New York State
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Jennifer Cuervo [sp?]
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Deborah Pollock
Director of Social Services
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Alex Leone
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Jacqueline Reinhard
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Kent Mark
Community Advisory Board
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Community Healthcare Activist/Advocate

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Christopher Bramson
Assistant Director
Crime Victims Treatment Center
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Irene Ninonuevo
Child Sexual Abuse Treatment &Prevention Program
Kingsbridge Heights Community Center

Noilyn Abesamis-Mendoza
Health Policy Director
Coalition for Asian-American Children and Families

Claudia Calhoun

Nora Chavez
Community Health Advocates
Community Service Society

SERGEANT-A-ARMS: Quiet, please.

[gavel]

CHAIRPERSON JOHNSON: Good morning, everyone. I am Council Member Corey Johnson, Chair of the Council's Committee on Health. The topic of today's hearing is the Mayor's Fiscal 2016 Preliminary Budget for the Office of the Chief Medical Examiner, the Department of Health and Mental Hygiene, and the Health and Hospital Corporation. This morning we will first hear from the Office of the Chief Medical Examiner on the Mayor's Fiscal 2016 Preliminary Budget. Before we begin, I'd like to note that we are going to be joined, hopefully sometime soon, by my colleagues on the Health Committee, and when they arrive, I will announce them.

The OCME's Proposed Expense Budget for Fiscal Year 2016 is $64 million, which is an increase of approximately $4.4 million for the Office's Proposed Budget of $59.6 million at the Fiscal 2015 adoption. The Committee would like to discuss the office's new proposed spending of $2.5 million, which includes new positions for around-the-clock coverage at all morgues, and funding for maintenance and

2 support services. Given OCME's body handing
3 incidents, which includes lost bodies, mistaken
4 cremations, and bodies mistakenly sent to a medical
5 school for student dissection, the Committee would
6 like--would like to hear about the corrective actions
7 OCME has put in place to prevent these avoidable
8 mistakes. And, have a third dialogue about the
9 finances needed to ensure that no other family
10 endures the mishandling of their loved one's remains.
11 In addition, the Committee looks forward to
12 discussion OCME's New Business Improvement Project
13 funded at $1.7 million, with asset forfeiture funds
14 that are covered by the Manhattan District Attorney's
15 Office. This project, which spans from Fiscal Year
16 2015 to Fiscal Year 2017 includes funding for
17 consulting, continuing education, and upgrades at
18 OCME. The Committee would like to know the intended
19 goals of this project, as well as the progress and
20 the timeline of the components of the project.
21 Finally, the Mayor would like--the
22 Committee would like to engage OCME in a conversation
23 on the Preliminary Mayor's Management Report,
24 including, but not limited to, increased Fiscal Year
25 2015 actual median times to complete autopsy reports,

2 toxicology sexual assault cases, and cremation
3 requests. Before It urn it over to OCME, I would
4 like to just acknowledge the incredible behind-the-
5 scenes work that you did in preparing for the Ebola
6 crisis that the city handled last fall. Thank God
7 the city did not have an Ebola related fatality. For
8 anyone who understands the nature of the disease and
9 how it spreads, you can imagine that the frontline
10 workers at the Medical Examiner's Office would be
11 directly exposed potentially to this deadly disease
12 at points at which it would most likely spread.
13 Thank you to Dr. Sampson and her fabulous team, we
14 were ready and ensuring that every link in the City's
15 disaster response chain was capable of handling a
16 potential outbreak with the utmost care. Hopefully,
17 this knowledge and capacity won't ever have to be
18 used, but we are grateful to know that you and your
19 of professionals are ready.
20 I also want to thank Crilhien Francisco,
21 the Finance Analyst for the Health Committee; Health
22 Committee Counsel Dan Hafetz; and the Policy Analyst
23 for the Health Committee Crystal Pond for their hard
24 work in preparing for today's hearing. And just a
25 reminder that public testimony begins today at 2:30

2 p.m., and if you wish to testify, you must sign up
3 with the Sergeant-at-Arms in the back of the room. I
4 will now turn it over to Dr. Barbara Sampson, Chief
5 Medical Examiner for the City of New York. And
6 before you begin, Dr. Sampson, I would just like to
7 swear you and your team in. If you could please
8 raise your right hand. Do you affirm to tell the
9 truth, the whole truth, and nothing but the truth in
10 your testimony before this committee, and to respond
11 honestly to all council member questions?
12 DR. BARBARA SAMPSON: I do.
13 CHAIRPERSON JOHNSON: Thank you very
14 much. You may begin.
15 DR. BARBARA SAMPSON: Good morning,
16 Chairman Johnson. Thank you for the opportunity to
17 testify. [coughs] I am Dr. Barbara Sampson and I am
18 proud to be sitting before you today as the appointed
19 Chief Medical Examiner of the City of New York. I
20 have a clear mandate from the Administration to lead
21 the Medical Examiner's Office to protect the public
22 health and service criminal justice through forensic
23 science. My personal commitment this city is to
24 build our Medical Examiner's Office into the model
25 for what the National Academy of Sciences defines as

the ideal forensic institution: Independent, unbiased, immune from undue influence, and as accurate as humanly possible. Seated with me are Dina Maniotis, the Executive Deputy Commissioner for Administration; Florence Hutner the General Counsel; and Frank DePaolo, the Assistant Commissioner of Forensic Operations. On behalf of the Office of Chief Medical Examiner, I would like to express my deepest condolences to the Sassoon Family and the community over the loss of their seven young lives. As they do every day, my staff supported an outstanding forensic investigation while meeting the needs of the family in a compassionate and timely manner.

My entire OCME team and I want to recognize the support of our Deputy Mayor Dr. Lilliam Barrios-Paoli and OMB for the fair and considered funding of our most urgent needs. I'm here today to discuss the Fiscal Year 2016 Preliminary Budget for the Office of the Chief Medical Examiner. But first, I would like to update you on key agency initiatives and progress. As you know, OCME's Department of Forensic Biology serves as the forensic DNA laboratory for the City of New York. The OCME houses

2 North America's largest public and most advanced
3 forensic DNA laboratory, and is a leader in DNA
4 technology and research. We are continuing to work
5 on the unidentified remains from the 9/11 attack on
6 the World Trade Center. In 2014, we identified three
7 previously unknown individuals, and in 2015 we have
8 already identified one. We have also re-associated
9 many remains to previously identified victims. The
10 Department for Forensic Biology is in its second near
11 of transformation using business improvement tools.
12 To date, the laboratory has been redesigned from a
13 system where three essentially self-contained silos
14 existed to one where everyone participates in six-
15 person work teams to examine 40 criminal cases in a
16 strict 10-day process. Casework is now flowing
17 efficiently through the laboratory.
18 Our success has been possible due to last
19 year's funding package that augmented the Lean Six
20 Sigma Business Improvement Plan. We were funded to
21 hire 16 new criminalists, and since July 1, 2014, the
22 Department has hired these 16 new employees, and also
23 promoted 54 more employees into more senior
24 criminalists titles. This is a rigorous process.
25 Every new hire and every promotion requires an

intensive three-month training program. The Department for Forensic Biology received 8,746 cases in 2014. Of that total, 1,940 were very violent felonies. Including assaults, sexual assault and homicides. Currently, the laboratory has no backlog in homicides and sexual assault cases. In other words, within days of receipt, the lab scientists start those cases and a case report is sent to the NYPD and the appropriate district attorneys offices within two to three weeks.

While it is common knowledge that DNA can be used to identify individuals, there are occasions when DNA is not an option due to national--natural or intentional degradation. Currently, individual identification in these cases is not possible. Proteins, however, also carry unique identifying genetic markers able to distinguish individuals. In addition, proteins are more stable and more abundant than DNA. Consequently, skeletal remains that have been buried for extended periods of time or mixed with chemicals or burned still possess genetic markers that can tell us who a person was, bringing closure to families and aiding the aiding the Criminal Justice System.

2 OCME is developing a fast, sensitive, and
3 inexpensive test capable of identifying individuals
4 based on protein. Because differences in proteins
5 can also distinguish species, this test is valuable
6 for rapidly identifying fragmentary human remains
7 following a mass disaster. It has also been used to
8 distinguish human from non-human cremated remains.
9 This research is funded by a competitive grant we
10 received from the National Institute of Justice.
11 As I said at the start of my testimony,
12 OCME aspire to be as accurate as humanly possible.
13 The office I lead is committed to 100% accuracy, 100%
14 of the time. At my direction last May, OCME
15 conducted an in-depth analysis of the mortuary unit's
16 operations that resulted in a number of recommended
17 emergency corrective actions. In response, I
18 immediately directed my team to implement all
19 measures necessary to gain control of operations, and
20 ensure rigorous quality control of OCME Medicolegal
21 and Mortuary Operations. I also made the difficult
22 decision to assign the agency's highly trained
23 doctors, the Medical Examiners, to a time-out
24 procedure that ensures quality control over the
25 release of decedents. These emergency measures

2 strained my agency and its personnel, and were simply
3 not sustainable. With a new needs package, I
4 proposed what needed to be done immediately to ensure
5 that we sustain improvements because even one
6 inaccuracy has the potential to harm families and
7 shake the faith and confidence of the entire
8 community we serve. As a result of my New Needs
9 Request, the OCME was funded in November to hire a
10 cadre of nine forensic quality specialist and one
11 supervisor to lead them. By January 19, 2015, this
12 cadre of specialists was hired, trained, and
13 successfully deployed throughout the agents--agency's
14 Mortuary Operations. Their primary role is quality
15 control in the mortuary. Additionally, to gain
16 control of operations, I directed my team to
17 establish and OCME Operations Center. Here, the
18 agency Tour Commander, the Administrator on duty and
19 the Communication and Transportation staff are all
20 co-located in the same work space under on
21 organizational structure to respond to day-to-day
22 forensic operations that manage information, manage
23 resources, and immediately respond and solve medical,
24 legal and mortuary problems.
25

2 We eliminated silos by implementing a
3 unit of effort, a unity of command to coordinate OCME
4 operations citywide 24/7. To make this staffing
5 model possible, OCME received funding for eight
6 additional Medicolegal Investigators, two
7 administrators on duty, and two communication staff
8 in the FY16 Preliminary Budget. We also received
9 funding to cover gaps in our Lab Information
10 Management System and Security Contracts as well as
11 baselined funding for a vehicle replacement schedule;
12 additional T3 lines necessary for security cameras;
13 and data backup; heavy duty cleaning; and a
14 replacement cycle for gurneys as they fall into a
15 state of disrepair requiring disposal and
16 replacement.
17 OCME's Proposed Fiscal Year 2016 Non-
18 Grant Expense Budget is projected at $48.6 million
19 for personnel, and $15.5 million for other than
20 personnel services. In summary, OCME will use these
21 expense funds to further improve the effectiveness of
22 critical operations. We embrace excellence, and
23 promote a higher performing culture in all the OCME
24 divisions to ultimately ensure 100% accuracy 100% of
25 the time. In doing so, we will be working to

2 implement our shared vision with the Administration
3 for responsible fiscal management, and the
4 progressive values necessary to move New York City
5 forward, and to continue to make OCME strong. I'm
6 happy to answer your questions.
7 CHAIRPERSON JOHNSON: Thank you, Dr.
8 Sampson for your testimony and for being here today.
9 I want to just hop right into the questions. So the
10 Fiscal 2016 Preliminary Plan proposes and increased
11 spending of $602,000 for OCME to provide around-the-
12 clock coverage at all morgues. You mentioned in your
13 testimony the 16, I believe, new criminalists that
14 were hired. This past year, OCME was found to have
15 misplaced and lost several corpses. This funding
16 that I talked about, $602,000 will cover ten
17 criminalists positions that will work to ensure that
18 there is coverage during every removal and arrival of
19 a decedent at an OCME morgue. Can you please explain
20 what contributed to the misplacement and the body
21 handling incidents that warranted this funding?
22 DR. BARBARA SAMPSON: Last summer, we
23 identified a number of deficiencies in our mortuary.
24 There was a lack of quality control, meaning that
25 when a human error occurred, we did not have adequate

quality control in place to catch it. There was a failure to adhere to protocols, and we had non-uniform protocols in the five boroughs. We had also misdirected priorities, I believe. We were emphasizing time over accuracy. Of course, time is important, but accuracy 100% mandated. Silos in different areas of our Forensic Operations existed. There was a lack of adequate supervision. And we had a problem with workload versus staffing. Remember that OCME works 24/7 365 days a year alongside first response agencies. And in 2003, we took over the mortuary operations for the City of New York. This is something no other medical examiner's office in the country does. And we were never adequately funded, and staffed for taking on that new responsibility.

So in summary, beginning in summer, we examined every aspect of what we do to use what we already have most efficiently to gain control of operations. And then to determine what new needs we had to meet our goal of 100% accuracy, 100% of the time. So what we did was establish a Forensics Operations Division, removing staff from silos and putting all operational departments under a single

2 chain of command. We established a Tour Commander
3 position and the OCME Operations Center to ensure
4 citywide unity of effort for all OCME operations.
5 The Tour Commander is a person on 24/7 that
6 coordinates timely and efficient response to all
7 fatalities throughout the city. We had established
8 new leadership in the forensic operations areas with
9 an emphasis on strong middle management. So that we
10 would have adequate oversight of all our operations
11 again 24/7 throughout the city. We required a
12 reconciliation process to be conducted in our
13 mortuaries three times a day, once on each shift. In
14 addition, as a measure of QA and QC, the Evidence
15 Unit from OCME oversees this process once per day to
16 make sure that all cases are accounted for, and are
17 being stored in the correct location. If we find any
18 issues, this allows us to address them in a timely
19 manner. We issued a number of directives to provide
20 formal, uniform instruction and guidance with uniform
21 protocols to all mortuary staff in all five boroughs.
22 We installed closed-circuit TV system at all OCME
23 offices in the check-in and checkout areas. This
24 provides us the ability to view and to record all
25 check-in and checkouts. And if a problem were to

2 come to light, we would be again able to take
3 corrective action in a timely manner.
4 I also mentioned before this time-out
5 procedure, which first the Medical Examiners were in
6 charge of and now our Forensic Quality Specialists.
7 and they oversee every checkout in conjunction with
8 our Mortuary Technicians and the Funeral Director
9 picking up the body. We made enhancements to our
10 Case Management System for the check-in and checkout
11 process. We did training and proficiency testing for
12 all mortuary staff on proper check-in and checkout.
13 We require mortuary staff to only use our Case
14 Management system. OCME is now totally paperless in
15 this area, and there are no paper case files. The
16 New Needs Request, as I described, gave us new
17 investigators, administrators on duty and the
18 criminalists.
19 We formed a working group with the
20 Metropolitan Funeral Directors' Association to
21 increase communication with the funeral director
22 community, and have efficient sharing of information
23 with them. We have formed working groups with our
24 Mortuary Technicians to increase communication to
25 improve and employee/employer relations, and

2 collaboratively develop new directives and new
3 standard operating procedures. We've established a
4 similar group with our Forensic Investigations, our
5 Medicolegal Investigators. And then we've lastly
6 organized--re-organized our Outreach Department. So
7 this is department that is responsible for attempting
8 to identify those who are at the Medical Examiner's
9 Office who are unknown. So we have a rigorous
10 protocol now in place, and we are increasing staffing
11 in that area.
12 CHAIRPERSON JOHNSON: That's all?
13 DR. BARBARA SAMPSON: That's it. Well,
14 there are a few more, but want to get into too much
15 detail.
16 CHAIRPERSON JOHNSON: Okay, that's a lot.
17 [laughs] I'm really pleased that you, Dr. Sampson,
18 have taken this so seriously, and clearly have
19 undertaken an enormous effort to try to ensure that
20 these incidents do not happen again. One of my
21 questions, though, is why weren't these very
22 thoughtful procedures, processes, levels of
23 protection, quality assurance measures, why weren't
24 they in place before? All of the things you were
25 talking about, how come all these things were just

2 recently implemented? How come these weren't things
3 that the Medical Examiner Offices hasn't been doing
4 the last five years, ten years?
5 DR. BARBARA SAMPSON: They should have
6 been. However, in the last few years, we had some
7 very serious budget cuts. The work, as you can
8 imagine, remains the same for us no matter what the
9 budget is like. And we were trying to do the best we
10 could with what we had. And unfortunately, the
11 series of events from last summer really brought to
12 our attention that they had to be dramatically dealt
13 with in a firm--with firm and decisive actions.
14 CHAIRPERSON JOHNSON: Do you believe that
15 with the additional funding that you've received and
16 the measures that you just described that the
17 funding, and protective measures to quality assurance
18 is now sufficient to ensure that no other decedent is
19 lost or unaccounted for?
20 DR. BARBARA SAMPSON: I believe that we
21 have taken every measure humanly possible to detect
22 an error that is made through human error before
23 there is an adverse effect on a family. And we
24 continue to re-examine every aspect of our
25 operations, and if we find more areas that need

additional funding or reorganization, we will certainly bring that to the Administration's attention and your attention.

CHAIRPERSON JOHNSON: So the new Criminalists positions that you mentioned, with those new positions how many total positions does your office have for coverage at OCME morgues.

DR. BARBARA SAMPSON: There's a number of different areas. So we have the Forensic Quality Specialists. Those are the new positions. So that ten, but we also have our Mortuary Technicians. Dina, would you please go ahead.

ASSISTANT COMMISSIONER DE PAOLA: [off mic] Fifty-six Mortuary Technicians.

DR. BARBARA SAMPSON: Fifty-Six mortuary positions. Anybody else?

ASSISTANT COMMISSIONER DE PAOLA: [off mic]

DEPUTY COMMISSIONER MANIOTIS: [off mic] Dina Maniotis, Executive Deputy Commissioner. I'll just give you--

CHAIRPERSON JOHNSON: [off mic] Could you please speak into the mic?

2 DEPUTY COMMISSIONER MANIOTIS: [on mic]
3 Yes, sorry. Dina Maniotis, Executive Deputy
4 Commissioner, Administration and Finance and I'm just
5 going to look at my manual, and I'll have the
6 personnel in one moment. Okay. In Forensic
7 Operations, we have currently 236 individuals. Of
8 those we--we include Forensic Specialists, Mortuary
9 Techs, Vehicle--Forensic Mortuary Techs who go out in
10 the vehicles and retrieve bodies. We have
11 Criminalists, Medicolegal Investigators, 34
12 Medicolegal Investigators. We just got funding for
13 another eight Administrators on duty, and I have a
14 whole list that I could provide you actually, if
15 you'd like it. With a list of all the staff within
16 the Forensic Operations Division.
17 CHAIRPERSON JOHNSON: Thank you. That
18 would be helpful. I mean this gives me great
19 confidence about the changes in mortuary services at
20 your office. Are you undertaking a similar view of
21 other divisions that may not have had incidents
22 recently to ensure that procedures are in place. So
23 that other divisions don't face similar problems?
24 DR. BARBARA SAMPSON: Absolutely. Yeah,
25 we're taking a deep look at all the areas of the

2 agency first. When I first took over as Acting
3 Chief, the DNA Lab was the focus. For the last year
4 or so, the Mortuary was the focus, and now I'm
5 turning my attention to our other laboratories, to
6 our Histology and Toxicology Laboratories. As you
7 mentioned, we have DNA Funding coming where we will
8 hire outside experts to come in, and to look at our
9 processes for efficiencies in those laboratories. I
10 have also asked Tim Cooperschmidt [sp?], who is the
11 head of our DNA lab, to assume supervision of all of
12 our laboratories. He is well trained in business
13 management practices, in Lean Six Sigma in particular
14 and he has just made a tremendous difference in our
15 DNA Laboratory. And he is now embarking on making
16 the same kind of analysis for our other laboratories.
17 So they will be equally efficient.
18 CHAIRPERSON JOHNSON: Thank you. I want
19 to acknowledge that we've been joined by my colleague
20 and friend, Council Member Rafael Espinal from
21 Brooklyn, and a member of this committee. If you
22 have any questions, feel free to jump in, Council
23 Member. The Preliminary Plan includes a million
24 dollars for maintenance and support services. The
25 Fiscal Year 2016 Preliminary Plan proposes an

2 increased spending of $1.1 million city funds if
3 Fiscal Year 2016, and $928,000 in the out years for
4 maintenance and professional support services. What
5 specific services does this new funding cover?
6 DR. BARBARA SAMPSON: I'll ask our--
7 Excuse me, one moment.
8 [pause]
9 DR. BARBARA SAMPSON: I'm just trying to
10 determine exactly where--what it is that you would
11 like to know. This is on other than personnel
12 services, is that correct?
13 CHAIRPERSON JOHNSON: That's right.
14 DR. BARBARA SAMPSON: Okay.
15 CHAIRPERSON JOHNSON: In 2016, this
16 upcoming fiscal year, $1.1 million for maintenance
17 and professional support services. And in the out
18 years $928,000. So I want to know what exactly
19 specifically that money is targeted for.
20 DR. BARBARA SAMPSON: We're making some
21 upgrades with our technology, with T3 Lines. They're
22 giving us a lot more capability to view through
23 videos, especially the check-in and check-out
24 process. This goes directly to DOITT. This funding
25 will go direct--directly to DOITT to provide this

2 capability. We're using some of that money to
3 exchange a--to have a replacement plan specific for
4 gurneys. We did not have that in the past, and as
5 they degrade, our concern for potential harm to the
6 users to our employees requires us to exchange and
7 replace them. We have for the first time ever added
8 a vehicle replacement expense budget into our budget.
9 We're very grateful to OMB for helping us plan that
10 out. We have included additional funds to help us
11 manage our Laboratory Information Systems
12 applications. And this funding is for maintaining
13 that system, not creating new applications but
14 maintaining the existing system that we have. We
15 have also some funding for increased security, or
16 maintaining the security level that we have. So we
17 have implemented a live security officer within each
18 one of our borough morgues in addition to our
19 electronic security surveillance. And one other
20 thing that we did not have was in the morgue areas,
21 we have-- Of course, the morgue techs do the
22 cleaning of the aftermath of autopsies and so forth.
23 But they were not specialized to do really deep
24 cleaning, and nobody goes into that area except the
25 morgue techs. We then asked for funding to bring in

2 a special vendor to go in and really clean the area
3 thoroughly once a year at each one of our morgues
4 beyond the capacity, let's say, of the morgue techs
5 who do that cleaning.
6 CHAIRPERSON JOHNSON: Who is that vendor?
7 DR. BARBARA SAMPSON: It's NYSED. It's
8 New York State--[off mic] It's--what is the acronym?
9 [on mic] It's New York State Employee--It's NYSED?
10 No--nobody is remembering. It's the--it's a New York
11 State employment vendor who works with people with
12 disabilities. And it's--we've used a State contract
13 before and this is--this is part of that contract.
14 CHAIRPERSON JOHNSON: So these services
15 you mentioned, Deputy Commissioner, are potentially
16 going to be used in all of those human needs
17 [sic]facilities, not just one facility?
18 DR. BARBARA SAMPSON: That's correct,
19 that's correct. We have--we have sufficient funding-
20 -
21 CHAIRPERSON JOHNSON: [interposing] And
22 not just the cleaning. I'm talking about all of the
23 services that you mentioned--
24 DR. BARBARA SAMPSON: [interposing] Yes,
25 yes.

CHAIRPERSON JOHNSON: --for all of your-- Across the board.

DR. BARBARA SAMPSON: Yes. Across the board. Five morgues.

CHAIRPERSON JOHNSON: Great. I want to jump into the Preliminary Mayor's Management Report, and we've also been joined by a member of the Health Committee, Council Member Peter Koo from Queens. So I want to talk a little bit about the median time to complete DNA property cases. Is there a reason other than shifting resources from DNA homicide and DNA sexual assault cases for the increase in median time to complete DNA property cases?

DR. BARBARA SAMPSON: No, it's--that is simply a reflection of the shifting of resources. We have been actively addressing now this backlog that we do have in property crimes. And right now we have 1,600 cases that are in this backlog, but it's dropping rapidly. In the last three months there's be a 34% decrease in that backlog. So by the end of 20--calendar year 2015, the backlog will be gone, and every-- Our goal and a very achievable goal will be that our turnaround time for every case of every type will be 30 days.

2 CHAIRPERSON JOHNSON: And so, if your
3 office plans to reduce, as you said, the median time
4 to complete DNA property cases, do you anticipate a
5 rise in median times for DNA homicide and DNA sexual
6 assault cases?
7 DR. BARBARA SAMPSON: No, absolutely not.
8 The way we've done it is to prioritize the most
9 violent crimes, getting that turnaround time now to
10 approximately 30 days. Unfortunately, that created a
11 backlog in the property crimes. But as I said,
12 that's decreasing rapidly. And once we're caught up
13 on that with this new system that I described of
14 these multiple small groups working a case from the
15 beginning to the end in a 10-day cycle, that all
16 property--all crimes including property crimes will
17 have a 30-day turnaround time.
18 CHAIRPERSON JOHNSON: Median time to
19 complete toxicology cases is 29 days higher than DUI
20 cases, which is 20 days. And in sexual assault
21 cases, which is 27 days in toxicology times. What
22 other toxicology cases are included in this number
23 that may be skewing it higher?
24 DR. BARBARA SAMPSON: Yeah, the highest
25 number reflects the toxicology testing for the

2 autopsy cases. So when we perform an autopsy, six
3 different specimens are taken from every single case
4 and tested as needed for hundreds of drugs. So that
5 testing is more complicated that the DUI testing and,
6 therefore, it takes longer and skews those numbers.
7 CHAIRPERSON JOHNSON: In Fiscal Year
8 2013, the average time for DUI cases was 14 days.
9 This past Fiscal Year or in the Preliminary Plan,
10 toxicology case review as 20 days, an increase of six
11 days. What is the reason for that increase?
12 DR. BARBARA SAMPSON: Well, just overall,
13 the number of DUI cases that we receive has
14 increased. Since FY10, the number has actually
15 doubled, but the main reason for this--that jump in
16 turnaround time was a change in the definition of the
17 turnaround time. Prior to January of 2014, the
18 receipt date was considered to be the date of the
19 start of testing within the laboratory. We felt that
20 that is not an accurate reflection of turnaround
21 time, and that the clock should start to the date
22 when the evidence is received in the Evidence
23 Department. So that added several days to the
24 turnaround time, just the change in that definition.
25 But, I--as I mentioned before, we're turning our

attention now to a laboratory--our other laboratories, and the toxicology turnaround times are of great concern to me. And we are looking at ways to be more efficient in order to bring those down.

CHAIRPERSON JOHNSON: Median time to complete toxicology sexual assault cases for the four-month actual of Fiscal Year 2015 was 38 days. It's up from the four-month actual of 2014, 22 days. So it's up 16 days in the comparative time on sexual assault cases. What is the reason for that?

[pause]

DR. BARBARA SAMPSON: Could you repeat the question? I'm sorry [laughs]

CHAIRPERSON JOHNSON: Yes. So, it's my--it's my understanding that the Preliminary Management--Mayor's Management Report shows that the median time to complete toxicology in sexual assault cases for this four-month period, the actual four-month period of Fiscal Year 2015 is 38 days. The previous actual year's actual four month was 22 days. So there was an increase of 16 days for the completion of sexual assault cases in the Toxicology Department. Why is there more than a two-week increase in time?

2 DR. BARBARA SAMPSON: I--that has to do
3 with some loss of staffing and staffing out those
4 sorts of changes. But there--like I said before, the
5 increase in the turnaround time within the Toxicology
6 Lab across the board is of concern to me. And this
7 is why we're doing this analysis of the procedures
8 for efficiency. To try to correct that as quickly as
9 possible.
10 CHAIRPERSON JOHNSON: So when you--at the
11 beginning of your testimony, Dr. Sampson, when you I
12 think very finely laid out all of the reforms and
13 quality assurance that you now are doing at Mortuary
14 Services, are you hoping that potentially taking a
15 hard look at what's happening? As we mentioned
16 before, in other divisions within OCME can
17 potentially give you some insight on now to make some
18 changes to improve some of these numbers like in the
19 Toxicology Department?
20 DR. BARBARA SAMPSON: Absolutely. Yes.
21 CHAIRPERSON JOHNSON: Okay.
22 DR. BARBARA SAMPSON: That's--that's our
23 goal.
24 CHAIRPERSON JOHNSON: So generally, why
25 does the median time to complete toxicology sexual

2 assault cases remain so high. Twenty-seven days this
3 past fiscal year. Seventeen days in Fiscal Year
4 2010. Is that because there's an increase in cases?
5 Is it because of a loss of staff? Is it a
6 combination of the two?
7 DR. BARBARA SAMPSON: I think it's mostly
8 some temporary loss of staff. It's a small--a much
9 smaller laboratory than our DNA laboratory. So there
10 is less room for events that may occur when someone
11 has to go out for medical reasons, et cetera. I
12 think that would be the major-- And also the fact
13 that a lot of the equipment in the Toxicology Lab is
14 nearing the end of it's life span. And this is part
15 of what we're looking--and sometimes breaks down and
16 needs to be repaired putting a piece of machinery
17 offline for a period of days or a week. And,
18 therefore, delaying the turnaround time in
19 Toxicology. So again, as part of this look, by both
20 our own staff at the processes in the laboratory, and
21 our outside consultant we're looking to replace this
22 equipment with the best equipment. The most
23 efficient equipment that's currently available. But
24 we want to do this not in a haphazard manner, but in
25 a very organized manner to make the best decision for

2 a decade that will-- You know, serve us well for the
3 next decade.
4 CHAIRPERSON JOHNSON: And the reason why
5 I'm really drilling down on these numbers and, you
6 know, I don't have to tell you this. I mean I think
7 it's important for the public to know that you all I
8 guess maybe not in the same way as we see on TV on
9 some of these shows that are on. But you all play a
10 crucial and important role when really horrific
11 things happen at giving us the evidence, and the
12 necessary data to be able to track bad people down.
13 And so, the longer there's a delay in getting the
14 results, and additional two weeks is potentially an
15 additional two weeks where a suspect or a perpetrator
16 is on the street. And potentially someone else could
17 be harmed because we're not getting the information
18 fast enough to the NYPD.
19 DR. BARBARA SAMPSON: Yeah.
20 CHAIRPERSON JOHNSON: And this is why I
21 think that all of the corrective actions that you've
22 taken as part of Mortuary Services I hope that as
23 quickly as possible you'll be able to look at the
24 Toxicology Division, and come up with some reforms
25 that are going to speed up the completion times on

some of these really important categories. And you all know this because you have to deal with this every single day. But, the trauma involved when one is assaulted in such a way, the quicker we're able to get the information to the NYPD so they can get on the case, the better it is for the public at large. But also for the individual that has been subject to that crime.

DR. BARBARA SAMPSON: And I--we do work closely with that NYPD if there is a case that they need the results quickly, we are to give that and to prioritize that case to give them their investigative leads as quickly as possible. The consultants that I mentioned, the outside consultants are scheduled to start in June--June 1st. So, this should be, hopefully, a very rapid process.

CHAIRPERSON JOHNSON: That's great. So you mentioned some of the toxicology equipment that is old and that has broken down. The Capital Commitment Plan includes funding for new toxicology equipment that the Council funded. I believe that mount is $2.9 million. Can you provide an update on where you are on actually purchasing that equipment?

And how does OCME expect this equipment will help the work of the Toxicology Lab?

DR. BARBARA SAMPSON: Absolutely, yeah. So we've begun to spend some of that. However, we wanted to wait for this outside consultant to examine what equipment would be the best for us to purchase with the long-term plan in place. So, we're hoping to more quickly proceed after the consultant comes in. [sic]

DEPUTY COMMISSIONER MANIOTIS: [off mic] Dina Maniotis. I can add that--

CHAIRPERSON JOHNSON: [interposing] Could you speak more directly into the microphone. thank you.

DEPUTY COMMISSIONER MANIOTIS: Yes. Sorry about that. What we've done is we already have an approved CP, and we have three specialized substance testing instruments that are coming in, which we require in the Toxicology Lab almost immediately. Meanwhile, we are working through a very long procurement process to get in the group of consultants who will come in and do a process engineering of the entire Toxicology Lab. And with their recommendation, and the analysis that we do,

2 we'll have a clear understanding of what equipment we
3 should purchase and bring into the lab. And we will
4 more efficiently and effectively use the capital
5 grants that the Council provided us with.
6 CHAIRPERSON JOHNSON: So when do you--
7 when do you expect those purchases to actually be
8 complete, and for you to have the new equipment?
9 DEPUTY COMMISSIONER MANIOTIS: The
10 capital projects that we have now, the CP is going
11 into the requisition process. So, we--OMB has
12 approved us to use the funds. We are now going
13 through the procurement process of getting bids for
14 the equipment. In terms of the remaining equipment,
15 once the consultants come in, do the process
16 engineering, which can take a couple months, then we
17 have to go into the--the procurement process. Which
18 is City has a very strict procurement process. We'll
19 follow that. It will most likely be around the one-
20 year mark before we're ready to purchase.
21 CHAIRPERSON JOHNSON: So, you're saying
22 that over the next few months consultants are going
23 to come in, take a look and see what's needed. Make
24 some recommendations to you all. When that is
25 complete, they will make those recommendations. You

2 will then start the City's procurement process.
3 You'll go through the process. You'll take
4 competitive bids, and then eventually you'll get the
5 equipment.
6 DEPUTY COMMISSIONER MANIOTIS: Correct.
7 CHAIRPERSON JOHNSON: So that could be--
8 that's a while.
9 DEPUTY COMMISSIONER MANIOTIS: It is. It
10 is. There's no way to avoid the procurement process
11 and we did not want to make a haphazard decision and
12 use the money to buy equipment that we were not
13 absolutely certain would be the most up-to-date
14 cutting edge equipment and effective and efficient
15 for our lab.
16 CHAIRPERSON JOHNSON: Yeah, the--I
17 understand. I mean, I--I--we're all frustrated in
18 many ways about how long the procurement process
19 takes in the city. Talk to any council member about
20 a local park, and how long it takes to get a new
21 piece of play equipment. But, we gave you this money
22 last year. Spend the money. I mean this should have
23 been-- Now, potentially two years after it was given
24 to you all by the Council that's when you're going to
25 get it when we're seeing an increase in numbers in

2 the Toxicology Lab, as we just talked about. So, I
3 wish that--I understand that you guys had a very busy
4 year last year, and you were doing an overhaul of
5 mortuary services. But it would have--I think been
6 better, more optimal to have started to conduct some
7 of these look backs with consultants earlier. So
8 that we would be farther along in the process.
9 DEPUTY COMMISSIONER MANIOTIS: May I
10 DR. BARBARA SAMPSON: Yes.
11 DEPUTY COMMISSIONER MANIOTIS: So one--
12 one of our constraints has been, and not making
13 excuses, but a constraint has been we are--have been
14 waiting for a little bit of time to get in the
15 forfeiture funds which then would pay for our
16 consultant, which we did get some time last December.
17 CHAIRPERSON JOHNSON: Your received your
18 Forfeiture Funds?
19 DEPUTY COMMISSIONER MANIOTIS: Yes--
20 CHAIRPERSON JOHNSON: [interposing] Yes.
21 DEPUTY COMMISSIONER MANIOTIS: --just
22 this past December. In the meanwhile, what equipment
23 we could identity that would be most effective to
24 purchase at this time, we have over a quarter of a
25 million dollars in equipment already in progress that

2 we should be getting on board within the next few
3 months. We've already done the CP process, and we're
4 in the actual bid process. But the--the bulk of the
5 money will be spent once we do have the consultants
6 give us a report on which equipment is most
7 beneficial for the Toxicology Lab.
8 CHAIRPERSON JOHNSON: Well, we are not
9 here to micromanage, but I--I do think that it's
10 important for us to know when you guys do have new
11 equipment coming online given that it was Council
12 funded. So when you actually receive--when you
13 actually are able to place the orders, and you
14 receive the new equipment, please let us know.
15 DEPUTY COMMISSIONER MANIOTIS:
16 [interposing] Absolutely.
17 CHAIRPERSON JOHNSON: And let us know
18 what the new equipment is, and what it's being used
19 for
20 DEPUTY COMMISSIONER MANIOTIS: Absolutely
21 CHAIRPERSON JOHNSON: Great. So I want
22 to jump a little bit back to the Management Report.
23 I'm going to talk about the median time to process
24 cremation requests. So the median time to process
25 cremation requests has increased over the last three

2 years. 78.6 minutes in Fiscal Year 2012; 123.9
3 minutes in Fiscal Year 2013; 146 minutes in Fiscal
4 Year 2014. What is the reason for the increase?
5 DR. BARBARA SAMPSON: All right. So we
6 do approximately 27,000 cremation requests a year.
7 And each of these must be scrutinized appropriately.
8 Our Medicolegal Investigators are the ones who do
9 these cremation approvals. And as you well know,
10 they also perform--they are the ones who investigate
11 death scenes. They are the--our eyes and ears at
12 death scenes, 24/7 365 days a years in all five
13 boroughs. They go to over 5,000 scenes per year. So
14 now that we are emphasizing accuracy over time, there
15 has been an increase in some of our indicators, in
16 particular, the cremation requests that you were
17 talking about. But, of course, accuracy is
18 important, and timeliness is also important. So this
19 is why--part of the reason why we asked for eight new
20 Medicolegal Investigators that will help facilitate
21 this process. And I'm still pleased to say that the
22 time to approve a cremation request is still around
23 two hours.
24 CHAIRPERSON JOHNSON: Has the number of
25 decedents' remains transported and stored by OCME

2 decreased over the last three years? 95,158
3 decedents in Fiscal Year 2012; 78,003 decedents in
4 Fiscal Year 2013; and 69,176 in Fiscal Year 2014.
5 Why the decrease?
6 DR. BARBARA SAMPSON: The FY13 and 14
7 numbers are incorrect. There was a transcription
8 error made when entering the data into the Mayor's
9 Management Report, and for '13 and '14, we reported
10 only Medical Examiner cases. And as I mentioned in
11 my testimony, not only do we handle Medical Examiner
12 cases, but what we call claim cases with the City
13 Mortuary. So those actual numbers in '13 it 10,372
14 cases and in FY14 it was actually 10,804 cases. So
15 the number of cases is steady. These reports I want
16 you to know are now automated. So the potential for
17 a transcription error has been eliminated, and I
18 apologize for that.
19 CHAIRPERSON JOHNSON: I'm glad we asked.
20 DR. BARBARA SAMPSON: Yes, please. Thank
21 you. [laughs]
22 CHAIRPERSON JOHNSON: The median time to
23 complete DNA homicide cases, I asked about that
24 earlier. We don't have to go back to that. I want
25 to talk a little bit more about the Capital Plan. So

2 the Capital Commitment Plan includes $11 million in
3 funding for Fiscal Year 2016, an increase of $5.5
4 million since Fiscal Year 2015 adoption.
5 COMMISSIONER FRANK DE PAOLA: It's 2017.
6 CHAIRPERSON JOHNSON: Sorry. It's an $11
7 million in funding for Fiscal Year 2017, an increase
8 of $5.5 million since Fiscal Year 2015 adoption. Why
9 does OCME's capital budget have an uptick in funding
10 for Fiscal Year 2017 only?
11 DEPUTY COMMISSIONER MANIOTIS: Yes.
12 DR. BARBARA SAMPSON: [off mic] Yes,
13 please.
14 DEPUTY COMMISSIONER MANIOTIS: [off mic]
15 One of the--and we're very fortunate with that--
16 CHAIRPERSON JOHNSON: If you speak more
17 directly into the mic.
18 DEPUTY COMMISSIONER MANIOTIS: [on mic]
19 Sorry. We're very fortunate in that OMB has funded
20 us for vehicle replacement. We have over $7 million
21 in the Capital Plan that we previously did not have,
22 and we're very--very heavy users of the vehicles to
23 transport decedents and so forth. So this was a very
24 important addition to our Capital Plan. The rest of
25 the budgeted increases span a number of areas

2 including additional purchases of things like
3 telephone where we've reached the end of our life on
4 telephones. Our infrastructure has been also
5 augmented. We've had additional monies that were
6 funded to us for--to increase capital security,
7 infrastructure changes. I'm looking through all of
8 the-- It's primarily for equipment changes and
9 vehicle changes.
10 CHAIRPERSON JOHNSON: So the Capital
11 Equipment Plan includes $2 million in funding for the
12 purchase of vehicles by OCME. What type and how many
13 vehicles will this funding cover?
14 DEPUTY COMMISSIONER MANIOTIS: It's
15 actually-- For the entire Capital Plan it's $7
16 million, and may I turn it over to Assistant
17 Commissioner DePaolo, who actually will--oversees
18 that area?
19 ASSISTANT COMMISSIONER DE PAOLA:
20 [coughs] Most of this funding will be used to replace
21 the mortuary vehicles, the vehicles that are used to
22 transport decedents in each of the boroughs. At any
23 given time, five trucks are on the road and five
24 back-up units that are rotated. There's a--obviously
25 a life to the--to those units that are on the road 24

2 hours a day, seven days a week. There's a lot of
3 mileage that goes on them. In addition, we have
4 vehicles that allow our investigators to respond so
5 they're investigative response vehicles. And then
6 other support vehicles to move equipment around day-
7 to-day. Most of those vehicles, as the Deputy
8 Commissioner pointed out, we did not have a
9 replacement plan for. So this is a--this is a
10 replacement plan that OMB put in--put in place
11 looking at the current fleet, and what it would take
12 to get that fleet upgraded over the next couple of
13 years.
14 CHAIRPERSON JOHNSON: Thank you. So the
15 Preliminary Capital Plan added an additional $1.7
16 million I believe for vehicles going from $352,000 to
17 $2 million. So that that increase is just covering
18 new vehicles that are being purchased?
19 ASSISTANT COMMISSIONER DE PAOLA:
20 There's--there's actually no increase--net increase
21 to the headcount. It's replacement vehicles.
22 Replacing the current vehicles.
23 CHAIRPERSON JOHNSON: [interposing] It's
24 replacing vehicles?
25 ASSISTANT COMMISSIONER DE PAOLA: Yes.

2 CHAIRPERSON JOHNSON: Great. So what's
3 the-- Forgive me, what's the total number of vehicles
4 the office has?
5 ASSISTANT COMMISSIONER DE PAOLA: I
6 actually don't have the full headcount with me. We
7 can get that number to you.
8 CHAIRPERSON JOHNSON: Great. The Capital
9 Plan includes funding for a new Medical Examiner
10 facility in the Bronx at HHC's Jacobi Medical Center
11 Campus. I wanted to see if you could give us an
12 update on the status of the construction of that new
13 Medical Examiner facility in the Bronx at Jacobi.
14 DR. BARBARA SAMPSON: We've done some
15 preliminary design work. The contractor is DASNY,
16 the State Design Authority. We're just--we're still
17 in that preliminary design phase. At this time we're
18 waiting to hear from our Administration at City Hall
19 on any new directives that we might receive from
20 them. But we are progressing with that in mind that
21 once the design is complete we're at 60% design. We
22 still have another next design cycle to bring it up
23 to 100% design.
24
25

2 CHAIRPERSON JOHNSON: So when do you
3 think--when do you expect it to be completed, the
4 facility not just the design? Is there a target?
5 DR. BARBARA SAMPSON: Yes, if that design
6 were to proceed, and we were happy with the design,
7 and all stakeholders including our Administration
8 were happy, then it could be a three to four-year
9 construction period.
10 CHAIRPERSON JOHNSON: Great. SO the
11 Capital Plan includes $8.9 million for the purchases
12 of IT equipment and services. Is that what you were
13 talking about earlier?
14 DR. BARBARA SAMPSON: Yes.
15 CHAIRPERSON JOHNSON: Yes. So it's
16 covering what we talked about earlier, and the
17 timeline for those purchase is--
18 DR. BARBARA SAMPSON: What we do is we
19 pro-rate it across the years, but anticipating what
20 the life cycle is of our IT equipment. And we roll
21 it-- We--we have the funding and we roll it into the
22 following years anticipating what we might be
23 changing, switching out.
24 CHAIRPERSON JOHNSON: The Capital
25 Commitment Plan includes $77,000 in funding for a

project titled Local Law Remedial Compliance. Can you explain to the committee what that project is?

DR. BARBARA SAMPSON: About three or four years ago we had a construction firm come in and give us an estimate of the upgrade. What it would cost to upgrade our flagstone building, which is at the 520 First Avenue location. The cost was really astronomical including to redo the envelope of the building, which was dropping bricks and other debris onto the sidewalk. Just for the envelope, it was over $10 million. We, therefore, as an interim solution built a sidewalk shed around the entire building in order to protect pedestrians on the street. That $77,000 is to maintain the sidewalk shed.

CHAIRPERSON JOHNSON: Thank you. Dr. Sampson, I know you mentioned in your testimony that in 2014 OCME identified three previously unknown individuals who dies in the attacks of 9/11. And, just in the past week or few weeks there was another individual who was identified. I want to see if you could give us an overview. I know that OCME has a space at the Museum Memorial for the families who want to come. Can you talk a little bit about the

2 work that's done there? What you office does there
3 at the Museum Memorial
4 DR. BARBARA SAMPSON: Next to the Museum
5 there is another OCME facility where the remains from
6 9/11 are housed. In that facility, there's an area
7 for families to come and visit and pay their
8 respects. Behind the actual room where there are
9 remains is a work area for anthropologists to be able
10 to re-sample any specimen that they need to. This is
11 an ongoing process. The new identification was, in
12 fact, made through a new reference sample that we
13 made. There is no DNA identification work going on
14 at the repository. The specimens are simply taken
15 there, and then brought back to our DNA Lab on 26th
16 Street where the actual DNA work occurs.
17 CHAIRPERSON JOHNSON: So when a family
18 comes and wants to visit the Repository, who is the
19 family interacting with, a criminalist?
20 DR. BARBARA SAMPSON: They [off mic] I
21 will have--could you please take this? [sic]
22 ASSISTANT COMMISSIONER DE PAOLA: So we
23 actually maintain full-time security at the
24 Repository as well as an anthropologist who is a
25 criminalist. So when a family member presents, they

can do it by appointment or walk-ins during the times that the memorial is open. They can avail themselves of either speaking directly with one of the criminalists anthropologists or just simply visiting and spending time to pay their respects.

CHAIRPERSON JOHNSON: And in the past the museum h as been open I guess for less than a year now or coming up on a year. How many families have visited the Repository?

ASSISTANT COMMISSIONER DE PAOLA: Do you have that number? I don't actually have the total number.

DEPUTY COMMISSIONER MANIOTIS: [off mic] We can provide it to you.

CHAIRPERSON JOHNSON: Has it been a significant number? Has it been a small--what you've expected?

DEPUTY COMMISSIONER MANIOTIS: [off mic] I believe during the launch--

CHAIRPERSON JOHNSON: [interposing] If you could speak directly into the mic.

DEPUTY COMMISSIONER MANIOTIS: [on mic] During the launch of the museum, we had a--over 50% visitation from families. Again, I'll have to get

2 the numbers for you. During the rest of the year, I-
3 -again, I'd have to bring those numbers to you. I
4 know just that launch that we had--the launch.
5 ASSISTANT COMMISSIONER DE PAOLA:
6 [interposing] Yeah, let me tell you. Several
7 families visit everyday, seven days a week.
8 Sometimes it's busy. Sometimes not as busy, but we--
9 we can--we actually track the appointments and we can
10 provide that.
11 CHAIRPERSON JOHNSON: And only families
12 were allowed to visit there last year.
13 ASSISTANT COMMISSIONER DE PAOLA: Only--
14 only families of victims of the World Trade Center
15 are allowed to visit the family. No one actually
16 goes through the Repository--
17 CHAIRPERSON JOHNSON: [interposing] Yes.
18 ASSISTANT COMMISSIONER DE PAOLA: --but
19 OCME personnel.
20 CHAIRPERSON JOHNSON: And how does one--
21 how do you determine if someone is a family member?
22 ASSISTANT COMMISSIONER DE PAOLA: So
23 there's a--a process, which we have in place and have
24 had in place for many years. For example the 9/11
25 ceremonies we work with the Mayor's Office of

2 Community Affairs as well as the memorial to identify
3 family members, and anyone who presents to the
4 Memorial or to the OCME identifying themselves as a
5 family member we allow to visit the family there.
6 It's a fairly liberal policy that's in place.
7 CHAIRPERSON JOHNSON: I understand why
8 there's a liberal policy in place. It also concerns
9 me a little bit that you could have potentially some
10 crazy people who would want to come and gain access
11 as to this very special place for the actual
12 families. And so, I'm not second-guessing what's
13 been put in place, but I would say that it would be
14 disastrous if something went wrong because you had
15 someone who was posing as a family member show up.
16 And pretended like they were associated with someone
17 who was lost on 9/11 and, in fact, were not. And
18 acted out or misbehaved or did something offensive.
19 It would be, I think, a real disaster for you all,
20 and for the city. So I'm sure there are very smart
21 people that have looked into this, but I would just
22 say I know we don't want to be exclusive and not
23 allow family members who need to be there. But at
24 the same time, we should maintain some level of
25 security and exclusivity so that you don't just have

2 random strangers showing up and gaining access to
3 this very sensitive area.
4 ASSISTANT COMMISSIONER DE PAOLA: [sic]
5 May I also this one. [on mic] So Council Member,
6 we--we--we certainly with you, and this has been a
7 concern. We've spent a lot of time, a lot of
8 discussion on this specific matter, and there is a
9 vetting process that's in place that allows us to
10 determine whether or not the--there is the likelihood
11 of a situation as you described occurring. That's
12 why we maintain full-time security at the site. We
13 also work very closely with the NYPD who--the
14 actually are allowed to--able to monitor the
15 situation down there in real time.
16 CHAIRPERSON JOHNSON: Is there security
17 in that room?
18 ASSISTANT COMMISSIONER DE PAOLA: There
19 is substantial security. That's--I don't want to
20 publicly discuss all of the security elements, but
21 let me assure you that it involved NYPD, the OCME,
22 the Port Authority and a number of other security
23 groups that designed the process, and so far it's
24 worked extremely well. We hope that that continues,
25

2 but we share the same concerns you have, and we have
3 put a lot of attention on this matter.
4 CHAIRPERSON JOHNSON: Good. I'm happy to
5 hear that. I just know that some of this museum
6 memorial I'm sure could be the magnet for crazy
7 people who are either mentally ill or people who just
8 want to make a spectacle. And this is too sensitive
9 to allow any incident like that to happen. So thank
10 you for answer the questions. I just want to back
11 and mention some of the things that I believe you
12 made a commitment to get to us as follow up. A list
13 of the total number of positions for Forensic
14 Operations; the total number of vehicles at OCME; the
15 name of the vendor for more cleanup; repository--the
16 number of repository visits since the launch' and
17 equipment details for toxicology equipment to be
18 purchased. The timeline and for you to let us know
19 when you actually receive that equipment. So I'm--
20 I'm done. I really appreciate the fact that you're
21 here this morning. I mean to mention earlier, Dr.
22 Sampson, that I want to congratulate you on your
23 recent appointment going from Acting Chief Medical
24 Examiner to Chief Medical Examiner for the City of
25 New York. I believe that this is your third budget

cycle representing the agency; two as acting and now today as the appointed Medical Examiner for the city. And it's great to have you here in a permanent capacity. The City is luck to have you, and I look forward to working together, and I also want tips on how to get such a glowing New York Times profiles. [laughter] Because the one that you got was--I don't know how you got that profile.

DR. BARBARA SAMPSON: We'll top that one. [laughs]

CHAIRPERSON JOHNSON: You got a good profile. So I appreciate you being here today. Thank you very much, and I look forward to working together.

DR. BARBARA SAMPSON: Thank you so much. We appreciate it.

CHAIRPERSON JOHNSON: Thank you very much. We're going to take a 10-minute break and the up next will be the Department of Health and Mental Hygiene.

[gavel, background conversation, pause]

CHAIRPERSON JOHNSON: Good morning. We will now resume the City Council's hearings on the Mayor's Preliminary Budget for Fiscal Year 2016. I'm

2 Council Member Corey Johnson, Chair of the Council's
3 Committee on Health. The Committee just heard from
4 the Office of the Chief Medical Examiner this
5 morning, and we will now hear the Mayor's 2016
6 Preliminary Budget for all public health spending for
7 the Department of Health and Mental Hygiene or DOHMH.
8 The Department's total fiscal year, Fiscal 2016
9 Preliminary Budget is $1.44 billion, which is an
10 increase of $71 million from the agency's proposed
11 budget of $1.37 billion aft Fiscal 2015 adoption.
12 The committee is please to see that the
13 Administration has added over $28 million in Fiscal
14 2016 for a range of new services that will help DOHMH
15 improve the lives of some of the City's most
16 vulnerable populations. Some examples of these new
17 initiatives include $8.2 million for the expansion
18 for health clinics. $258,000 to increase the
19 fundraising prowess of animal care and control. A
20 million dollars for a media campaign to help parents
21 improve brain development in young children through
22 language exposure at an early age. A million dollars
23 for the development of an annual child health survey,
24 as well as increased services for individuals on
25 Rikers Island. As such, the committee is looking

2 forward to a detailed discussion with the Department
3 on how these new initiatives with the agency's
4 efforts to address disparities, and advance the fight
5 against health inequities.
6 In addition to the new spending, this
7 Committee is interested in hearing from DOHMH on
8 other programmatic highlights including, but not
9 limited to dog licenses, neighborhood health hubs,
10 the increase of smokers in New York City, school-
11 based health services; and other initiatives
12 currently in development. As a final point with
13 roughly $28 million in baseline funds in Fiscal Year
14 2015, this committee would like to engage the
15 Department of Health and Mental Hygiene in a
16 conversation regarding baseline public health
17 services that are being procured. While a majority
18 of their Requests for Proposals, RFPs have yet to be
19 released, this committee and I have very real
20 concerns, serious concerns. That some of the
21 services that have been historically funded by the
22 Council such as the NYU Mobile Dental Van, which
23 treated 2,200 children citywide in 2014 may be
24 negatively impacted through the City's Procurement
25 Process. Furthermore, the timing of the RFP results

2 and award start dates may limit this committee from
3 ensuring that the Council's priorities are reflected
4 in the budget.
5 Before we begin, I would like to note
6 that we have been joined this morning by some of my
7 colleagues, Council Member Ydanis Rodriguez from
8 Manhattan is here, and I will introduce others as
9 they arrive. I'd also like to take a moment to
10 particularly thank Dr. Mary Bassett, and the entire
11 department, including Dr. Jay Varma for their
12 astounding efforts to address what impacted us last
13 fall an Ebola scare in New York City. When the world
14 learned that a patient had contracted Ebola, terror
15 could have spread across our entire city.
16 Thankfully, we have the greatest Health Commissioner
17 in the world. You became a household name, Dr.
18 Bassett, projecting calm and steadiness, and doing
19 what a great--what great public health professionals
20 do. Arming the public with facts and knowledge
21 necessary to combat fear and taking reasonable
22 measures. You and your team--and again I'd like to
23 take a moment to really single out Dr. Varma, who is
24 with us here today--embody our city at its very best.
25 It maybe a little known fact that at the height of

our vigilance for Ebola, hundreds of DOHMH staff were participating in the response. Hundreds of people from your department from the brilliant contact tracers and community liaisons to lab workers and others. And so, you did us proud. We're lucky that we--we're really grateful and glad that there were no fatalities. It could have been a lot worse, but your leadership was incredible during that time.

Again, I want to thank Crilhien Francisco, the Finance Analyst for the Health Committee; my Health Committee Counsel Dan Hafetz; the Policy Analyst for the Health Committee, Crystal Pond for all of their hard work in preparing for today's hearing. Just a reminder that public testimony begins at 2:30 p.m., and if you wish to testify, you must sign up with the Sergeant-at-Arms in the back of the room. I will now turn it over to Dr. Mary Travis Bassett, the Department of Health and Mental Hygiene Commissioner. Before I do that, if the three of you who are up in front of us today could please raise your right hand to swear you in. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this

2 committee, and to respond honestly to all council
3 member questions?
4 COMMISSIONER BASSETT: I so affirm.
5 CHAIRPERSON JOHNSON: Thank you. Thank
6 you very much. You may begin, Dr. Bassett.
7 COMMISSIONER BASSETT: Thank you for
8 those kind words of introduction, and good morning,
9 Chairman Johnson and members of the Committee. I'm
10 Dr. Mary Bassett, Commissioner of the New York City
11 Department of Health and Mental Hygiene, and I'm
12 joined by Dr. Oxiris Barbot, the Department's First
13 Deputy Commissioner, and Sandy Rozza, the
14 Department's Deputy Commissioner for Finance. Thank
15 you for the opportunity to testify on the
16 Department's Preliminary Budget for Fiscal Year 2016.
17 As you can hear, I have a pretty scratch voice today,
18 and though I've been saving it--
19 CHAIRPERSON JOHNSON: A cough drop?
20 COMMISSIONER BASSETT: I have cough
21 drops.
22 CHAIRPERSON JOHNSON: Okay.
23 COMMISSIONER BASSETT: I have tea, and
24 I've been saving my voice to today's hearing. But
25 we'll have to see how it goes, and I will be drawing

2 on my wonderful who you have kindly acknowledged
3 already as needed during today's testimony. I just
4 can't tell you what my voice is going to do so-- But
5 before I discuss the Department's Budget and
6 programmatic highlights, I want to acknowledge the
7 tremendous partnership between this committee and the
8 Department. Since I presented my testimony on the
9 Department's Preliminary Budget last year, and that
10 was just some four weeks after I became Commissioner.
11 The Department and this Commission--this committee
12 have worked together in several areas including
13 enrolling people in health insurance under the
14 Affordable Care Act. Finally changing a 19th Century
15 law so that the Department has the authority to
16 control its own dog license fee. Funding a
17 significant expansion of Cure Violence, the largest
18 municipal violence prevention program nationwide.
19 And making it easier for transgender people to amend
20 their birth certificate. Improving the regulatory
21 environment for food service establishments, and
22 celebrating a memorable World's AIDS Day at the
23 Apollo Theater. I'm proud of all the work that we've
24 done together to make this city healthier.
25

2 The Department has approximately 6,000
3 employees, and a current operating budget of $1.4
4 billion of which $629 million is city tax levy. The
5 remainder is Federal, State and private dollars. I'm
6 pleased that the Mayor has increased the Department
7 of City Tax Levy budget from $579 million in FY2015
8 to $629 million FY2016. This City tax levy increase
9 includes 48 million to enhance Criminal Justice
10 related health services; $8.2 million to create
11 additional community health clinics; $2.6 million for
12 Early Childhood Services; $5.3 million to prepare for
13 and respond to future emergencies. These funding
14 increases will help the Department strengthen these
15 programs, and build on the successes we've had in
16 these areas. I thank the Mayor and the Council for
17 their support.
18 The State Budget presents a more mixed
19 picture, and I hope that we can work together to make
20 improvements before the Legislature adopts a final
21 budget at the end of the month. Our concerns start
22 with the need for more supportive housing. As New
23 York/New York III agreement comes to a close, the
24 Governor had proposed creating just 5,000 units of
25 supportive housing statewide. Stable housing enables

2 people to make doctor's appointments, take
3 medication, and do other things necessary to maintain
4 and improve their health. Moreover, we know that the
5 need for supportive housing is much greater than
6 5,000 units and for every supportive housing unit
7 that we create we save $10,000 on average in
8 healthcare costs mainly by avoiding hospitalizations.
9 New York City has asked the State to provide 12,000
10 units of supportive housing in the five boroughs over
11 the next decade. We also oppose language in the
12 Governor's Proposed Executive Budget, which the
13 Senate and the Assembly thankfully also did reject.
14 That would require New York City to pay 50% of the
15 operating costs of units designated for people with
16 mental illness. I urge this committee to support the
17 Legislature's changes so that the City will not have
18 to cover these additional costs.
19 Tobacco control remains a priority for
20 the Department. I'm extremely concerned that the
21 smoking rate in New York City increased to 16.1% in
22 2013, bringing the total number of smokers to over
23 one million for the first time since 2007. In this
24 context, we need the State to increase its funding
25 for tobacco control from $33.1 million proposed by

the Governor. These funds support critical programs such as Nicotine Replacement Therapy and the State Quit Line, and they should not be understated.

We are pleased that the Governor has set a goal to end the AIDS epidemic. And we are proud that two of the Department's senior leaders have participated in the statewide task force charged with implementing a three-point plan to decrease new HIV infections in New York State to 750 by 2020. To date, this initiative has received a $10 million appropriation in the Fiscal Year 2016 Budget proposed by the Governor and Senate, and $11.1 million from the Assembly. I urge the committee to advocate for the Assembly's proposal in the final negotiations. And also to recognize that the need for funding is still greater. [coughs] In particular, we must support the Pre-Exposure Prophylaxis Assistance Program, known as PrEP-AP, which reimburses eligible providers for services that include HIV testing, STI and STD testing and supportive care services. How am I doing? [laughs]

It's also gratifying that for the first time the Governor's Proposed Executive Budget includes funding in the amount of $3 million for the

2 Nurse Family Partnership Program. However, because
3 the program has been so successful in improving
4 health outcomes for low-income first-time mothers and
5 their babies, while also reducing healthcare and
6 other costs, we believe the funding should be
7 increased to at last $4 million being now proposed by
8 the Assembly? The Nurse Family Partnership is a
9 voluntary evidence-based intervention that pairs new
10 mothers with registered nurses who provide individual
11 home visits from before birth through the child's
12 second birthday. The program has been shown to
13 improve pregnancy outcomes, child health and
14 development, and family economic self-sufficiency.
15 While saving New York City an average of more than
16 $10,000 per child by the time the child turns 18. I
17 want to thank the Council for supporting this
18 terrific program, and I hope you will continue to
19 advocate for additional funding.
20 Let me turn briefly to Federal Budget
21 Issues. The Department fully supports prevention
22 activities under the Prevention and Public Health
23 Fund, which finances innovative evidence-based
24 initiatives. Though the funding was maintained in
25 the most recent spending bill, at roughly $914

2 million, cuts have been proposed numerous times, and
3 protecting the fund should be a priority.
4 Preventing chronic disease in New York
5 City will save millions in future health costs.
6 Programs supported by the fund make healthier food
7 more accessible, increase physical activity, reduce
8 tobacco use, and promote breast-feeding. These are
9 health promotion strategies that can help reduce
10 racial and ethnic health disparities, and avert
11 costly medical conditions such as diabetes or heart
12 disease. For these reasons, we support funding at
13 the level of $1 billion. Another important area of
14 federal funding is emergency preparedness. The City
15 supports the President's Fiscal Year 2016 Budget
16 Request of $254.6 million for the Hospital
17 Preparedness Program, which funds areas such as
18 hospital and healthcare systems, emergency planning
19 and response. In addition, the Administration
20 supports $643.6 million for the Public Health
21 Emergency Preparedness Cooperative Agreements used
22 for detecting and responding to all hazards including
23 disease outbreaks.
24 New York City is both a gateway to this
25 nation and its largest city, it is more vulnerable to

emergencies than other cities. For example, New York City remains at risk for Ebola as a result of the West African outbreak, and it's vital that we support federal programs, which strengthen long-term public health preparedness. We rely on robust funding to build capabilities and effectively respond to health emergencies.

I would now like to highlight a few programmatic initiatives within the Department. As you know, our work has and will continue to pursue the idea that one one's chance for good health and long life should be determined by where she or he lives. Every neighborhood should be a health neighborhood. To that end, we recently solicited requests from other city agencies to participate in a project we are calling health hubs. This idea, which originated under Mayor La Guardia in the 1930s, providers physical space in seven of our district health buildings for co-location of community-based organizations, providers of medical services and other City government agencies. The aim is to move beyond the current models of collaboration, and foster cross-sector work that addresses the root causes of health inequities in communities with the

2 greatest burden of disease while building on the
3 wealth of existing assets in those neighborhoods.
4 The hubs will be overseen by the former head of our
5 Brooklyn District Public Health Office, Dr. Aletha
6 Maybank, who is now Associate Commissioner for the
7 Center for Health Equity. I created the center last
8 year to focus the Department's efforts around
9 reducing disparities.
10 Early Childhood is another department
11 priority because so many of the health outcomes we
12 seek to achieve and the disparities we want to reduce
13 can addressed in a child's first few years of life.
14 To ensure greater focus on these early years, I
15 created a new Division of Child and Family Health,
16 which includes maternal, infant and reproductive
17 health, as well as the Department's work in school
18 health. The Division is headed by Dr. George Askew
19 who previously served as the First Chief Medical
20 Officer for the Agency for Children and Families at
21 the U.S. Department for Health and Human Services.
22 I want to thank the Council again for
23 enabling us through legislation to include the Early
24 Intervention Program in this new division. This is
25 an important change that enables us to coordinate our

work with young children. And I would be remiss finally if I did not mention the initiative that consumed a great deal of the Department's energy over the last year, our response to Ebola. Fortunately, all of that work coordinated with City, State and Federal Agencies paid off. We've had no further cases of Ebola. This response was one of the finest examples of public service that I have witnessed. Yet, it's critical to remember while the patient was admitted to Bellevue Hospital in October of last year, preparedness efforts began during the summer. Months before we had a case, we addressed hospital readiness, risk communication, emergency transports. We also increased lab capacity. As a result, when our public health lab had to test for Ebola virus disease, it delivered these results in record time, just three to four hours for each of the nine tests conducted. Our Public Health Surveillance and Epidemiology staff investigated hundreds of suspect cases. We prioritize community engagement. Our community outreach teams distributed over 100,000 Am I at Risk Palm cards and spoke at over 100 public events to address the public concerns of New York City's diverse communities.

2 I want to thank the more than 1,000
3 department staff who participated in the response.
4 And particularly Dr. Jay Varma, Deputy Commissioner
5 for Disease Control, and the Incident Commander for
6 our response for his leadership and service. And I
7 also thank Marisa Raphael, our Deputy Commissioner
8 for Emergency Preparedness and Response and Deputy
9 Incident Commander who had a key role in
10 coordination. And, I want to thank you, Mr.
11 Chairman, for supporting our outreach to the West
12 African Community in Staten Island and the entire
13 Council for its recent resolution acknowledging the
14 work of this Department. And, of course, thank you
15 to our Mayor. He set an important standard by making
16 science the guidepost of our response. That's always
17 important to remember that reliable information is a
18 great anecdote during times of fear.
19 I am grateful for a City budget that
20 advances goals to protect New Yorkers preserve
21 communities and make our city healthier, and I look
22 forward to working with the Council on these
23 important priorities in the months ahead. And I
24 would be happy to answer your questions.
25

2 CHAIRPERSON JOHNSON: Thank you,
3 Commissioner. That was an amazing effort to get
4 through that testimony given your state.
5 COMMISSIONER BASSETT: [off mic]
6 CHAIRPERSON JOHNSON: No, it's okay, and
7 if you need to take a break or have someone else
8 answer questions, that's totally fine. I want to
9 just make a few comments on your testimony. I think
10 areas that we are in agreement on. You had mentioned
11 that in New York/New York III, the Governor has
12 proposed 5,000 units of supportive housing--
13 COMMISSIONER BASSETT: [off mic]
14 [interposing] Statewide.
15 CHAIRPERSON JOHNSON: -- statewide. Yes,
16 I believe only 3,900 of them would be in New York
17 City. I know the Administration has proposed 12,000
18 units in the City, and I know that advocates who have
19 worked on this for many, many years when there was
20 the original New York/New York I and New York/New
21 York II, give the crisis that we're in have proposed
22 30,000 units of supportive housing. It's my hope
23 that we can get closer to 30. Ultimately, we know
24 that this is entirely up to us, but as you mentioned,
25 really housing is healthcare. If you are not stably

2 housed, you cannot maintain a good level of health.
3 The science was clear on that. And so, we stand
4 ready to work with you all and our friends and
5 supporters in the Legislature to try to get more
6 supportive housing in New York City for people that
7 need it most. Many individuals, as you know, who are
8 currently in DHS facilities do have chronic health
9 conditioning--health conditions. Many of whom are
10 people with serious mental health issues, and we need
11 supportive housing for them. Similarly, you
12 mentioned, Commissioner, the Governor's goal to end
13 the AIDS epidemic. I'm glad he has this goal. He
14 has not done much to show what he's going to do to
15 advance the goal. The cost to end the epidemic in
16 New York City and New York State to create a single
17 point of access, and to expand HASA for all people
18 that need it who are low-income and are HIV positive
19 is somewhere around $100 million. So a $5 million
20 increase from last year is really just sort of
21 pittance when it comes to what is really needed. So
22 a year ago, he makes a big splashy announcement on
23 Gay Pride Sunday that we're going to end AIDS in New
24 York State. And we have seen no level of commitment
25 in a real and meaningful way in the State Budget.

2 Now, we have a week, and I hope that something
3 changes. But the City should not be on the hook for
4 the entire cost of trying to end the epidemic in the
5 State. And, though it is my hope that if the State
6 did put forward a meaningful amount of money, that
7 the City would match. And that we could come up with
8 a plan just like we did with renal assistance for
9 homeless families that we could do something similar
10 in the city. And I look forward to having that
11 conversation with you and with Dr. Varma and Dr.
12 Daskalakis on what we need to do moving forward
13 because this commitment is not real so far from the
14 State. And I'm terribly disappointed at what we've
15 seen so far in the budget.
16 COMMISSIONER BASSETT: Well, I appreciate
17 those remarks. As you're aware, the blueprint was
18 completed in January, and it has been submitted to
19 the Governor. It was an effort that some 40
20 stakeholder participated in, this agency, Dr. Varma
21 and Dr. Daskalakis participated similarly in that
22 effort. And I think that that is a very useful
23 product whatever happens. I can't disagree with you
24 that the--that the price tag is not in anyway met by
25 the current recommendation by the Governor.

2 CHAIRPERSON JOHNSON: I want to
3 acknowledge that we've been joined by Majority Leader
4 Van Bramer, and we're going to get to his question,
5 and also Council Member Rodriguez's question in a few
6 moments. Majority Leader Van Bramer is a member of
7 this committee. I want to just get back. There are
8 a lot of things to talk about today. I'm not going
9 to keep you all afternoon. I'm just going to try to
10 hit some key points, but as I mentioned in my
11 opening, I am really, really, really concerned that
12 the $28 million in baseline funds for Fiscal Year
13 2015, which covers things like the HIV and AIDS
14 Communities of Color Initiative that the Council
15 funded for many years. The initiative to combat
16 infant mortality in New York City. An increase of
17 funding to Callen-Lorde, all of these great things
18 that the Council had made a priority, the previous
19 Administration as a parting gift, baselined those
20 funds. Last year, we got a one-year reprieve from
21 having to go through the procurement process, to have
22 it RFP'ed and the Council then enhanced some of those
23 initiatives like the HIV Communities of Color and
24 Infant Mortality and Callen-Lorde. And there are
25 many, many others.

2 Now, the concept papers were worked on by
3 the Department, and the RFPs have gone out on some,
4 though not all of these important initiatives. It is
5 my real fear that given the procurement process we
6 could potentially go from funding hundreds of groups
7 that are doing really important work in local
8 communities across the city, to now down to just a
9 handful of groups. And as you know, Dr. Bassett,
10 last year the Federal Government there was a massive
11 cute for HIV testing. I believe it was over $7
12 million in HIV testing. Many of these groups that
13 the Council has funded year in and year out picked up
14 the slack, and have really tried to fill the void on
15 testing, but on many, many other things. So if we
16 move forward through this procurement process, and we
17 do not figure out a way to somehow fund the groups
18 that are doing the work, I believe that is a
19 significant loss of public health services in local
20 communities. That the Department relies upon, that
21 the Council relies upon, that local communities rely
22 upon. And I just want to know what your thoughts on
23 this are. It wasn't your choice. I mean it got
24 baselined in the previous administration. But I
25 think there is going to be a significant impact. And

2 it's my hope that over the next few months, we can do
3 something to try to limit the impact or fix this to
4 come up with additional monies to cover the groups
5 that were doing the work.
6 COMMISSIONER BASSETT: Thanks. I'm going
7 to start and then I'll ask Dr. Varma who changes to--
8 to add. [sic] As--as you've said, this baselining
9 occurred in the previous administration in 2013 with
10 --and what baselining funds did on the positive side
11 I think I want to point those out, is that it created
12 the possibility for multi-year funding. So by
13 enabling us to put out RFPs, we had the possibility
14 to bypass the annual designation registration
15 process, which also presented an enormous hardship to
16 many organizations. It was, despite all of our best
17 efforts between the Council and the Administration
18 there were always delays in getting worthy
19 organizations contracts registered. So that there
20 were annual delays in funding flows that were
21 disrupted, and harmful to the activities of the
22 organizations. And took a great deal of time of many
23 individuals in community-based organizations and the
24 Administration and the Council. So the--there's an
25 advantage to--to baselining the funds and releasing

2 them through the only mechanism available to us,
3 which is an RFP process. That advantage is the
4 opportunity for multi-year funding.
5 So I think that we should acknowledge
6 that that is an advantage. We released concept
7 papers in advance of--in advance of the RFPs. And
8 the purpose of a concept paper is to get some
9 feedback on what the department is planning to do.
10 The HIV RFPs have, as you've noted, have already been
11 released, the Requests for Proposals. We expect the
12 others will be released by May 15th or before then.
13 And those will be a bit longer before they're
14 released. They haven't been released yet. And we
15 had raised in some of our other comments in response
16 to the concept papers this concern that you've raised
17 about smaller organizations. And the challenge that
18 the RFP process may present to smaller organizations.
19 It's certainly something we've been talking about
20 with larger organizations, and encouraging them to
21 work with smaller organizations. And, I'll turn it
22 over to Dr. Varma to talk about how we've responded
23 to the comments in the case--this is just for the HIV
24 contracts.
25

2 COMMISSIONER VARMA: Thank you very much.
3 I'm Dr. Jay Varma. I'm the Deputy Commissioner for
4 Disease Control, and HIV and STD programs fall under
5 my division. I think Dr. Bassett has addressed many
6 of the issues. I think two specific--I think areas
7 that need to be addressed is number one is who does
8 the work, and what work gets done. Obviously because
9 its in an official procurement process we cannot, you
10 know, comment on any specific one vendor. But as Dr.
11 Bassett has mentioned that during the original
12 requests the concept paper process we received
13 comments about the importance of making sure that
14 smaller organizations did get funding. The eventual
15 RFP was then modified to include specific language to
16 encourage what we call grassroots organizations.
17 They have the ability to apply on behalf of a larger
18 organization to be the funding conduit for them. So
19 we believe that that is one way in which we will be
20 able to make sure that smaller organizations receive
21 funding. Because many of them, as you know, don't
22 necessarily have the infrastructure to file for this
23 process.
24 During the RFP comment session that we
25 held recently we received a number of positive

2 comments, you know, in the question and answer
3 session. So we believe that this process will play
4 out in a way that ensures that smaller organizations
5 do get funded. Whether all of them get funded as
6 they had in the past is obviously something we can't
7 guarantee because it's part of the technical review
8 process. But our hope is that this process will be
9 completed by June, which would then give the Council
10 the opportunity for us to discuss about designations
11 to any organizations that the Council feels are
12 worthy of funding. In terms of the work that needs
13 to get done, I do think there is also a lot of
14 concern from some of these smaller organizations. In
15 fact, many of them are pursuing sort of technical--
16 have in the past been funded for activities, what are
17 known as evidence-based interventions that are not
18 actually the current standard for what we recommend
19 and what CDC recommends. So there is also the
20 challenge of trying to make sure these organizations
21 adapt to sort of the newer approaches that we want
22 for linking people to care. We're putting heavy
23 emphasis on Pre-Exposure Prophylaxis. So again, we
24 hope that the work that gets done over time will
25 eventually be highly effective in these communities.

2 CHAIRPERSON JOHNSON: Well, you know the
3 respect that I have for you all in the Department and
4 the work that you do. I would just say that I don't
5 think that we were entirely happy with the concept
6 papers, and what was in the concept papers. And
7 things that were previously done by organizations.
8 Some of the work and the breadth of the work that was
9 done were not included in the concept papers. So you
10 have organizations, and maybe, Dr. Varma, it falls
11 under the latter part of what you just said. They
12 were not using evidence-based interventions, and you
13 are moving away from that. But this is going to have
14 a significant impact on many organizations, and Dr.
15 Bassett, I don't feel entirely comfortable or
16 confident with a master contract going out and
17 relying upon whoever is executing that master
18 contract to somehow try to include all these
19 organizations. It's really up to the person who has
20 the master contract. There's no way to force them to
21 do it. So we're relying on one organization or two
22 organizations to potentially work with 50
23 organizations or 100 organizations that do this work
24 in neighborhoods and communities across the city.
25 So, it is great that now we have a multi-year

2 commitment because the funds are baselined. But I'm
3 not sure--the devil is in the details. Because if
4 you're not getting the work in local communities
5 through the organizations that have been
6 traditionally doing the work. I would maybe rather
7 take the chance of having the Council take it on in a
8 non-baselined way. Having us then go through the
9 designation process to work with you all and your
10 organizations to figure it out. I raise all of this
11 because I believe there is still time to fix this. I
12 believe that if we put our heads together and we work
13 together with OMB and with the Deputy Mayor's Office
14 that we can-- And with the Speaker, the Finance
15 Division here at the Council that we can potentially
16 come up with a solution. The RFPs are going to go
17 out. They're going to get scored. We're going to
18 see who, in fact, is going to get those awards. When
19 we learn who gets--when we learn who gets those
20 awards, and we see who was left off, and who was not
21 able to participate in a real way, I think that we
22 all should work together to figure out a way to
23 continue to fund those groups so that we do not lose
24 those services in local communities. I feel really
25 strongly about this.

2 COMMISSIONER BASSETT: The RFP process,
3 as you know, is a competitive process in which anyone
4 can apply. I think that it's fair to say that
5 smaller organizations don't have--may not have the
6 infrastructure to compete as effectively as larger
7 organizations. But everyone has the possibility of
8 applying. And that's a mechanism, which we are bound
9 to in order to release funds. So, that is a process
10 that's underway. Thankfully, for the HIV-related
11 projects because we have an existing mechanism
12 through Public Health Solutions for our HIV awards
13 that there is no gap in funding. They're
14 anticipating the other RFPs will be related--will be
15 released later in the spring. And these we expect
16 will begin on September 1st. So that means that
17 there will be a gap between July and August. So, you
18 know, I would just caution that this is something we
19 need to look at. I think the train has left the
20 station on this with respect to-- Mr. Chairman, I
21 certainly would look forward to talking with you when
22 we have more information about which organizations
23 have been selected.
24 CHAIRPERSON JOHNSON: [interposing] Well,
25 I--

2 COMMISSIONER BASSETT: I'm sure you'll
3 understand that the agency holds and dear its
4 commitment to evidence-based approaches by using the
5 most up-to-date information that we have at our
6 disposal.
7 CHAIRPERSON JOHNSON: Well, I would just
8 go back and reiterate the fact that I'm sure if HIV
9 testing is considered an evidence-based approach. It
10 probably should be, if it's not. But many of these
11 organizations were picking up the slack on the loss
12 of funds around HIV testing. I do not believe the
13 train has left the station. We are at a Preliminary
14 Budget hearing. We are not at an Executive Budget
15 hearing. And I will spend the next weeks and months
16 advocating to the other side of City Hall that they
17 should come up with additional funds to give to the
18 Council because the budget forecasts look really good
19 right no. There's a lot of money to say enartfully
20 to play with. And if there is a significant surplus
21 and greater revenue than we expected this year, OMB
22 could say, Okay, well, $28 million we're going to
23 give that to the Council, and you can come up with
24 some new initiatives to continue some of the
25 initiatives for the organizations that potentially

2 may not be able to participate in the process. I
3 think this can be figured out. I'm not blaming you
4 all because this was done by the previous
5 administration. And, as you said, Dr. Bassett, there
6 are some upsides to the multi-year funding, and to
7 ensuring that it's going to evidence-based
8 intervention approaches. But I don't want us to look
9 at this like the train has left the station. I want
10 us to look at this like these organizations do really
11 good work, and we need to find a way to figure this
12 out. Because for many of these groups, the amount of
13 money they receive is meaningful, and it's going to
14 hurt them in a real way. So I want us to figure it
15 out.
16 COMMISSIONER BASSETT: I appreciate that,
17 and I think that Dr. Varma has made clear that we're
18 seeking ways through the RFP process to encourage the
19 participation of smaller groups and alliances and
20 others with applications.
21 CHAIRPERSON JOHNSON: But we can
22 encourage, but we can't force.
23 COMMISSIONER BASSETT: We can't tell you
24 what the outcome will be of a review process because
25 that is something that, you know, obviously would not

2 be consistent with the notion of a competitive
3 process, or where there is no foregone conclusion on
4 who will be funded and who won't be.
5 CHAIRPERSON JOHNSON: And I would just
6 add that next year, or however long you and I get to
7 work together for, that we get to work together in a
8 better way in the concept papers.
9 COMMISSIONER BASSETT: I appreciate it
10 although I would point out to you that with respect
11 that--that it is in the interest of getting comments
12 back from anyone who wishes to submit them that we
13 make comments available--the concept papers
14 available. So anyone can comment on those concept
15 papers, and give us feedback. We've notified
16 everybody who was a current awardee that the concept
17 papers were on their way, and encouraged their
18 feedback.
19 CHAIRPERSON JOHNSON: Thank you. So I
20 have--there is a lot of stuff outside of this that I
21 want to talk about. But I want to go to my
22 colleagues that have been patiently waiting. And
23 first I want to go to Council Member Rodriguez, who
24 I'm sure has some questions and the Majority Leader
25 Van Bramer.

2 COUNCIL MEMBER RODRIGUEZ: Thank you.
3 Commissioner, thank you the great--the great
4 leadership that you have as a Commissioner in this
5 important department. My first question is can we
6 agree that we live in a city that the services of New
7 Yorkers depend on what type of insurance they have?
8 [pause]
9 COMMISSIONER BASSETT: Well, as--as I
10 think the House Committee Chair had said, the devil
11 is always in the details. [coughs] I think that we
12 have the privilege of living in a city that we have a
13 very robust public health system, and public hospital
14 system, which takes everybody regardless of their
15 ability to pay.
16 COUNCIL MEMBER RODRIGUEZ: Good. Because
17 I think it's important, you know, to--especially as
18 we are getting ready to move and establish our $77
19 billion for 2016 that we'll understand the critical
20 moment where we are. Where we have hospital that,
21 you know, that they take the families who are from
22 the President or the Governor the quality of the
23 services is not the same as my mother, my father even
24 myself that has a child. [sic] So there's a lot
25 more, you know, that we need to do, and again we can-

2 -we don't have a solution to all the problems. All
3 we can do is to expand those investments, and the
4 best we can. So that the working-class New Yorkers
5 they can say-- One of my friends that whose daughter
6 suddenly has a cancer, they want to make chemo. He
7 said it was when I went to the doctor and they did a
8 test on my daughter--she went to the same school as
9 my daughter--and he said it only took me from leaving
10 the doctor's office, taking a taxi and going to my
11 house, to my apartment ten blocks away. And get a
12 phone call from the doctor to say you need to come
13 back here immediately. And because of the insurance
14 that he was able to get his daughter in the best
15 kinds of hospitals. All the services were provided.
16 The daughter survive and she's doing fine. So like
17 this--
18 COMMISSIONER BASSETT: [interposing]
19 Like we say, I believe that every individual deserves
20 the best available care regardless of their national
21 origin--
22 COUNCIL MEMBER RODRIGUEZ: [interposing]
23 So--so--
24 COMMISSIONER BASSETT: --their insurance
25 status.

2 COUNCIL MEMBER RODRIGUEZ: Now, on--on--
3 and again like I'm--I'm-- I believe that we are
4 doing good, but looking forward to the future
5 generation we know that now there's like the genetic
6 tests that, you know, if people can afford and pay,
7 they can take child and they can have some idea of
8 the potential illness that that individual can have
9 in the future. How can we make those types tests
10 also affordable to the working class?
11 COMMISSIONER BASSETT: I think the first
12 part of your observation, first I would stipulate
13 with you that health status does vary by whether or
14 not a person is poor. You know, I'm poor that the
15 wealthiest in our society in general have better
16 health and longer lives than the poor. And that, of
17 course, is not only due to access to healthcare.
18 It's due to many other factors that have to do with
19 some of the other things we've discussed. The non-
20 medical factors, the food we eat, the jobs we have,
21 the housing that's available to us. All of those
22 also have a bearing on health status. Not only
23 access to medical care. That said, and anyone who
24 needs medical care I couldn't agree with you more,
25

should have access to the best quality medical care available.

And your question about genetic testing, this is a whole and personalize medicine. This is a whole area that is emerging, which I think in terms of the health of the population the jury is still out. So I can't really tell you which one of these tests are ones that ought to be covered by health insurance policies of all sorts. But, you know, I understand that the general principles that you're advocating for is that people get the highest quality healthcare that's available regardless of their ability to pay. And I fully endorse that belief.

COUNCIL MEMBER RODRIGUEZ: At the local-- Well, before we get into a question, at the local level in Northern Manhattan, I have one question about how much--how much is the Department--does the Department get enough funding or will get in your understanding 2016 to have the men and woman power to do enforcement on those business establishments that they are not following up the No Smoking Policy that we have in there, and what you also play a great leadership in that initiative.

COMMISSIONER BASSETT: [off mic] Well, the whole [on mic] question of how we enforce smoking policies is an important one to ask. And these are largely self-enforcing policies. Ones, which are enforced by all of us here. When we walk in a park and someone is smoking, I would encourage everybody here to say, By the way, smoking is not allowed here. Not on a beach. Not in a park. And I think--I don't know when any of us last saw somebody smoking in a restaurant. Everybody it's really been--become a social norm that on one expects that anyone will light up a cigarette in a restaurant or a bar. So these are policies that are largely self-enforcing. Not ones that we send people out, and we check mainly on after hours smoking. And, we do check--we do check bars for smoking, and I think that we're doing very well in ensuring that these are smoke-free locations. And the best enforcers of this are the general public who are-- Remember, the vast majority of adults don't smoke. Don't want to come back from being out at night smelling like cigarettes, and they tell other people not to smoke.

COUNCIL MEMBER RODRIGUEZ: Okay. Recently you did a great operation where you were--

2 COMMISSIONER BASSETT: The Hookahs.

3 COUNCIL MEMBER RODRIGUEZ: Yeah, the

4 Hookahs.

5 COMMISSIONER BASSETT: Yes.

6 COUNCIL MEMBER RODRIGUEZ: I told my

7 colleagues and everyone they should know that all the

8 research says that using 40 minutes of Hookahs is

9 equal of that to 100 cigarettes. So I think that I

10 do believe in the individual private--the decision,

11 but, you know, when people don't know those

12 information it's very clear that they don't know that

13 that's happening. For me it's about--do you have--

14 When you look at this budget, do you feel that you

15 have enough funding for the unit that you have doing

16 enforcement, or do you think that you need more in

17 order to be able that you have what you need to

18 institute it?

19 COMMISSIONER BASSETT: I'm satisfied

20 with our funding.

21 COUNCIL MEMBER RODRIGUEZ: You're

22 satisfied with it. My last question is at the local

23 level. As you know, we have a building at 600 West

24 168th Street. It's at the corner of 168 and

25 Broadway. In the past, when Columbia didn't have

2 much space, there was an agreement with the City--
3 that Columbia had with the City for them to use that
4 space. However, today, you know, Columbia has been
5 doing great. They've been doing much better. They
6 have another space, and I believe that that
7 particular building should be used as a health hub in
8 our community. Because, you know, even though in the
9 past up until recently people live in Northern
10 Manhattan and have more than 200 residents
11 communities, they were going to Harlem or Washington
12 [sic] to get some services. How can we--how is that
13 building being used, and how can we working with you
14 use that building to do more prevention on obesity
15 since one of five residents in Northern Manhattan are
16 obese? It's a big crisis that we're facing right
17 now, and this is one of the areas that we want to be
18 working with you. How are we using that building?
19 How can work so that the Department of Health can use
20 it as a health hub?
21 COMMISSIONER BASSETT: Thanks for that
22 question and for the opportunity to talk about health
23 hubs, which are basically building on our assets in
24 many poor neighborhood, which are--labor under an
25 excess disease burden. We have building, district

2 health centers. You mentioned one that is on 168th
3 and Broadway. That actually isn't one that we made--
4 that we included in our requests for expressions of
5 interest recently. But it is one of the district
6 health centers that the Department has. The history
7 of this one is a little--is a little complicated and
8 I'm going to ask our Deputy Commissioner for
9 Administration to explain it to you. This is a
10 building where the Health Department and Columbia
11 University School of Public Health began jointly
12 offering public health services in midst of time.
13 These buildings were built in the 1930s. So, my
14 understanding of it is that we have the right of
15 occupancy to that building unless we give it up. And
16 I'll ask Julie Friesen if you can introduce yourself
17 and answer [off mic] and answer the Councilman's
18 questions.
19 DEPUTY COMMISSIONER FRIESEN: Yes. Good
20 afternoon, my name is Julie Friesen. I'm the Deputy
21 Commissioner of Administration with the Health
22 Department and I oversee facilities in that capacity.
23 So, this building we actually have an arrangement, an
24 agreement with Columbia University that dates back to
25 1937 where we can occupy it as a district teaching

2 facility for as long as we wish until we not longer--
3 if we no longer wish to occupy it, it reverts back to
4 Columbia University. So you asked what the building
5 is being used for now. We are in there. We have a
6 TB Clinc, HHC has a Pediatric Clinic, and Columbia
7 University uses a number of floors, almost half the
8 building for the School of Public Health.
9 COUNCIL MEMBER RODRIGUEZ: [off mic]
10 CHAIRPERSON JOHNSON: If you could turn
11 your mic on.
12 COUNCIL MEMBER RODRIGUEZ: I would like
13 to, you know, see how we can get a copy of that
14 document of that agreement.
15 DEPUTY COMMISSIONER FRIESEN:
16 [interposing] Yes, you can.
17 COUNCIL MEMBER RODRIGUEZ: I look at
18 Columbia as a great partner. They just yesterday
19 announced a plan to rezone 100 acres, and the focus
20 of that rezoning is going to be on tech and health.
21 And we know that Columbia is a very important partner
22 for that. But not seeing an--and expansion of
23 Columbia and their facility in my community, no doubt
24 that that building could be better used right now if
25 it is used and run by the Department of Health. What

2 we have seen is a reduction of services in that
3 building. And I believe that---and that's what
4 believe that all agencies should follow Sal Grant
5 [sic] as he opens his satellite office in Northern
6 Manhattan. He became the first one that did it, and
7 I believe that the need is there in Northern
8 Manhattan for us to continue expanding more
9 departments that build satellite offices. So I just
10 hope that we can continue conversations to see how
11 the city take full control of that building.
12 DEPUTY COMMISSIONER FRIESEN: Yes.
13 CHAIRPERSON JOHNSON: Thank you. Thank
14 you, Council Member. Majority Leader Van Bramer.
15 COUNCIL MEMBER VAN BRAMER: Thank you
16 very much, Mr. Chair, and thank you for your
17 leadership on this issue. Commissioner, it's a
18 pleasure to hear your testimony, and if I may say, I
19 believe you're getting stronger as the day goes on.
20 I also want to say, as the person who represents Long
21 Island City, I feel a special bond with all of you
22 since all of you spend a lot of time in my district
23 whether you live there or not. And I hope Queens
24 Plaza is treating you all well.
25

2 I wanted to ask you about some of the
3 metrics that I see and hear. Obviously, as a member
4 of this committee, but particularly as a gay man, I
5 watch very closely your work on HIV/AIDS. And I'm a
6 big supporter of PrEP, and I want to thank Dr. Varma
7 and Dr. Daskalakis for their work. But a few things
8 that I notice, and I guess I want to ask your
9 thoughts and maybe Dr. Varma on the relationship
10 between them.
11 But as PrEP we hope becomes more widely
12 available, and more widely recommended by doctors and
13 used by MSMs. And your own data and the PMMR shows
14 condon use a slight decrease. And then Syphilis on
15 the increase. And what is the relationship, and how
16 do we get into this place where we're both increasing
17 and promoting PrEP, and then maybe seeing a causal
18 relationship between condom use. But then also
19 seeing increases in other STDs. And how do you get
20 at that as a department as your unit, Dr. Daskalakis'
21 work to make sure that the overall health picture is
22 one that is good, and getting better. And not only
23 related to exposure, and preservation of HIV?
24 DEPUTY COMMISSIONER VARMA: Okay. Thank
25 you very much for your question. So let me try to

2 touch on a few things. So, yes, we are very
3 interested in promoting new approaches to the
4 prevention of HIV. We know that condoms are highly
5 effective when used consistently and correctly. And
6 we believe that the widespread availability of
7 condoms through our NYC Condom Program has had a
8 substantial impact on preventing increase in HIV
9 infection. But we are also very well aware of the
10 fact that new tools need to be used. Different
11 approaches work better for different people. And so
12 we are working very actively on the promotion of Pre-
13 Exposure Prophylaxis. We've visited hundreds of
14 physicians' offices around the city. We prioritized
15 those places based on diagnoses of STDs in those
16 communities, as well as, you know, the volume of
17 patients that they see. And we hope over time to
18 continue expand that. A lot of physicians who
19 specialize in men's health have really been focused
20 on HIV, and no so much on HIV uninfected me. And so,
21 this is an important transition for them to increase
22 that. You are well correct that one of the issues we
23 don't know about is whether or not expanded use of
24 medicines to prevent HIV infection will reduce condom
25 use. We know in the clinical trials that this has

2 not been seen. But whether or not it plays out in
3 real life is a different issue. And Syphilis is also
4 an infectious disease that predominantly infects--
5 affects men who have sex with men in New York City.
6 And so, yes, it is very possible for an expansion of
7 one method of HIV prevention to have a negative
8 consequence. We don't if that's going to happen.
9 The evidence to date indicates that it's not, but
10 it's something we're very well aware about. So I
11 think our responsiveness has been focused primarily
12 on continuing to make condoms available. There was a
13 slight dip in the number we distributed, but not
14 really in terms of availability. A lot of facilities
15 stockpiled them. So there really has been no
16 reduction in availability, and we know that from our
17 site visits. We're being very aggressive in our STD
18 program about linking together. STD infection
19 treatment and HIV linkage to care, and for people who
20 are HIV uninfected getting them linked into PrEP. So
21 trying to make sure that all health issues for men
22 are addressed in those--in the people that come to
23 those types of settings. And then I think the last
24 thing is really an issue that's very near and dear
25 obviously to the Commissioner and everybody else is

2 the issue of health disparities. And we know that
3 young men or men who have sex with men have a number
4 of health disparities beyond just STDs and HIV,
5 although those, I think, are the most acute and
6 pressing problems. So we have been working very hard
7 to expand the education or providers around the city
8 as it relates to the health of men who have sex with
9 me. And that includes being vigilant for STD use--
10 doing HIV prevention, but also focusing on a number
11 areas--other areas, mental health, substance abuse
12 and other issues. So I hope that addresses your
13 issues. Feel free to ask additional questions, if
14 you didn't get it.
15 COUNCIL MEMBER VAN BRAMER: Thank you.
16 No, it was--it was great, and so if the increase in
17 Syphilis cannot at this point be tied to PrEP use or
18 what you're seeing is a noticeable decrease in condom
19 use, even though the distribution is slightly down, I
20 get that they're all over. You know, it's been a
21 multi-year process. Then, where are we seeing it?
22 Why are seeing it and a fairly large increase last
23 year, an increase over the first four months of this.
24 How do we get to it?
25 COMMISSIONER BASSETT: Of Syphilis?

COUNCIL MEMBER VAN BRAMER: Yeah.

COMMISSIONER BASSETT: Because the main way that we understand condom use is by surveys, not by the distribution numbers. Not by the numbers within that. [sic]

COMMISSIONER VARMA: Yeah, to emphasize that point, condom use has been stable. We do surveys of different populations and, you know, the--there are--it's obviously challenging to measure it. It requires some self-reporting, but we usually among people we consider high risk or whichever, we ask about condom use at the last, you know, anal intercourse. And that has been very stable. So we don't think condom use has changed. Syphilis is a very complex problem because what you see over time is variations in incidents rate that don't necessarily correlate directly with the amount of money we put into Syphilis. There is a tremendous amount of investment made at the national level to eliminate Syphilis in the late '80s--late '90s and early 2000s. And paradoxically over time there's been an increase particularly among men who have sex with men. So it is a problem that we are trying to address aggressively through our sort of standard

2 measures. Which is, you know, finding cases, tracing
3 contacts around them, and getting people treated. I
4 think one of the biggest challenges we face is that,
5 you know, the anonymity of sex. You know, people
6 meet each other in the virtual world, and our efforts
7 at contract tracing are not particularly successful.
8 We are using Internet search grooves. We are trying
9 to find contacts over the Internet. But to be quite
10 honest, we haven't found methods that are fully
11 adaptable to the way in which people meet their
12 parents today. And so, it is a problem that we're
13 trying to do what we can to treat.
14 COUNCIL MEMBER VAN BRAMER: Thank you for
15 that, and obviously while we--we must continue to see
16 rates go down and--and we're all working towards
17 that. I do want to say thank you because the--having
18 met with Dr. Daskalakis, and seeing all of your work,
19 I'm very, very please to see sort of the overall
20 approach to wellness for MSMs in gay and bisexual
21 men. And I know that Dr. Daskalakis said to me that,
22 you know, when someone tests for HIV and when they
23 get the results whether it's positive or negative,
24 that's just the beginning of the approach to
25 wellness, right, and the discussion that follows.

2 Whereas, in the past in terms of the negative
3 results, it was like you're okay. Now go. It's that
4 point sort of intervention, and wellness. And I also
5 just want to say you have a- you have a texting
6 function. And I and Dr. Daskalakis and a presentation
7 in Brooklyn once and I signed up for it. Because he
8 said you--you should sign up for it. And I forget
9 the name. You all know the exact name of it, and I
10 still get messages. I find that every once in a
11 while I have a doctor say thank God I have good
12 healthcare and good health. But I'm wildly impressed
13 with it, that it keeps checking in on me, and asking
14 if everything is okay. And I probably should not
15 subscribe, but it's great.
16 DEPUTY COMMISSIONER VARMA: I--I'm HIV
17 negative, but I get text messages from it, too. So I
18 know it works well. [laughs] So, thank you very
19 much for your work and thank you, Chair Johnson.
20 CHAIRPERSON JOHNSON: Thank you. I want
21 to get back to health clinics, and also the health
22 hubs. So the Preliminary Budget includes new
23 spending of $8.2 million to support the expansion of
24 six clinics. How will the Department choose the six
25 clinics to support for expansion, and what areas is

2 the Department looking to have these clinics service?
3 And is their capital funding tied to the expansion?
4 I'll also mention that we've been joined by Council
5 Member Mathieu Eugene.
6 COMMISSIONER BASSETT: Thank you. I'll
7 start and then I'll ask Dr. Barbot to-- Oh, goodness.
8 I apologize.
9 CHAIRPERSON JOHNSON: Okay. Well, we
10 should, doctor.
11 COMMISSIONER BASSETT: [laughs] Do you
12 want to start then or not?
13 DEPUTY COMMISSIONER BARBOT: Sure. So,
14 there are--
15 CHAIRPERSON JOHNSON: [interposing] If
16 you could just introduce yourself.
17 DEPUTY COMMISSIONER BARBOT: I'm Dr.
18 Oxiris Barbot. I'm the First Deputy Commissioner at
19 the Health Department. We have a request for
20 expressions of the interest for seven health hubs,
21 and in that RFEI, we have listed out the various
22 communities, and buildings that we are looking to
23 develop as health hubs. The clinic expansions that
24 will be taking place, there may be clinical services
25 within those health hubs. But there may also be

2 other buildings yet to be determined that would be
3 utilized for the delivery of health services. The
4 Health Department in and of itself will not be
5 delivering clinical services. We are looking to
6 partner with federally qualified health centers with
7 Health and Hospital Corporation. The idea being to
8 create areas--geographic areas in communities that
9 are identified as health promoting spaces that co-
10 locate both clinical services as well as mental
11 health services. In addition, co-locate services
12 that help to address what the Commissioner referred
13 to earlier as the underlying social determinants of
14 health. So bringing together organizations that can
15 provide let's say for example support in housing.
16 Support in other areas to allow residents of
17 particular communities to really improve their health
18 and wellness overall.
19 CHAIRPERSON JOHNSON: So how will the
20 neighborhood health hubs interface with HHC federally
21 qualified health centers, and other community-based
22 organizations?
23 COMMISSIONER BASSETT: There are sort of
24 two parallel concepts here. One is the expansion to
25 primary healthcare services something is--that is--

that is assessed as needed in this city. And there are areas, which Chakanis [sp?] has identified as areas that are particularly in the primary healthcare services. To this, the Health Department brings an asset, it's District Health Centers, which in the past have had such health services, and which in the future may--Our hope is that they will continue to have these services on site. The process whereby these six clinics noted in the budget will be identified and selected is still being sorted out. The funds for it are--are op-- I'm not--I'm going to try and get the word right. It's really Operational Budget, right? Operating Budget. The idea is that--that they would help with whatever entities, federally qualified health centers. And as you know, FQ--the HHC has recently been--had it's Gotham House designated as an FQHC look-alike so that these would have some initial capital to get them up and running, then they would become self-financing in the space. So there are--there are various city properties that might be used, the Health Department's being--being one of them.

2 CHAIRPERSON JOHNSON: So, Commissioner,
3 are you saying that there non-DOHMH clinics that
4 potentially could be chosen--
5 COMMISSIONER BASSETT: We--we only-
6 CHAIRPERSON JOHNSON: [interposing] --on
7 HHC?
8 COMMISSIONER BASSETT: Yeah, the answer
9 to that is yes, but what I possibly have not made
10 clear, although I think Dr. Barbot made it--made it
11 clear is that our--we would not be directly
12 delivering primary healthcare services. We would
13 seek to partner with others, and offer up the city
14 space for such services. At present, we have child
15 immunization clinics, but that--
16 CHAIRPERSON JOHNSON: [interposing] But
17 non-HHCs, FQHCs are eligible for the expansion?
18 COMMISSIONER BASSETT: The process is
19 still being sorted out.
20 CHAIRPERSON JOHNSON: So--
21 COMMISSIONER BASSETT: I can't tell you
22 what the answer is.
23 CHAIRPERSON JOHNSON: [interposing] So
24 who's determining that process?
25

COMMISSIONER BASSETT: They're still discussing it.

CHAIRPERSON JOHNSON: But who's in charge of determining the process, the Department is?

COMMISSIONER BASSETT: Right--right now we are--the--the funds sit in our budget, but we're still working on how--what process--what the process would be to--to--yeah.

DEPUTY COMMISSIONER BARBOT: So there's two distinct processes going on at the same time. One is the health hub development, and through that development Article 28's FQHCs, HHC will be available to eligible to apply to apply use space for clinical delivery service. Separate and distinct from that is the process that's going on with regards to this clinic expansion. And so, while there may be some new clinical services delivered in health hubs, the two are distinct.

CHAIRPERSON JOHNSON: But was the RFEI amended to include Article 31s as well?

DEPUTY COMMISSIONER BARBOT: ?As well, yes.

CHAIRPERSON JOHNSON: So when is the process going to be determined? When are you going to have--?

COMMISSIONER BASSETT: The Administration is still working it out. [coughs]

CHAIRPERSON JOHNSON: Okay. Well, this is really important to me, and I know it's important to you as well, and I think it's not entirely mirrored after the Center for Health Equity, but in some ways to create these health hubs in communities that need it most to fight disparities is a really exciting thing. And one that I hope will be open to a multiplicity of providers, and folks that are doing this type of work.

COMMISSIONER BASSETT: The RFEI that was opened--

CHAIRPERSON JOHNSON: [interposing] Allows for that.

COMMISSIONER BASSETT: --if anyone--it allows for that.

CHAIRPERSON JOHNSON: Okay. I want to. So is there any capital funding tied to any of this?

2 COMMISSIONER BASSETT: The--the capital
3 funding for which one? Which one--which one are we
4 talking about? [laughs]
5 CHAIRPERSON JOHNSON: For the--
6 COMMISSIONER BASSETT: [interposing] For
7 the 8.2 and the--?
8 CHAIRPERSON JOHNSON: Yes
9 COMMISSIONER BASSETT: --the--that's all
10 Operating Budget.
11 CHAIRPERSON JOHNSON: That's all
12 operating for the--for the clinic expansion--
13 COMMISSIONER BASSETT: [interposing]
14 Operating capital.
15 CHAIRPERSON JOHNSON: For the clinic
16 expansion, not the hubs, but the clinic expansion
17 that is operating dollars and not capital dollars?
18 DEPUTY COMMISSIONER BARBOT: Yes.
19 COMMISSIONER BASSETT: Correct.
20 CHAIRPERSON JOHNSON: And for the health
21 hubs, the RFEI that went out, is there going to be
22 any city or department capital funds tied to that?
23 COMMISSIONER BASSETT: We have some
24 capital funding allocated for that.
25 CHAIRPERSON JOHNSON: How much?

COMMISSIONER BASSETT: We'll have to get back to you.

[pause]

CHAIRPERSON JOHNSON: And that is by building? [sic] What did you say?

COMMISSIONER BASSETT: By building?

CHAIRPERSON JOHNSON: Yes, please.

COMMISSIONER BASSETT: Sure.

CHAIRPERSON JOHNSON: Thank you. So I--I want to jump to an issue that I know we've talked a bunch about, Commissioner. I know I raised it when you and Dr. Belkin testified last week at the Mental Health Preliminary Budget hearing. And it is the situation on Rikers Island. I just want to maybe reiterate some of the things we talked about, but also ask some questions that I didn't have the opportunity to ask last week. So, how much of the Bureau of Correctional Health Services of the proposed $190 million OTPS Budget is allocated for Corizon? Do you know? There's $190 million.

COMMISSIONER BASSETT: I believe the Corizon budget is about $140 million.

CHAIRPERSON JOHNSON: $40 million per year?

2 COMMISSIONER BASSETT: $140.
3 CHAIRPERSON JOHNSON: And aside for the
4 funding earmarked for--
5 COMMISSIONER BASSETT: $145.
6 CHAIRPERSON JOHNSON: $145? For this
7 year?
8 COMMISSIONER BASSETT: For this year.
9 CHAIRPERSON JOHNSON: The total three-
10 year budget is over $400 million for Corizon. Aside
11 from the funding earmarked for correctional services,
12 how much more or less is the budget for the Corizon
13 from Fiscal 2015 to Fiscal Year 2016? Is it $145 for
14 both years or is there an increase?
15 COMMISSIONER BASSETT: It was slight--
16 DEPUTY COMMISSIONER BARBOT: [off mic]
17 Slight increase.
18 COMMISSIONER BASSETT: A slight increase.
19 CHAIRPERSON JOHNSON: Why is that?
20 COMMISSIONER BASSETT: New needs.
21 CHAIRPERSON JOHNSON: What are the new
22 needs?
23 COMMISSIONER BASSETT: I know that we're
24 providing--we're providing healthcare services to
25

2 additional special units on Rikers, the enhanced
3 supervision housing units.
4 CHAIRPERSON JOHNSON: I just want to just
5 try to be clear on the enhanced. I know you're not
6 the Department of Corrections, but I want to just
7 have an understanding.
8 COMMISSIONER BASSETT: I'm not the
9 Department of Corrections.
10 CHAIRPERSON JOHNSON: I know that.
11 Sometimes I wish you were. I want to just a question
12 about these new enhanced supervision units that were
13 created. I know the Board of Corrections voted on
14 this, and I think it was tied to the elimination of
15 punitive segregation and solitary confinement for 16
16 and 17-year-olds on Rikers Island. This enhanced
17 unit, someone can be put in this unit for 17 hours a
18 day without any contact with anyone else for not--
19 for--for no infraction. Haven't done anything wrong.
20 COMMISSIONER BASSETT: That is correct.
21 This is a non-punitive unit.
22 CHAIRPERSON JOHNSON: It's a non-punitive
23 unit you said?
24 COMMISSIONER BASSETT: Correct.
25

CHAIRPERSON JOHNSON: But they're being treated punitively. They're being put for 17 hours a day in this type of cell and they haven't broken any rules. They've done nothing wrong.

COMMISSIONER BASSETT: That this is a non-punitive unit. The people who will be placed there will be placed there according to an assessment of their potential.

CHAIRPERSON JOHNSON: It sounds like a punitive assessment.

COMMISSIONER BASSETT: They will be based on the things that they've done in the past, or attributes. For example, gang membership that had been determined about them. Their potential--they will be considered people that are potentially violent and, therefore, will be in need of this--this enhanced supervision.

CHAIRPERSON JOHNSON: And what do we know from an epidemiological standpoint, from a medical standpoint about what solitary confinement, what punitive segregation does to an individual that may not have mental health issues, or may have mental health issues? Is it--right now does the

2 epidemiology say that it potentially exacerbates
3 one's mental illness?
4 COMMISSIONER BASSETT: No. I'm going to
5 ask Dr. Angel who has joined us to speak more to
6 this. But, as you know, the Department has really
7 used data to look at the sets--settings and their
8 relationship to violence--violence in three
9 categories: Inmate on inmate violence; inmate on
10 guard or correctional officer violence; and self-
11 harm. And the data that had been collected on
12 solitary confinement and self-hard were very
13 worrying, suggesting in particular that very young
14 people, adolescents 16 and 17-year-olds as well as
15 people with mental health issues had a particularly
16 high risk for self-harm. Six or seven fold higher
17 than others. Our data supports the notion that
18 therapeutic settings are--support the best outcomes.
19 CHAIRPERSON JOHNSON: Like caps and base?
20 [sic]
21 COMMISSIONER BASSETT: Correct.
22 CHAIRPERSON JOHNSON: Before we go to Dr.
23 Angel, I have just one more thing.
24 COMMISSIONER BASSETT: Okay.
25

2 CHAIRPERSON JOHNSON: Just one more
3 thing. I wonder if Dr. Angel can answer this. She
4 may know. Was the Department involved in making the
5 determination that these enhances supervision units
6 were the best course of action, or was that a DOC
7 decision? I know it was a Board of Health decisions,
8 but it was proposed by the Department of Corrections.
9 COMMISSIONER BASSETT: This is a security
10 matter.
11 CHAIRPERSON JOHNSON: A security matter,
12 not a health matter.
13 COMMISSIONER BASSETT: Correct. Not a
14 health matter.
15 CHAIRPERSON JOHNSON: Great.
16 COMMISSIONER BASSETT: But as you're
17 aware, we have been given additional funding to--
18 Because providing services on these units creates
19 certain challenges. People even though they're
20 there, [sic] don't have that much out-of-cell time.
21 Because only half of them will be released from
22 their--from their cells at any given time. That
23 means that we have to--had to have additional
24 staffing in order to meet the service needs of this
25 population.

2 CHAIRPERSON JOHNSON: It's a--that's--
3 that's it? Okay. So I just want to--want to ask
4 about discharge planning, but before I say that I
5 mean I thought we had a very good hearing. Again, I
6 want to say I'm grateful for Dr. Angela and Dr.
7 Venters for being at the oversight hearing we had on
8 Corizon. And what was happening on Rikers Island
9 with regard to healthcare services both from a mental
10 health perspective, and just a health perspective
11 generally. I won't read the really awful and
12 gruesome reports to what has happened to I believe 12
13 inmates in the lat five years. But, I think Bradley
14 Baird is probably one the, you know, most upsetting
15 examples of what happened on the island. But the
16 list goes on and on of people dying from not getting
17 insulin to people causing self-harm, and not getting
18 the help that they need. And after that hearing, I
19 do not have really any confidence in Corizon from
20 anything they said to change course, and to do things
21 better.
22 During their testimony they didn't even
23 acknowledge the 12 deaths that occurred. It was
24 offensive, and it was wrong. And I know that the
25 City, DOHMH, DOC, OMB, the Mayor's Office, the

Mayor's Office on Criminal Justice, and other players are determining how to best move forward when this contract is up for renewal or expiration on December 31st of this year. I know that it's challenging to get a provider to come in and do these difficult services on Rikers Island. And I know that in the past when much fewer other folks participated, they may not want to do that any more because of the obstacles that are involved. But I just want to make the point that if this contract gets extended with Corizon, it must be renegotiated so that there is not an indemnification clause where the city is paying when people are dying at Corizon's fault, and we're picking up the cost of it. There needs to be greater performance indicators involved to understand what outcomes they're actually achieving.

And we need to have better understanding of how and why they are doing things. And so, I know that your department is not the sole player her in determining how things move forward. But, from a health perspective given that these things are happened, and we've had these tragic preventable deaths, it's my hope that-- First of all, I hope the contract doesn't get renewed. But if it does, I think

2 that we need to renegotiate the contract and change
3 some of the terms, and conditions of the contract so
4 that there is more accountability involved. And I
5 just wanted to make that point. On discharge
6 planning, the Preliminary Budget included new
7 spending of $1.7 million to expand discharge planning
8 for individuals leaving Rikers Island. If you could
9 please give us the numbers, Dr. Angel on how many
10 individuals currently receive discharge planning, and
11 how many individuals will this now cover with the new
12 money for expanded discharge planning on the Island?
13 DEPUTY COMMISSIONER ANGELL: Sure.
14 Absolutely, and to introduce myself, I'm Dr. Sonia
15 Angell. I'm the Deputy Commissioner of the Division
16 of Prevention and Primary Care. With respect to the
17 number of--at the expansion of Discharge Planning
18 Services these resources are focused on non-Brad H.
19 [sic] patients. So they are really going to expand
20 opportunities beyond which we are currently focused.
21 Currently, we provide discharge planning for certain
22 subgroups including those with HIV, some small
23 proportion with substance use. But we really want
24 and we need to expand that proportion also to include
25 and capture those vulnerable patients that leaving

also with chronic diseases such as diabetes and Hepatitis-C. Currently, these non-Brad H. discharge-planning recipients total about 4,000. And we are going to basically double that to an additional 4,000.

CHAIRPERSON JOHNSON: Give me the number again. I'm sorry.

DEPUTY COMMISSIONER ANGELL: They're currently at 4,000. We'll be expanding it to an additional 4,000 of Non-Brad H.

CHAIRPERSON JOHNSON: Non-Brad H.?

DEPUTY COMMISSIONER ANGELL: So I'm focusing only on Non-Brad H.

CHAIRPERSON JOHNSON: So that's going to--

DEPUTY COMMISSIONER ANGELL: [interposing] So, sorry. Excuse me. So the Brad H.--

CHAIRPERSON JOHNSON: [interposing] They are people with mental health diagnoses.

DEPUTY COMMISSIONER ANGELL: Are diagnosed within the Mental Health system and those currently we have a very, as you probably know, a very extensive process of providing and targeting that population. Not only because of the Brad H.

2 stipulations, which require us to report, but
3 because, of course, this is a remarkably vulnerable
4 population that definitely needs those services to be
5 able to make the transition into the community in a
6 way that allows them to remain in the community, and
7 hopefully improve their health trajectory.
8 CHAIRPERSON JOHNSON: So Non-Brad H. from
9 4,000 to 8,000?
10 DEPUTY COMMISSIONER ANGELL: That's
11 correct. Yeah.
12 CHAIRPERSON JOHNSON: But that's only
13 really a drop in the bucket with regard to the total
14 number of people that come through Rikers Island?
15 DEPUTY COMMISSIONER ANGELL: Yes, we
16 would absolutely acknowledge that. Ideally, one
17 would expand these services to the entire population
18 at large. But there are resource limitations. So the
19 way in which we have really thoughtfully gone through
20 this process is to identify cohorts of populations.
21 Those that we see beyond the mental health population
22 that really do need those services most immediately.
23 CHAIRPERSON JOHNSON: Which cohorts?
24 DEPUTY COMMISSIONER ANGELL: So for the
25 example that I'm giving we're expanding here. It

includes those with substance use disorders, and also those with chronic illnesses. And we're very hopeful certainly with this--these new opportunities in electronic communications. Health homes as they get up and running that this will become more and more efficient. It will be something that will be easier and less costly to be expanded. But given the limited resources we have, we need to do this in a very methodical way.

CHAIRPERSON JOHNSON: The number of people that came through Rikers Island last year was over 70,000?

DEPUTY COMMISSIONER ANGELL: That's correct.

CHAIRPERSON JOHNSON: And so, right now if we are able to expand to around 8,000 for discharge planning, we're hitting a little more than 10% of the population.

DEPUTY COMMISSIONER ANGELL: So then recall that the Brad H. are already hit. So they're about--

CHAIRPERSON JOHNSON: [interposing] Okay.

DEPUTY COMMISSIONER ANGELL: --20% so about of that population is already receiving

2 discharge-planning services, and we're adding an
3 additional 8,000.
4 CHAIRPERSON JOHNSON: So if you take the
5 number of Brad H. plus the 8,000, what's the number?
6 DEPUTY COMMISSIONER ANGELL: [off mic]
7 20--what's the exact number?
8 CHAIRPERSON JOHNSON: Does Dr. Venters--
9 DEPUTY COMMISSIONER ANGELL: 30,000.
10 CHAIRPERSON JOHNSON: [interposing]
11 30,000.
12 DEPUTY COMMISSIONER ANGELL: Yeah.
13 CHAIRPERSON JOHNSON: So we're getting
14 30,000 out of over 70,000?
15 DEPUTY COMMISSIONER ANGELL: That's
16 right.
17 CHAIRPERSON JOHNSON: So, we're a little
18 less than 50%.
19 DEPUTY COMMISSIONER ANGELL: That's
20 correct.
21 CHAIRPERSON JOHNSON: So I would love to-
22 -it's good, but I would love to work with you all so
23 that next year we can expand it even further. We
24 know that discharge planning works. It makes a
25 difference, and many of the cohorts-- Are one of the

2 cohorts what are called-- This isn't the most
3 articulate term. I think it's used by other folks,
4 frequent flyers? You know, people that are coming to
5 Rikers quite a bit? Is that cohort part of discharge
6 planning?
7 DEPUTY COMMISSIONER ANGELL: Let me ask
8 Dr. Venters to provide a specific answer to that
9 question.
10 CHAIRPERSON JOHNSON:
11 DEPUTY COMMISSIONER ANGELL:
12 ASSISTANT COMMISSIONER VENTERS: Hi,
13 Homer Venters, Assistant Commissioner of Correctional
14 Health. So, paradoxically, the people who come to
15 jail most frequently spend the least amount of time
16 there. So it's very hard for us to do discharge
17 planning efforts for people that are in jail for 48
18 hours. We need to see them, hook them up with
19 providers in the community. So the people who come
20 to jail who we know, we do make efforts to connect
21 them back to care. But for people who are in jail
22 less than 10 days, which is the median length of
23 stay, it's actually quite challenging. That's why
24 we've asked for the new funding for the Substance
25 Abuse expansion, the money that Dr. Angell just

2 referenced. So that we can think about innovative
3 ways to connect people with relatively light touches.
4 So that we don't do that--we may not have the time to
5 do comprehensive discharge planning efforts for
6 everybody. And so, that's our next step for this
7 funding to figure out the people who have quite a few
8 needs, but who we don't see for very long, how do we
9 connect them back to their care in the community
10 CHAIRPERSON JOHNSON: What's the total
11 number of people with substance abuse problems? If
12 we're hitting 8,000, and then we have part of that
13 8,000 over the cohort of substance abuse, what
14 number?
15 ASSISTANT COMMISSIONER VENTERS: So just
16 the people who tell us that they have a substance
17 abuse concern, and we talk to them about it. It's
18 about 45% of the people who come into the jails.
19 Really, we think it's much higher. It's about 70% of
20 people we think of people we think who come through
21 the jails who have a substance abuse concern.
22 CHAIRPERSON JOHNSON: So we need a
23 significant amount of money to expand all the folks
24 that would need to be covered under the substance
25 abuse cohort?

2 ASSISTANT COMMISSIONER VENTERS: And/or
3 think about alternative dispositions than sending
4 them to jail.
5 CHAIRPERSON JOHNSON: Exactly. That's
6 the key.
7 COMMISSIONER BASSETT: That's the key.
8 CHAIRPERSON JOHNSON: That's the key is
9 that these people should not be ending up at Rikers
10 Island in the first place. And I know that my
11 colleagues--I think Council Member Lancman asked last
12 week Commissioner Bratton at the Public Safety
13 Preliminary Budget Hearing about potentially changing
14 the way we do summonses. So that they're not
15 criminal summonses, but civil summonses. So we're
16 not sending people away. So thank you. I appreciate
17 it, Dr. Angell and Dr. Venters.
18 Commissioner, I only have a few more
19 questions because I know we have HHC that's up next,
20 and I appreciate your time here today. So, just a
21 couple more things. You mentioned that maybe Dr.
22 Maybank wants to come up, but you mentioned the
23 Center for Health Equity. Can you update the
24 Committee on the work the center has undertaken thus
25 far since it was created? And has the department

2 considered expanding some of these services at the
3 Center of Health Equity to other areas across the
4 city, potentially other sites. To maybe do a mix of
5 some of the things you offer at the Center for Health
6 Equity, and potentially some of the other DOHMH site?
7 COMMISSIONER BASSETT: I'm going to let
8 Dr. Maybank in the interest of comprehensibility.
9 CHAIRPERSON JOHNSON: Yep.
10 ASSOCIATE COMMISSIONER MAYBANK: So, as
11 far as what we've-- Yes, I'm Dr. Aletha Maybank and
12 I'm Associate Commissioner for the Center for Health
13 Equity. Thank you for today. So, far our priorities
14 for the Center have been one, establishing our
15 Community Health Worker Initiative that's in Harlem,
16 which is a focus on five NYCHA developments to
17 improve disease management of folks with diabetes as
18 well hypertension. We are working at the individual
19 level helping residents with coaching, individual
20 coaching as well as working at community level, and
21 working on community organizing the residents as
22 well. And working with clinical stakeholders to
23 create good linkage to care. And understanding
24 better some gaps as well as assets in care
25

2 coordination, and how we can improve that for the
3 residents within the NYCHA developments.
4 Another key priority, which you mentioned
5 earlier, the neighborhood health hubs, which we are
6 fully immersed in, and we have our pre-application
7 meetings that are coming up for the RFEI over this
8 week actually for our residents in the three boroughs
9 in Brooklyn and Bronx as well as in Manhattan. To
10 inform folks about what this is about, and what is
11 going to be at the hubs as well. And then as far as
12 your last point, we are working to expand hopefully
13 the District Public Health Offices within Staten
14 Island as well as Queens. We have submitted new
15 needs requests in order to do that, and to hopefully
16 get some more funding. And the types of activities
17 we would do would be very similar to what we're
18 currently doing in the district offices. Really,
19 one, also establishing the relationships that we
20 have. I think you know that that has been one of our
21 strengths of being able to reach out, and assess
22 people pretty quickly especially during the Ebola
23 response because of all the relationships we have
24 developed. So that would be a key piece of building
25 that and nurturing that. But also better

2 understanding through our research and evaluation
3 efforts what's really happening locally within those
4 neighborhoods as far as access to food. We've done
5 you know, perinatal depression. Whatever we feel is
6 responsible or important for us to know. And then
7 also a big part of our work is working with other
8 City agencies promoting and support interagency
9 collaboration. So we've been meeting really on a
10 weekly basis especially with Parks with DOT, City
11 Planning, for some of our work in East Harlem to
12 really think through how do we better coordinate our
13 work? Especially with all the focus with
14 neighborhoods, and ensure that we're not operating in
15 silos within our various neighborhoods across the
16 city.
17 CHAIRPERSON JOHNSON: Thank you.
18 Congratulations. I think you've done a great job
19 since it started, and I'm really excited about the
20 expansion, and seeing the results of some of the
21 investment that you all have made in these
22 communities. I think it's going to make a big
23 difference. It's very exciting.
24 ASSOCIATE COMMISSIONER MAYBANK: Thank
25 you.

2 CHAIRPERSON JOHNSON: Thank you. I don't
3 want to leave anyone out. So I think we should call
4 up Deputy Commissioner Kass, because I have-- We want
5 to give everyone a chance to be a star today. And
6 there were unfinished questions in business from our
7 animal shelter hearing. And so, I want to talk a
8 little bit about the Capital Plan. I had a bunch of
9 questions. I rattled them off to you, Dan, at that
10 hearing. I know that the Health Committee staffed
11 something over. So the most recent Capital
12 Commitment shows the moving of an allocation of $5.9
13 million for the Queens facility. I think it was a
14 receiving site in Queens. What was that $5.9? Was
15 that $5.9 million budgeted for a full-service shelter
16 or for upgrades to the receiving center? And where
17 did DOHMH reallocate that $5.947 million?
18 COMMISSIONER BASSETT: Please.
19 CHAIRPERSON JOHNSON: I'm trying to save
20 your voice.
21 COMMISSIONER BASSETT: I appreciate it.
22 CHAIRPERSON JOHNSON: That's why I'm
23 calling up the supporting cast. [laughter]
24 COMMISSIONER BASSETT: We've got a really
25 excellent team.

2 DEPUTY COMMISSIONER KASS: So the--

3 COMMISSIONER BASSETT: [interposing]

4 Introduce yourself, please.

5 DEPUTY COMMISSIONER KASS: I'm Dan Kass.

6 I'm the Deputy Commissioner for Environmental Health

7 Services. The--these--the $5.9 million that you were

8 referring to originally is slated for property

9 acquisition for Queens. And in that property

10 acquisition process that we attempted over several

11 years, the intent was to create an expanded receiving

12 center. So that was--that was--and where did it--it

13 was reallocated as part of an overall $8.2 million.

14 I'm sorry, $8.4 million in capital funding for a

15 variety of initiatives that I think we've described

16 in hearings before. But, you know, largely go to

17 upgrades at the Brooklyn Animal Shelter, and the

18 creation of an adoption--a dedicated adoption center

19 at the Manhattan Shelter. And the acquisition of

20 mobile adoption units for animal care and control.

21 CHAIRPERSON JOHNSON: So there was $3.5

22 million in the Capital Plan for the HVAC upgrades at

23 the Brooklyn site. $500,000 in Fiscal Year 2016; $3

24 million in the out years, specifically Fiscal Year

25 2018; $500,000 to the Manhattan Shelter for upgrades.

2 And what you're telling me is out of the $8 million
3 in new funding that was announced in January, part of
4 that money was just a reallocation of the money that
5 was supposed to be spent in Queens?
6 DEPUTY COMMISSIONER KASS: That was
7 originally slated for property acquisition in Queens.
8 That is correct. And with regard to the specific
9 fiscal years in which the money was allocated, these
10 have no real bearing on the timing of the--of the
11 scoping and construction of the efforts. So that
12 will precede--that is preceding now, and as we can
13 put shovels in the ground we will.
14 CHAIRPERSON JOHNSON: So, where is the
15 money for Queens?
16 DEPUTY COMMISSIONER KASS: The money--
17 the--I believe I testified to this before. The money
18 that was allocated for property acquisition in Queens
19 was no longer necessary in the moment because that
20 property that we pursued was not--was deemed not
21 appropriate. I think as I mentioned earlier--
22 CHAIRPERSON JOHNSON: [interposing] It's
23 still necessary--it's still necessary for the
24 borough.
25

DEPUTY COMMISSIONER KASS: Well, we are still looking for a receiving center, but we're also are prepared to rent a better space if necessary. So for the purpose of trying to allocate money toward malleable and controllable construction projects we've reallocated to those. As you know, the Manhattan shelter is owned by the city, and the Brooklyn shelter is already owned by the city. So any construction associated with those things are well under the City's control. And are not subject to the current whims of the marketplace.

CHAIRPERSON JOHNSON: So, I am very excited about Manhattan and the adoption shelter space. Very excited about the upgrades for Brooklyn. Though I'm not any less excited, but I feel slightly duped by the fact that when that $8 million was announced, I thought it was $8 million in addition to the $5 million that was still going to be slated to be spent in Queens for a site. So it really wasn't new monies. It was--a significant chunk of it was monies that was already in the budget to do this type of work. It was just shifted over to do quicker work in places that needed help. That's right?

2 COMMISSIONER BASSETT: That's right.
3 These were capital projects that were badly needed at
4 these locations. And, your-- Yes, your analysis is
5 correct. The cost for shelter is something like $25
6 million. I know I--
7 CHAIRPERSON JOHNSON: [interposing]
8 Well, it depends. I meant the cost for shelter
9 depends on what type of shelter we want to do. If we
10 want to do a full service shelter with veterinary--
11 COMMISSIONER BASSETT: [interposing]
12 Well, that's what I'm talking about.
13 CHAIRPERSON JOHNSON: Yeah.
14 COMMISSIONER BASSETT: I mean this was in
15 no way adequate to meet the--the needs for--
16 CHAIRPERSON JOHNSON: [interposing]
17 Well, I understand.
18 COMMISSIONER BASSETT: --full-service
19 shelter.
20 CHAIRPERSON JOHNSON: But I think the
21 Council--I don't want to speak for Council Member
22 Vallone, who has the bill on this. But, I would say
23 that we're open to not--I don't want to negotiate in
24 public. But I think that we're open to figuring out
25 what works in a particular borough. And so,

2 potentially, you could do an enhanced receiving site
3 that may not have veterinary services, but may have
4 an adoption component. And if you do that, it could
5 be significantly less than the $25 million.
6 DEPUTY COMMISSIONER KASS: Yes, and as I
7 mentioned before, we remain committed to having that
8 conversation going forward.
9 CHAIRPERSON JOHNSON: But what's the
10 incentive to opening up the facility in Queens if the
11 money is gone?
12 DEPUTY COMMISSIONER KASS: Well, the--we
13 have a, what we refer to as a receiving center right
14 now that provides the opportunity for people to
15 surrender animals. And it provides basic counseling
16 to potential surrenders. And try to influence them
17 not to, and transport those animals to full-service
18 shelters. At the moment, we remain committed to
19 providing that service in Queens. As you know, we've
20 expanded the level of service enormously from one
21 that was only a day or two a week. To one that is
22 now seven days a week, 12 hours a day. We also are
23 providing additional services through the--through
24 the eventual rollout of new adoption--mobile adoption
25 units. But as to any future for--for additional

2 services in Queens, those would--those like any other
3 services would be dependent upon the resources. And
4 that's the conversation that we plan to continue
5 having with the Council.
6 CHAIRPERSON JOHNSON: So, there's no
7 money for Queens?
8 DEPUTY COMMISSIONER KASS: Well, as we--
9 currently, we are pursuing--we've been looking
10 through our Department of Citywide Administrative
11 Services for a different facility. But that would be
12 a rental facility at this point.
13 CHAIRPERSON JOHNSON: Well, I--I don't
14 think that's good enough. I think we have to come up
15 with the money to get a real facility in Queens. We
16 also need one in the Bronx. Why is--out of the $8
17 million in new funding added for upgrades to the
18 current shelters only $3.5 million is added within
19 the next three fiscal years? And the five--the $4.5
20 million, the balance, is allocated in Fiscal Year
21 2021; $4 million allocated in 2021. So six years
22 from now, and $500,000 is allocated in 2023--seven--
23 eight years form now. What is the purpose of those
24 amounts, and why is there such a significant lag in
25 time.

2 DEPUTY COMMISSIONER KASS: So--I--I will
3 just fairly acknowledge that I'm not an expert in how
4 the Capital Budget gets allocated, or the fiscal
5 reasons why it's allocated as such. But I will just
6 reassure you that despite the allocation in out
7 years, these projects are starting now, and they will
8 be built as soon as they can be. So without regard--
9 the allocation by fiscal year is done without respect
10 to the thought of how rapidly it can be done. They
11 will be--they are working on this now.
12 CHAIRPERSON JOHNSON: Well, again, I
13 always appreciate you being here, and answering
14 sometimes our tough questions. But I would say that
15 this is not good enough for me. And the Council has
16 a bill before it that there are over 40 sponsors on,
17 and I think it will pass quite easily to require
18 full-service animals shelters in all five boroughs.
19 And, we have I believe waited to take action to try
20 to get an update at this hearing on what the plan was
21 to achieve shelters in the Bronx and in Queens. And
22 I don't really hear--hear a good plan today.
23 DEPUTY COMMISSIONER KASS: Well, what I
24 think we committed to do certainly in answering your
25 questions, but we also committed to continuing to

work with the Council. But we weren't prepared today, nor were we authorized to discuss a specific plan.

CHAIRPERSON JOHNSON: But we're in the budget process. This is a Preliminary Budget hearing. We're going to have an Executive Budget hearing soon, and I would hope that in the intervening time that we could work together to come up with a plan for additional capital monies spent in sooner years to do this type of work. And again, I would say we're open to figuring out a hybrid model. Something that may not cost between $25 and $50 million, but still achieves the services that are needed in the Bronx and Queens.

COMMISSIONER BASSETT: Understood.

CHAIRPERSON JOHNSON: Thank you. So there's a lot more to talk about, but I'm going to finish. And I'm going to just say that we're going to--

COMMISSIONER BASSETT: [interposing] Yeah, please make your questions available to us--

CHAIRPERSON JOHNSON: Yeah, we will

COMMISSIONER BASSETT: --in a day or two. [sic]

2 CHAIRPERSON JOHNSON: And there are some
3 on the Language Development Campaign, which his very
4 exciting. [coughing] Childhood surveillance, the
5 Mayor's Management Report looking at smoking rates,
6 which you--
7 COMMISSIONER BASSETT: [interposing] Yes.
8 CHAIRPERSON JOHNSON: --mentioned.
9 Infant mortality rates, which we didn't get a chance
10 to talk about; day care; initial site inspections.
11 COMMISSIONER BASSETT: So much.
12 CHAIRPERSON JOHNSON: Condom use, which
13 Dr. Varma talked about; emergency funding for various
14 clinics; the IDNYC Ad Campaign; the Bushwick Health
15 Center; and the East Harlem Health Center; and the
16 Chelsea Center, and much, much more. I appreciate
17 your time. Go rest. Go home. We have paid sick
18 days in New York City now, Commissioner. [crowd
19 laughter] Take advantage of it.
20 COMMISSIONER BASSETT: Thank you, Mr.
21 Chair.
22 CHAIRPERSON JOHNSON: Paid sick days in
23 New York City.
24 COMMISSIONER BASSETT: That was supposed
25 to be my last line.

2 CHAIRPERSON JOHNSON: Yes. Thank you
3 very much. And we're going to take a--we're going to
4 take a 10-minute break, and then we're going to do
5 HHC.

6 [gavel]

7 [pause]

8 [gavel]

9 CHAIRPERSON JOHNSON: Good afternoon. We
10 will now resume the City Council's hearings on the
11 Mayor's Preliminary Budget for Fiscal Year 2016. I'm
12 Council Member Corey Johnson, Chair of the Council's
13 Committee on Health. The Committee on Health has
14 just heard from the Department of Health and Mental
15 Hygiene, and will now hear from the Health and
16 Hospital Corporation on its Fiscal 2016 Proposed
17 Expense Budget, which totals $7.1 billion. Given the
18 many changes in healthcare delivery in the past year
19 both at the state and federal level, a good portion
20 of today's discussion will cover the many challenges
21 to HHC's long-term financial sustainability. HHC's
22 projected operating deficit, which is $753 million in
23 Fiscal Year 2016 is expected to grow to $1.5 billion
24 by Fiscal Year 2019. The Committee looks forward to
25 discussing HHC's impending offer--operating deficit,

2 and corrective actions, which include, but is not
3 limited to privatization of dialysis services, FQHC
4 designation, Metro Plus Enrollment, and other actions
5 planned. Given the many uncertainties found in HHC's
6 Preliminary Plan, the Committee is extremely
7 interested in fully understanding HHC's previous cost
8 containment measures to ensure that quality of care
9 and continuity of care are sustained in times of
10 reform and restructuring.
11 Today's hearing will also examine the
12 corporation's funding from the Delivery System Reform
13 Incentive Payment District Program or Medicaid State-
14 -or State Medicaid Waiver. This Committee is
15 troubled to see that HHC's Financial Plan includes
16 much less than the $400 million a year from these
17 sources that the Administration expected. Further,
18 this Committee would like to hear the details on
19 HHC's performing provider system called One City
20 Health, which includes 400 local citywide community-
21 based organizations, and community providers. And
22 more importantly, this Committee would like to hear
23 how the City plans to support HHC with City money in
24 the absence of these vital funds.
25

Lastly, the Committee would like to receive an update and information from HHC on its Capital Program, FEMA Projects, and priorities in Fiscal 2016 and beyond. Again, I want to thank Crilhien Francisco, Dan Hafetz, Crystal Pond for all their hard work in preparation for today's hearing. Also, public testimony is supposed to begin at 2:30 p.m. We'll see if we get there at that time, and if you wish to testify, you must sign up in the back with the Sergeant-at-Arms. Before I turn it over to Dr. Ram Raju from HHC, if you could--if the three of you could please--Le Ray, Dr. Raju and Marlene if you could please raise your right hand. Do you affirm to tell the truth, the whole truth, and nothing but the truth in your testimony before this committee, and to respond honestly to council member questions?

DR. RAM RAJU: I do.

CHAIRPERSON JOHNSON: Thank you very much. So Dr. Ram Raju, I turn it over to you. Thank you for being here.

DR. RAM RAJU: Good afternoon, Chairman Johnson, and member of the Health Committee. I'm Dr. Ram Raju, President and CEO of New York City Health and Hospital System, New York Public Hospital System.

I'm joined here by Marlene Zurack, our Senior Vice President for--and Senior--and Chief Financial Officer, and Ms. La Ray Brown, Senior Vice President for Strategic Planning, Community Health and Intergovernmental Relationship. Thank you for this opportunity to discuss our financial year 2016, Preliminary Budget and Financial Plan, and also our programmatic initiatives. In my testimony, I will outline the strategic priorities that I have established for our corporation; a review of our Financial Plan; and provide an update on recent key initiatives.

At the beginning of the year, I put forth strategic priorities to preserve Health and Hospital Corporation's mission. These priorities will benefit our patients, our staff, and our bottom line. They are:

1. Expand access to care.
2. Increase our market share.
3. Stabilize our financial health, and
4. Focus on workforce development.

When expanding access to care, when I first came before the Council last year I said that we can't rest on the laurels of what you've achieved

2 so far. We have made significant progress on may
3 fronts, including strengthening and preventing of
4 primary care services we provide. There is more that
5 needs to be done. We work to expand access to care
6 so that our patients can more readily receive
7 services they need when they need it. We already
8 expanded hours on night and weekends in every
9 borough. So that our patients have a wider range of
10 appointment times. We will continue to adjust
11 schedules based on demands and feedback off our
12 patients. The only way to expand access is to reduce
13 wait times. We are working to reduce the wait time
14 it takes for the patients to see their doctors and
15 finish the appointment. By becoming more efficient,
16 we can create additional capacity and save our
17 patients time.
18 Next, we are working on a system to allow
19 patients to log into a secure site so they can review
20 their medical information such as care plans, lab
21 results, diagnosis, discharge information, and more.
22 Patients will be able to send messages to their
23 providers. By providing patients with the tools they
24 need to help them play an active role in their own
25 care, we expect that they will become more engaged

2 with their healthcare and remain healthier as a
3 result.
4 The next initiative is to increase our
5 market share. Right now, we serve roughly one our of
6 every six New Yorkers. I want this number to grow
7 over the next five years. If we continue to improve
8 the patient experience and increase the customer
9 satisfaction rates, we will see the--that that will
10 proof will be later moving in the right direction.
11 [sic] Our patients can be our best advocates, but
12 only if they are satisfied with their experience with
13 us. As patients spread the word about the great care
14 the receive in the Health and Hospital Corporation,
15 we expect our new partners will do the same. We will
16 be working with many community organizations, and
17 other healthcare organizations as a part of New York
18 State Delivery System Reform Incentive Payment
19 program called DSRIP. I will discuss DSRIP later in
20 my testimony, but I will briefly mention how this
21 relates to the increase in market share. Under
22 DSRIP, the State's goals are to promote community
23 level collaboration and focus on system reform in
24 order to achieve the state and federal government's
25

2 goal of 25% reduction in avoidable hospital use over
3 the next five years.
4 The Performing Provider Systems are
5 required to collaborate with one another to implement
6 innovative projects, focus in on system conservation
7 critical improvement, and population health
8 improvements. Given this mandate, Health and
9 Hospital Corporation will be working with more than
10 200 different partners on numerous DSRIP projects
11 over the next five years. If we are successful, the
12 partnerships will provide being effective and
13 attracting the returning and new patients for us.
14 However, our best partner in attracting the returning
15 patients is Metro Plus. Metro Plus is our award
16 winning health plan. It is primarily ranked as the
17 best among the New York State highest performing
18 Medicaid managed care providers both in terms of
19 customer satisfaction and quality.
20 They now have more than 469,000
21 enrollees. My goal for this number to grow to
22 600,000 by the end of the financial year 2016. We
23 have already formed alliances with HRA and DOHMH as
24 well as community-based organizations that provide
25 navigator services about how to work together more

2 closely. We are hoping through these partnerships to
3 leverage the next two cycles of open enrollment, and
4 capture new members into Metro Plus and our system to
5 ensure they are paying Medicaid and join a qualified
6 health plan, and ultimately a design for a basic
7 health plan as it rolls. Recently, the enrollment
8 has increased to the coverage expansion with certain
9 funding implementation of the Affordable Care Act.
10 Medicaid membership across the 400,000 barrier for
11 the first time in December of last year. And now it
12 stands at 411,000 enrollments. Additionally, Metro
13 Plus Qualified Health Plan enrollment is more than
14 27,000 members now at the most recent open enrolment
15 period. This number will likely increase threefold
16 [sic] as individuals discover during the tax filing
17 process that they will face penalties and choose to
18 sign up for the coverage instantly. The next priority
19 is to stabilize our financial health, and members of
20 this committee know all too well about our budget
21 gaps, and all too well that to accomplish a right
22 solution, we need financial security.
23 Each year we find ways to--new ways to
24 close the gap that results from our structured budget
25 deficit. If we achieve the goals I have just

outlined, we will be in a better position to fulfill the goals to stabilize our finances, and protect our unwavering mission to turn no one away. While increasing revenues from the new patients is an important part of our strategy, it is not just enough. We need to obtain the fairest prices possible from our vendors, and we must manage the supply chain. We also need to consistently raise the critical reimbursement issue with all our payers. Currently, we all these changes we are implementing, managed care followed by behavioral health outpatients. We have uncovered and began discussions with the State about important Medicaid underfunding issues. This issue is one of the many about which are in negotiations. The final big priority is to focus on workforce development. The diverse, well-trained mission driven culturally competent staff is one of our greatest assets. As you work to increase the tools available to improve the patient experience, you also need new and ongoing programs that benefit our 36,804 employees. We are expanding E-learning opportunities for our staff so that they have an opportunity outside the traditional training rooms to learn new skills. We are investing in

2 programs to train our managers to design systematic
3 improvements and make strategic decisions. We are
4 also identifying the new generation of leaders within
5 the Health and Hospital Corporation. In order for
6 them to be ready to meet the future challenges, we
7 must work now to develop the skills they will need in
8 the future. As a part of this effort, we are working
9 with our labor partners in an innovative
10 collaborative. For example, in a recently signed
11 agreement with the New York State Nurse Association,
12 NYSNA, we are committed to establish facility based
13 nursing practice council that will work with the
14 corporate wide nursing practice councils to improve
15 among other things patient satisfaction, patient
16 outcome and employee satisfaction. These councils
17 will be comprised of an equal number of members of
18 NYSNA and nursing management. The councils of the
19 employees inter-waiting [sic], collaborated on
20 evidenced-based techniques to achieve its goals.
21 As I mentioned, we work constantly to
22 identify matters to reduce an element of budget gaps.
23 Through restructuring, cost containment, revenue
24 optimization, and ongoing support from the city, we
25 have been successful in balancing our budget. Last

2 year at this time we were projecting the $430 million
3 gap in the Financial Year 2015. This deficit was
4 projected to grow to nearly $1.4 billion in FY2018.
5 Currently, we are projecting the FY2015 closing
6 balance of $1 billion. Before you ask me is that
7 number a title, let me caution you that this positive
8 balance is solely attributable to the unanticipated
9 receipt of several years of outstanding Upper Payment
10 Limit Funds totaling $1.2 billion before the close of
11 this financial year.
12 I want to stress the fact that these
13 funds do not recur. These are one-time funds, which
14 are due to us for the services rendered between the
15 years of 2012 to 2014. If we did not have these UPL
16 funds, our deficit revenue would have been a negative
17 $900 million--$920 million or a negative $227 million
18 on a cash basis. After this year, our gaps went back
19 to the pattern you normally anticipate with the
20 deficit growing each year. Before corrective
21 actions, we project this $753 million gap in FY2016.
22 These gaps grow to slightly more than $1 billion by
23 FY17, and further balloons to $1.5 billion in FY19.
24 As with any financial plan, we are doubling up on
25

2 corrective actions to address these gaps. I can more
3 fully discuss them at our next budget hearing.
4 One step we are taking now is through a
5 productivity based benchmarking initiative to right
6 size the staffing levels across the corporation.
7 These measures will monitor full-time positions
8 globally including our fleet staff, temporary staff
9 and use of overtime. This will allow the hospitals
10 more--allow the hospital more discretion to fill the
11 positions of full-time and part-time staff while
12 reducing their reliance on temporary staff and remain
13 within their productivity target. There are risks
14 and opportunities that could affect our forecast.
15 Our plan does not include current budget proposals on
16 the table in Albany, or in Washington, D.C. The 2015
17 State Budget that should pass in the next couple of--
18 next week will include a modest amount of new funding
19 for a quality implement program. There is also a
20 proposal to eliminate the re-admission penalty that
21 could save us $4 million.
22 The positive benefits of these items will
23 likely be lost if a reduction in the Medicaid
24 reimbursement for certain low-income Medicare
25 beneficiaries is approved. One of the most important

items for us in the year's Executive Budget was proposed extension of the State Charity Care Law for three years and granting the new authority to the State Department of Health to revise the disproportionate shared funding formulas without having to seek further legislative proposal when the federal discussions begin in the federal financial year 2017, which begins on October 1st of 2016. We remind the Committee that this program provides federal Medicaid matching dollars, which strives to make payment to hospitals that treat a disproportionate share of uninsured and Medicaid patients. But, this funding that we receive is critical to supporting our mission and allowing it to serve low-income and uninsured patients.

We believe and we advocate the State policy should be changed so that these funds follow the patient and it is directly targeted to hospitals that serve disproportionately high numbers of uninsured patients and Medicaid patients. We are concerned that without changes to the present methodology of distribution of these funds, we will absorb all the initial federal discussed. We are optimistic the State budget will include a financing

2 work group with our participation to come to come up
3 with a recommendation to the Legislature and the
4 Governor on how these funds should be distributed in
5 the area of federal cuts. We appreciate your help
6 and support of your colleagues in Albany.
7 As it stands now, we estimate the
8 potential loss of $180 million in total, and this not
9 including the Federal Financial Year of '17. This
10 grows to $508 million in total dollars in Federal
11 Financial Year '18, and more than $3 billion over the
12 period from Federal Financial Year '17 to '24. This
13 is slated to expire [sic] in the Federal Financial
14 Year of 2014--2024, but may be extended. It may be
15 extended further to provide initiatives. For
16 example, the President's Budget Proposal should add--
17 is to add another year of these cuts into Federal
18 Financial Year 2025. The Preliminary Budget also
19 reflects our latest projections of the impact of the
20 Affordable Care Act. Our Financial Plan assumes a
21 12.5% reduction in the uninsured patients for FY19
22 translated into $50 million in additional revenues of
23 care. The Plan also recognizes significant increased
24 in Medicare DSH [sic] payments. However, the
25 Medicare DSH payments will decline over the life of

the plan as more patients get insurance. These increases in Medicare DSH are not to be confused with the cuts we will see in the Medicaid DSH funds that I just mentioned. While we see the gains in Medicare DSH funds, we will lose Medicare funds due to payment reforms that are projected to cost us up to $34 million annually. In FY16 the SCAA is expected to provide a net of $206 million in benefits to our corporation. However, these benefits are short lived. When you calculate the loss of Medicaid DSH Funding, this translates into an overall years-end [sic] reduction of $130 million for FY18 and $138 million in FY18.

On a bright note, though, our application for Federally Qualified Health Center, who collects designation of the Garten Health Plan, was approved last month by the Health Resources Service Administration HRSA. We estimate that we will actually receive an additional $30 million per year in federal funding to support our strategic goals, we expand access to geographically convenient, and culturally sensitive healthcare services for all New Yorkers, and strengthen our ability to keep New

2 Yorkers healthy. I want to thank Council Member
3 Johnson for writing a letter to HRSA on our behalf.
4 We are pleased with a part of the
5 Preliminary Budget. We received funding for the
6 Collective Bargaining Agreement reaching the union
7 partners, as well as funding for all of Ebola
8 Preparedness and Cure Violence Program. We have
9 budget--budgeted increased revenue in two key areas:
10 The first is through increased Metro Plus enrollment,
11 which I mentioned. We are anticipating $15 million
12 this year as a result. The other source of DSRIP
13 funding that was a part of the Federal Medicaid
14 Waiver that New York State received approval last
15 year. These dollars are to be used to support the
16 Delivery System Reforms throughout New York State.
17 Over the next five years, investments will be made to
18 improve access, CAD management and CAD coordination
19 consistent with the transformation goals set forth in
20 the waiver.
21 As a part of the DSRIP, the entities are
22 requested--are required to form and be approved as he
23 Performing Provider System, PPS. Our PPS, once city-
24 held, submitted its application to the State in
25 December. It required to perform the Community Needs

2 Assessment to analyze the needs of the different
3 neighborhoods. Then, we are required to choose
4 projects from the list created by the State--to
5 choose the projects from the list created by the
6 State that address those needs. There are three main
7 categories: System Transformation, Clinical
8 Improvements, and Population Wide Projects. Our
9 application details some approaches to meet community
10 needs through 11 projects. These include: Initiated
11 to further increase access to care; double up care
12 coordination program, and double up Family Care and
13 Behavioral Health Integrated Initiatives, and double
14 up IT initiatives to link these programs in a
15 population health improvement based platform. We
16 expect to hear soon what our performance and what it
17 will be. Unless there are delays, funds are expected
18 to begin to flow immediately. Each of these will be
19 mainly for process improvement, but transition in the
20 performance based payment over the course of the
21 waiver. In the Financial Plan we currently project
22 $60 million in DSRIP funds for FY15, that is now
23 below the line. Once these awards are announced, it
24 will bring this amount above the line in the next
25 plan. It is important to emphasize that these funds

2 are not granted funds, and they should not be
3 considered as a solution to our budget deficit.
4 There is a second component of DSRIP
5 applied funding. It is for the Capital Projects.
6 These are funds where we intend to support the
7 sustainability of DSRIP transformation effort. We
8 submitted an application for our projects total $435
9 million last month. These projects are critical to
10 achieving the important goal of improving access,
11 care coordination. We are enhancing information with
12 our partners, which includes many community based
13 organizations. However, the State Senate is pushing
14 for a repeal of the auto fee, and for which we have
15 submitted an application. They are in favor of the
16 new process that will combine the available funding
17 with the new capital funding that will be available
18 as a part of the State budget.
19 Now, turning to our own Capital Program,
20 work has been completed or near completion on several
21 major projects. Gouverneur Healthcare System in
22 Lower Manhattan is preparing for a grand reopening
23 ceremony next month to mark the completion of the
24 major modernization. Which includes a renovated
25 state-of-the-art nurse facility with an additional 80

2 beds. At North Central Bronx Hospital we completed
3 renovations of labor and delivery suite and reopened
4 this vital service last fall. We are very grateful
5 that Council Member Ritchie Torres, Council Member
6 Andrew Cohen, and members of the Bronx Delegation
7 provided capital funding through last year's budget
8 to make this possible. At the Elmhurst Hospital in
9 Queens, we will open a new mother's recovery unit.
10 [sic]. In the coming months, we will expand the
11 services to prenatal care and comprehensive with all
12 these services.
13 As a follow up to our hearing in the
14 Council here in 2013, on access to healthcare
15 services for patients with disabilities, the Council
16 appropriated $2.5 million in capital funding for
17 FY2014 to make improvements of those facilities.
18 These funds were used to make renovations and
19 purchase equipment. To make exam rooms and bathroom
20 optimally accessible for patients with disabilities.
21 The first phase of our preliminary design work
22 including cost estimates is complete, and the
23 construction will begin later this year at four of
24 those sites. We are very appreciative of the Council
25 for this investments, and we ask you to consider

2 restoring $97.25 million that was previously
3 allocated, but eliminated from the FY17 Capital
4 Budget.
5 Before I conclude, I will share with you
6 the details of the recently amount FEMA award to
7 rectify the damage caused by Hurricane Sandy. As
8 you, the corporation suffered serious losses as a
9 result of Hurricane Sandy. We experienced physical
10 damage to four of our facilities and nearly $250
11 million in losses with the closure of Bellevue and
12 Coney Island hospitals. I was extremely please to
13 stand with Mayor de Blasio and Senator Schumer last
14 fall when we announced the award of $1.723 billion to
15 complete repairs of protected hospitals that were
16 damaged by Hurricane Sandy. We are working closely
17 with the Mayor's Office of Recover and Resiliency on
18 these projects. I am very thankful to all the
19 support and advocacy we received from the Council,
20 which helped us immensely with this award. This
21 award includes $933 million for Coney Island Hospital
22 to build a free-standing building on the hospital
23 campus that will be raised about the 500-year flood
24 level to house critical infrastructure including the
25 Emergency Department, Imaging Services, and surgical

2 suites. This project will also include funding for
3 the hospital's power plant. The amount includes
4 funds previously awarded to make the repairs to the
5 hospital basement, first floor and the electrical
6 system.
7 $499 million for Bellevue Hospital to pay
8 for restoration work on the electrical systems and
9 the commitment [sic] is already completed. This will
10 also pay for the installation of the flood walls, and
11 gates to provide the hospital to--to protect the
12 hospital to the 500-year flood level, new flood proof
13 elevators and to raise the vital infrastructure out
14 of the basement. $181 million for Coler [sic] to
15 build a flood wall. Pay to replace the generator that
16 was destroyed and create additional protection to
17 these critical facilities' electrical systems. And
18 $120 million for Metro Plus--Metropolitan Hospital to
19 build a flood wall around the facility to pay for
20 electrical repair.
21 In summary, by achieving the strategic
22 goals I've outlined, we will succeed in this dynamic
23 and challenging healthcare environment with our
24 mission impact. We will continue to find ways to
25 mitigate losses in revenue from traditional sources.

2 We will continue to refine our work [sic] to align
3 how to deliver care with the transformed delivery
4 model that emphasizes population health. And we will
5 continue to collaborate with our labor partners to
6 double up ways to engage our workforce in meaningful
7 ways. We appreciate the Council's support, and
8 believe that with your support we will continue
9 leading the way both here and in New York City and
10 nationally away from sick care and towards a new era
11 of health and wellness care. And we implored all New
12 Yorkers without exception to lead the healthiest life
13 possible. This concludes my testimony. Now, I'm
14 looking forward to listening your comments and
15 answering your questions. Thank you.
16 CHAIRPERSON JOHNSON: Thank you, Dr.
17 Raju, for being here and for your leadership. It's
18 great to be able to work with you. I was really
19 remiss earlier. I forgot to mention which is very,
20 very important. It's important, I think, to mention
21 you shine a light on HHC for their absolutely
22 incredible work in preparing the city's hospitals for
23 the Ebola response, and for treating a patient who
24 had contracted Ebola. Before the world learned of
25 this patient contracting the illness, I think many

2 people feared that our system would not be able to
3 handle the spread of the disease. Your team and your
4 fabulous staff at Bellevue delivered a powerful
5 message in your superb handling of the patient, and
6 bolstered everyone's confidence in our system. You
7 demonstrated that we have the greatest public
8 hospital system in the world. I think the message is
9 all the more stark today as we hear about the
10 difficult financial outlook facing HHC. This city is
11 blessed to have this system, and we must do whatever
12 we can to sustain it. It was very nice to have some
13 of the folks here a couple of weeks ago for a
14 ceremony honoring the workers at Bellevue here at the
15 Council, and I wanted to mention that before we got
16 into the questions. So thank you.
17 DR. RAM RAJU: [off mic] Thank you.
18 CHAIRPERSON JOHNSON: So, Dr. Raju, you
19 mentioned in your testimony that the projected
20 operating deficit of $753 million, which begins in
21 Fiscal Year 2016? 2016 and then by 2019, grows to be
22 close to $1.5 billion. I think may people who may
23 not be as well versed, and it's very complicated. I
24 mean your testimony if you aren't entirely proficient
25 or have a very strange hobby of studying these

2 things, it would be very hard to understand all of
3 the money involved, the different programs, and how
4 it all interlocks. But I think there is--was a myth
5 out there, and it's important for us to educate
6 people that the $8 billion State Medicaid Waiver that
7 that money even if HHC gets its fair share, which in
8 my estimate would be over $2 billion, that money is
9 not the panacea, the band-aid that fixes all of HHC's
10 problems. Correct?
11 DR. RAM RAJU: That's correct.
12 CHAIRPERSON JOHNSON: And part of the
13 issue here, as you outlined in your testimony, is the
14 structured diminishing of DSH payments from the
15 federal and state government, the match, how that
16 affects HHC's bottom line. Coupled with not knowing
17 what the outcomes are going to be that are part of
18 your PPS. You have to hit certain goals. The goal
19 of this State Medicaid Waiver is to reduce
20 hospitalizations by 25%. And so you are all--you are
21 all going to have to hit certain benchmarks. So we
22 can't even judge at this point the amount of money--I
23 mean you could guess, but you don't fully know the
24 amount of money that you are going to potentially get
25 in the DSRIP payments. Is that right?

DR. RAM RAJU: That's correct, yes.

CHAIRPERSON JOHNSON: So I want to hit on what I think you mentioned, which is really significant in this. The UPL, the Upper Payment Limits. So in your testimony you mentioned the significance of the transition to managed care, which reduces HHC's ability to receive UPL funds. I want to understand what conversations HHC has had with federal, state, and city officials to try to either change this or see if HHC is going to be hit in such a hard way because of the loss of UPL funds. What is going to be done to make HHC whole?

DR. RAM RAJU: Okay. Well, I will let Marlene take the first round on that, and then I will come back.

MARLENE ZURACK: Thank you. Thank you, Mr. Johnson. So, just to kind of summarize I think where you're going with that because you covered a lot of points, and I'm going to talk about the math of it. And then turn it over to Dr. Raju to talk about the policy, and the important implications of the math of it. But I think you've kind of hit the nail on the head. There are essentially two things happening in our financial plan, and they all have to

2 do with state and federal reform. So having to do
3 with the Medicaid Redesign Team and the movement of
4 all sorts of services into managed care that had
5 formerly been in Fee-for-Service, HHC will lose the
6 ability to receive matching federal dollars under the
7 Upper Payment Limit provisions of the Medicaid
8 program. So what happens is for the Fee-for-Service
9 Medicaid population for public hospitals in the
10 county, states are allowed to make what are called
11 Upper Payment Limit payments, which essentially pay
12 the public hospitals for the difference between what
13 they're getting in Medicaid and what they would have
14 gotten with a Medicare reimbursement scheme.
15 That may sound really complicated, but
16 the simple piece is Medicaid usually pays well below
17 cost. And Medicare typically pays either reasonable
18 cost or something that's either greater or lesser
19 than reasonable cost. So in the current scenario,
20 HHC is an extremely high Medicaid system. So even
21 though Medicaid pays below cost when it's Fee-for-
22 Service, for HHC we get a supplement. That
23 supplement is our Upper Payment Limit payment. Now,
24 as you move into Medicaid Managed Care, the federal
25 governments require the states to identify

2 efficiencies in going to this contracted out system
3 of Medicaid managed care. And accordingly, the
4 ability to make Upper Limit payments is gone. So,
5 for example, the next big set of services that are
6 going to managed care in July are behavioral health
7 services. So for our patients whether in managed
8 care or not, if they're an SSI or they're seriously
9 and persistently mentally ill, their behavioral
10 health services, their psyche inpatient, their psyche
11 outpatient, their substance abuse services are paid
12 as if they were Fee-for-Service Medicaid.
13 Now, Fee-for-Service Medicaid on the
14 inpatient side is paying about 79% of behavioral
15 health service costs. On the outpatient side it's
16 paying 35%. Well, HHC because of the Upper Payment
17 Limit we're in the Fee-for-Service environment
18 getting the differential as a supplement. You lose
19 the capacity to get a supplement when you move to
20 managed care. So the whole process that came out of
21 the Medicare Redesign Team to move all these
22 services, behavioral health, long-term care in to
23 managed care, eliminate the ability of HHC to get
24 Upper Payment Limit payments. The State did provide
25 for this somewhat in the 1115 Wavier in so far as the

2 years 4 and 5 of the waiver, the State can negotiate
3 with the feds to use a DSRIP type methodology for
4 Upper Payment Limit payments. Unfortunately, we're
5 only in year one of the waiver, and for example, the
6 behavioral health cut starts in July. So that
7 happens way too late in the process. So there
8 clearly were discussions about what happens when we
9 lost Upper Payment Limit payments. There even is a
10 proposed solution. It's just not going to happen
11 fast enough.
12 The second major area where our financial
13 plan is troubled is the loss of DSH funds. And the
14 loss of DSH funds came out of the premise that when
15 we implement the ACA so many more people are going to
16 get Medicaid and get into qualified health plans that
17 you won't need this funding for the uninsured. Now,
18 we know that in New York since we had a very generous
19 Medicaid program that the numbers are not necessarily
20 in our favor in so far as the DSH cuts are greater
21 than the Medicaid expansion. So these two major,
22 major events happened. The Medicaid Redesign Team
23 and the ACA, which result in a drastic diminutization
24 of our revenue base. At the same time, our expenses
25 are-- You know, while they're growing very slowly,

they're still growing over the same period of time, and that generates our gaps.

In terms of DSRIP, DSRIP was a major sources of gap closing initiatives. We call them corrective actions in the HHC plan. And I just want to sort of lay out the understanding of it. When DSRIP was first announced, HHC was in our plan saying that we felt we should get, and we asked for $2 billion of the $6 billion in waiver funds. Now, what you're seeing in the plan today for the January plan is a much lower number. And some of that is for technical reasons. One being that the DSRIP program is going to go on beyond the life of the plan, which is simply something we didn't know when we did the first cut at what we felt we should get, and what we asked for in the $2 billion. So there is DSRIP through 2020 and the plan is only through 2019.

Also, when we were showing the $2 billion below the line in the old plan, we weren't showing the net of expenses. And there are many kinds of DSRIP expenses. There's expenses for bonus payments. There's expenses for revenue loss. But in the process of actually applying for the DSRIP funds, we learned a lot more about project implementation

2 costs. And so, now what you're seeing below the line
3 is not only an extra year that it's pushed out to,
4 but you're also seeing the number net of expenses.
5 In addition, a piece of the program was awarded
6 through something called the IAF Program, which was
7 already awarded and HHC received $152 million.

8 Taken together, our plan today if you
9 accounted for IAF and the extra year, has $1.5
10 billion in DSRIP revenue assumed. But that revenue
11 is net of $250 million in project implementation
12 costs. Your other costs--

13 CHAIRPERSON JOHNSON: Repeat that number
14 again, Marlene.

15 MARLENE ZURACK: $1.5 billion in revenue
16 for HHC--

17 CHAIRPERSON JOHNSON: [interposing] Yes.

18 MARLENE ZURACK: --but there is
19 additional revenue for the rest of the PPS that we're
20 not counting in our plan. Less $250 million for what
21 I'm calling project implementation costs. There are
22 other costs that were already above the line in the
23 plan for revenue loss and performance kind of payment
24 kinds of things. So the net of this is the--is the
25 $1,250,000. So it's $1.5 billion in new revenue,

2 less $250 million in new expenses. And as we were
3 going through the applications--
4 CHAIRPERSON JOHNSON: [interposing] How
5 much of that did you guys have to put upfront?
6 MARLENE ZURACK: The expenses are going
7 to happen throughout the period, throughout the life
8 of this. So, so far we've had to pay for the
9 planning grant, for the planning and that piece,
10 which is about $8 million. And we've received
11 something like $6 million in a planning grant.
12 [background comment]
13 MARLENE ZURACK: So we've had to put that
14 up. We also had the IAF funding, which required us
15 to do the intergovernmental transfer. But we did net
16 out of that transaction $152 million. So let me
17 restate that. When--when the State first announced
18 the waiver, they actually did something that was very
19 helpful to us. They said for safety net hospitals,
20 public and non-public, with major cash flow problems,
21 we're going to give you a quick infusion of cash.
22 And that was done through the IAF Program, and we
23 were able to get $152 million of that. Then the
24 State issued requests for planning grants, and we
25 were able to get I believe $5 million in a planning

2 grant. I believe the activities for doing the work
3 to this point are about $8, maybe $9 million. So
4 we're actually--it costs a bit more upfront. In
5 terms of the project, and that's not in the project
6 implementation costs because I didn't include the
7 planning grant piece. In terms of the project
8 implementation costs, we're assuming, for example,
9 that we'll have $80 million in 2016 in project
10 implementation costs. And we're assuming, for
11 example, that we'll $146 million in new revenue. So
12 in the first year, we have quite a bit of the
13 expenses, and not as much of the revenue. So a lot
14 of the investments need to be made up front.
15 CHAIRPERSON JOHNSON: Thank you. That
16 was very comprehensive. It's not easy to understand.
17 MARLENE ZURACK: [laughs] Sorry.
18 CHAIRPERSON JOHNSON: No, it's--it's just
19 not--I mean I'm able to follow just because I've read
20 a lot. But the average person--the number of people
21 in New York that can explain this and understand it
22 could fit in this room probably. So, to get to the
23 heart of the matter, Dr. Raju, with all of that that
24 Marlene laid out, and with the issues around UPL,
25 around DSH funds with the deficit growing to $1.5

2 billion in 2019, after the Road Ahead Plan, which
3 closed a $1.4 billion deficit.
4 MARLENE ZURACK: [off mic] Right.
5 CHAIRPERSON JOHNSON: $1.2--a $1.2
6 billion deficit, do people--does the public, does the
7 City Council have to worry about the financial health
8 of HHC and us continuing to have the best public
9 hospital system in America because of these
10 systematic financial issues that the corporation
11 faces?
12 DR. RAM RAJU: I think you are absolutely
13 correct because the first part of the DSRIP risk is
14 that it is not a grant. We need under money the
15 money. We need to perform and the under money. Not
16 only we are to perform, our partners in our PPS need
17 to perform, and the State as a whole has to perform.
18 So that is a big risk we need to manage. On the UPL
19 and DSH going forward, they all depend in a large
20 extent on the federal policy. And it all depends on
21 how the federal government is going to look at the
22 impact on the public hospital system in the country.
23 And how they're going to support it. How they're
24 going to do that is a big risk. That is why with the
25 Strategic Plan we said real clearly do not depend

2 totally on the credit issue payments we get for the
3 public system. We need to improve the market share.
4 So that we are able to generate enough patients into
5 the system so there is enough revenue for the
6 patients and able to manage that. So that is where
7 the patient experience component comes into the
8 picture. We've got to excell. We give a great
9 quality care. We keep a patient safe. We keep the
10 patients very, very safe in the system. But the
11 patient experience component we need to work very
12 hard so that the patients, we don't lose our existing
13 base of our patients. And we also have to get new
14 patients in the system so that we can mitigate those
15 losses, which we're going to face in the future
16 years.
17 CHAIRPERSON JOHNSON: So could you all
18 expand on the corrective actions that HHC is
19 currently undertaking or may have to undertake given
20 the financial difficulties that the corporation is
21 facing?
22 MARLENE ZURACK: Sure. So the HHC
23 corrective actions consists of a few things. The
24 first being revenue, process transformation. Which
25 is essentially we're constantly doing revenue

2 improvement initiatives. It's very difficult to do
3 and collect revenue in a healthcare system. So we
4 have in our plan $72 million assumed for improvements
5 in our revenue collection, and it's something we've
6 been doing year over year. We put a team on it, and
7 typically we do achieve much success with that. We
8 have another $75 million for what we're calling
9 supply chain savings. We've centralized procurement
10 and we're working to get best vendor prices, and also
11 what we call supply chain improvement, which is
12 managing inventory effectively. Getting the
13 physicians to agree to use the same items. You get
14 better prices, et cetera.
15 The other piece, which is $53 million in
16 Fiscal 15 growing to $100,000 in Fiscal 16 is
17 something Dr. Raju referred to, which is the new
18 process we're doing for budgeting for personal
19 services. We used to at the corporation monitor very
20 closely what we called the FTEs or the new hires.
21 And essentially the hospitals had to have internal
22 vacancy control boards that had to be approved by
23 Central Office Vacancy Control Board. What we've
24 said now is no we want the hospital leadership to be
25 responsible for their budget. But we're going to

give you total personnel costs--personnel services costs, including affiliates. So that it removes the perverse incentive to hire people ineffectively. Like to hire them on a tempt contract rather than to hire them full-time. We've also taken a workload driven model to figure out how to be fair across the different facilities. We look at how much--how many inpatient missions they have. How severe they are. How many outpatient visits they have, et cetera. And we are able to say well, you know, if Elmhurst can do it with these resources, so can Queens, et cetera. So taking together, that's $100 million. And then we have $50 million in other assorted little items. So that's sort of the crux of our Corrective Action Plan. It's--it's revenue. It's supply chain savings. It's changing the way we budget for personal services to remove perverse incentives. And then a number of smaller initiatives.

DR. RAM RAJU: Other of corrective action is we got the Federally Qualified Look-Alike Status. As I mentioned in my testimony that lacked $30 million.

MARLENE ZURACK: Yeah, that's in our restructuring line in the plan. So in our

2 restructuring line we're carrying lab savings, FQHC
3 benefits, and other programs that were started a
4 couple years ago and they're now coming to fruition.
5 CHAIRPERSON JOHNSON: How helpful was it
6 for the first time for the City to say that they were
7 going to cover the collective bargaining costs--
8 MARLENE ZURACK: [interposing]
9 Enormously.
10 CHAIRPERSON JOHNSON: --that in the--that
11 in the past were not covered by the City. If you
12 could be specific in how much money that is going to
13 end up saving the corporation?
14 DR. RAM RAJU: Let me tell you and
15 Marlene will give you the figure. It was extremely
16 enormously helpful to us in that it give us really an
17 advantage to collect the--to pay for the collective
18 bargaining. We are really thankful to the City for
19 that.
20 MARLENE ZURACK: And then the numbers
21 are-- There was a--there was a larger amount in this
22 fiscal year, because we had a large retroactive
23 component. As you may recall, there some unions that
24 had not received the last pattern, 1199 NYSNA, which
25 were our unions that were in that situation. So that

had a significant amount of retro activity. That was--so in total for this year we received in Fiscal 15 $127 million. Then it grows--

CHAIRPERSON JOHNSON: [interposing] From the City to cover your collective bargaining --

MARLENE ZURACK: [interposing] Absolutely.

CHAIRPERSON JOHNSON: --costs?

MARLENE ZURACK: It covered all of our collective bargaining costs, and then it grows in Fiscal 19 to $132 million. So it was--it was enormously helpful.

CHAIRPERSON JOHNSON: But, if the City decided to--when the DSH payments start to decrease, if the City decided to stop its local match-- Sorry. I'm conflating two things. The collective bargaining it's great the city is doing that. That's a big help. Separately, one thing the city could do to be helpful is to even though the DSH payments are going to decrease from the federal and state government if the City kept the local match at the same level without the decrease, that would significantly help the corporation.

2 MARLENE ZURACK: They already did and
3 that's already in the plan. So the plan assumes that
4 the City match is retained. It just eliminates the
5 federal share.
6 CHAIRPERSON JOHNSON: Has the City made
7 that commitment?
8 MARLENE ZURACK: Yes, and it's in the
9 City budget. [off mic] It's in the plan.
10 CHAIRPERSON JOHNSON: And how much money
11 does that end up?
12 MARLENE ZURACK: So for--and that's why
13 we started to reflect our plan showing the City,
14 State and Federal share of DSH. So when we see the--
15 the big--what we're calling, you know, the DSH cliff,
16 in Fiscal 17, we anticipate $1,470,000 in DSH. In
17 Fiscal 18, it goes down dramatically to $1,185,000.
18 However, the City's share, in fact, creeps up a
19 little bit. It goes from $719 to $726. The real
20 loss is in the federal share, and this is how we've
21 been reflecting the plan for the last couple years.
22 You know, and we've been working with the City on
23 this particular characterization because frankly
24 we're trying to find other ways to get matching
25

2 federal funds restored here. So, you know, the city
3 has been very supportive in retaining that match.
4 CHAIRPERSON JOHNSON: Who ultimately has
5 authority on--is it done legislatively, or who in the
6 federal government could make the decision? Could
7 the Secretary of Health and Human Services grant you
8 guys so you could continue to get the DSH payments?
9 Or, is it done legislatively through the ACA?
10 MARLENE ZURACK: It actually would
11 require--it requires-- At the federal level there is
12 a federal DSH cut, which is the cut to the maximum
13 amount states can spend. That cut has to be
14 implemented to the individual states by the HHS
15 Secretary. That's step one, but I think the--perhaps
16 the more arduous step happens at the state level
17 where the DSH payments are allocated via the
18 legislation. So the current funding--DSH funding is
19 allocated via approximately 10 different provisions
20 in state law that sets certain pools of money for HHC
21 and other hospitals, other publics and then not--not-
22 for-profit hospitals in the state. So the
23 distribution of the DSH dollars locally is determined
24 by state law. The amount--the maximum a state can
25 get is based on a total national allotment, which

2 Congress controls that is distributed. The cut is
3 distributed based on provisions in the ACA that also
4 authorize the HHS Secretary to distribute this cut.
5 She has been instructed by the legislation, however,
6 to distribute the cute more favorably to states that
7 target their DSH to high Medicaid and high uninsured
8 providers.
9 CHAIRPERSON JOHNSON: And that's HHC?
10 MARLENE ZURACK: Well, yes, but New York
11 State is an interesting state. HHC gets a very--HHC
12 and the other publics because of a lot of the DSH
13 maximization efforts in the last 10 years get
14 approximately half of the DSH dollars in the state.
15 So when you look at the aggregate DSH spending, it
16 really does look targeted on some level to hospitals
17 that have high Medicaid and uninsured. But unlike a
18 lot of states, hospitals that don't have all that
19 much Medicaid and uninsured get some DSH so-- And
20 that's unusual. In some states, really they wouldn't
21 get any. So it's hard to know how the Secretary is
22 going to choose her methodology.
23 CHAIRPERSON JOHNSON: When does she
24 choose by?
25

2 MARLENE ZURACK: She had to implement
3 regulations in October of 2013, which she did, but
4 there was so little known about where the uninsured
5 would be reduced that she issued regulations that
6 were for two years only. And there were times when
7 there is virtually no cut. So she's promising new
8 regulations. So I'm assuming, but I'm--don't hold me
9 to it, that it's October 2015 because I don't know
10 exactly how they expired. But they were issued in
11 October 2013. And they set a methodology for the
12 first two years contemplating a new methodology.
13 CHAIRPERSON JOHNSON: Well, I would hope
14 that Senator Schumer and Gilllibrand and other
15 elected officials who represent us at the federal
16 level would weigh in with Secretary Burwell to ensure
17 that we are treated fairly. Are those conversations
18 happening with other federal elected officials?
19 MARLENE ZURACK: We've had ongoing
20 conversations with our entire New York Delegation
21 around the significant risk to HHC specifically, but
22 to all of the staking at hospitals. And we've had
23 very specific conversations around the manner in
24 which the State would itself target those dollars.
25 And most recently in the current discussions around

the Governor's Proposed Budget, and the proposal related to the extension of the existing practice for another year. We've articulated a concern that certain language needs to be put into the State budget that would actually-- As Dr. Raju said in his testimony, that would put in place mechanisms for ensuring that the dollars be more targeted. and that HHC would not be at significant risk. And by again establishing a working group that would make recommendations prior to the implementation of whatever the Secretary would promulgate in terms of how New York might be affected. And that movement, and we are also engaged with a level of advocacy not only directly, but also through our other community advocates. And other consumer advocates around this very, very important issue.

DR. RAM RAJU: I think the DSH cuts are part of--[coughs] they're a part of the ACA. So we can only mitigate that, or we can kind of postpone it a little bit. But they are a part of ACA that's going to come down. So, last Tuesday, I met with Secretary Burwell with exactly the point that how when the DSH Cut comes in, we need to make sure that the public hospitals are protected. And then we made

2 a trip to Albany to talk to our legislators making
3 sure that the DSH cuts--that when the DSH cuts come
4 in we need to make sure that Charity Care love and
5 protect the public hospital to an extent. So, we
6 firmly believe, which I said in my--in my testimony,
7 I think Charity Care dollars should really follow
8 hospitals to provide that kind of care. And we
9 really advocate for that, and we take a very strong
10 stand on it both federally as well as in the State.
11 And any help or advocacy the Council and community
12 based advisors can give us, it would be very, very
13 helpful.
14 CHAIRPERSON JOHNSON: Anything we can do,
15 we're here to be helpful.
16 DR. RAM RAJU: Yes.
17 MARLENE ZURACK: And we're happy to share
18 the language that we put forward to state legislators
19 to your staff.
20 CHAIRPERSON JOHNSON: Great. I'm going
21 to turn it over to Council Member who has been
22 patiently waiting to ask some questions.
23 COUNCIL MEMBER MILLER: Thank you, Chair
24 Johnson, for your depth of understanding on this
25 obviously complex agency, but necessary so much. I

2 want to just speak a little bit, and question a
3 little at the human capital involvement with HHC. It
4 appears that in the past few years, HHC has achieved
5 significant savings through outsourcing of services.
6 I'd like to know if this is something, a mechanism
7 that would be continued during your tenure and if, in
8 fact, as pursuant to Local Law 63. Are you guys
9 covered by Local Law 63, which requires a cost
10 analysis before farming out work.
11 [background comments]
12 MARLENE ZURACK: I think we'll have to
13 get back to you on that, but I do not think we are
14 covered by that.
15 COUNCIL MEMBER MILLER: So--so then, let
16 me just briefly speak about the Renewed Dietary
17 Initiative with Sodexo. Obviously, the French
18 company that launches the food services, and recently
19 has a 10-year contract. What was the guidelines in
20 which that contract was procured? And prior to that,
21 were you aware of the labor history or labor
22 management history of disputes of this particular
23 company? And the fact that they were-- In 2010,
24 they settled with the State of New York for
25

2 approximately $20 million that was supposed to go to
3 SUNY and New York City Public Schools.
4 DR. RAM RAJU: Well, this under my--
5 Since I came in here, we are not outsourcing
6 anything. The contract you're talking about has been
7 in effect over 10 years, and it's going to be
8 extended. And we have our plate extremely full
9 because I'm sorry, we are very, very busy with a lot
10 of the initiatives we got that we need to get
11 ourselves into the transformation healthcare system.
12 And we need to concentrate on the core healthcare
13 businesses. So, I have no plan as of today that we
14 are going to outsource anything, which is new. But
15 we need to keep that option open in case if we ever
16 do it in the future. But I don't think anything
17 right now I see as anything we are going to outsource
18 at this time.
19 COUNCIL MEMBER MILLER: So, prior to
20 outsourcing, would you, in fact, agree to a cost
21 analysis to ensure that the work could be done in-
22 house as efficiently and as effectively. Am I
23 correct in stating that there was also recently a
24 dialysis thing that was outsourced as well. And that
25 was done, or was it being--

2 DR. RAM RAJU: It was passed--it was
3 passed before I came here, but the fact of the matter
4 is I just want to let you know that every initiative
5 we do in Health and Hospital Corporation has got a
6 cost analysis done. It shows all the product time
7 and what the impact is. The impact on the cost,
8 impact on labor, and impact on the overall, you know,
9 financial--financial state of the corporation we take
10 it into consideration. And also, all the contracts
11 are bid, right. Sometimes we extend the contract,
12 but all of them are bid in a--in a way so people are
13 able to apply for it. But you are--you are right.
14 We are very, very careful, and we very due diligence
15 on what we plan to do with this. But the things we
16 have already being outsources, right, at the present
17 time I have no intention of bring them inside because
18 we constantly double up that in such a short period
19 of time. Especially, when we have the sudden real
20 issues facing us. A huge financial issue we've got,
21 and we have to transform the entire healthcare
22 system. We need to increase the access to, you know,
23 emergency care all through New York City. So there
24 are a lot of things, which are--we are working on
25 right now. So, at the present time, you know,

2 bringing some of the outsourced projects into the
3 corporation is not possible. We could consider that
4 in the future if our situation improves, and we are
5 able to do that. We'll take a look at it, and we
6 will cross the bridge when it comes.
7 COUNCIL MEMBER MILLER: So, you're saying
8 that the savings that are achieved supersedes the
9 value that you put on workers and that--
10 DR. RAM RAJU: [interposing] I did not
11 say that.
12 COUNCIL MEMBER MILLER: Wait a minute.
13 Wait a minute, wait a minute, wait a minute. That
14 they cannot--that there is no possibility that you
15 would even visit those evaluations now until you get
16 this budget under control when the budget. Whatever
17 savings that you have achieved to now have done and
18 done significantly on the backs of workers. Which is
19 what we're trying to say now to figure that if we are
20 going to save this, is it worth saving if you
21 undermine the values of the men and women that are
22 performing these services?
23 DR. RAM RAJU: I completely understand.
24 I agree with you. I didn't say that we would not do
25 a cost analysis, and we will not talk about the labor

2 impact on this. But the fact is those are overall
3 considered as we do that. But in the future, as this
4 comes up, I will take into consideration all those
5 factors we talked about.
6 COUNCIL MEMBER MILLER: So, can someone
7 speak to the headcounts in terms of the full-time,
8 part-time, hourly, provisional, per diem employees?
9 The commensurate stay of those--of said employees--
10 MARLENE ZURACK: [interposing] Yes.
11 COUNCIL MEMBER MILLER: --and those who
12 fall under the Civil Service system?
13 MARLENE ZURACK: [off mic] No. No, I
14 don't have that. I don't have that kind of detail.
15 [on mic] I don't have that kind of detail with me. I
16 could prepare something for you for later.
17 COUNCIL MEMBER MILLER: Okay. So thank
18 you very much. That--that would conclude on my human
19 capital. Just briefly, if you would indulge me, the
20 Borough of Queens is--we think is--which has
21 obviously the two municipal hospitals having just
22 lost a significant number of hospitals and-- What is
23 your plan to address those 2.3 million individuals
24 which have been experiencing a--a bed shortage in the
25 hospitals? And whether or not the--the--the--I don't

2 want to call them urgent care, but the place that--
3 Is there any plan to do anything locally to provide
4 those services that were lost with the closing of the
5 hospitals in recent years?
6 DR. RAM RAJU: No. The entire DSRIP idea
7 is to bring the care to the communities, and we are
8 working with the other healthcare providers in
9 community-based organizations. We are working very
10 closely looking at how do we expand the access to the
11 people. And there has been--that's why the community
12 needs assessment, and find out what communities need
13 what services. And we are able to kind of close the
14 gap. So hopefully, that is why I'm telling that DSRIP
15 is going to be a large undertaking for us, and we
16 really had to work very, very hard to make that
17 happen. Not only from the Health and Hospital
18 Finance shares [sic], but also for the community's
19 healthcare needs need to be taken care of. So, we
20 have a tough challenge ahead of us in this DSRIP, and
21 how do we get all the partners to work together?
22 But, we are confident that we can do that because we
23 are in this business much longer than any other
24 healthcare system in New York City. We are--it was
25 not fashionable to do community based care, community

care, primary care. We have been doing that as a part. So we believe that we are much better strategically situated to do these things. And we have a great workforce. Our workforce is really reflective of the communities we serve. And we are abele to leverage that workforce to get the best market share forces.

COUNCIL MEMBER MILLER: How far along are we in this process?

DR. RAM RAJU: We just got the-- The first plan is there. So we had to wait for the State to give us the complete pro forma. Then we just started monitoring it, how it goes. So we just started.

COUNCIL MEMBER MILLER: Okay, and my final question is who are your partners in this initiative?

DR. RAM RAJU: Well, we have more than 200 partners. We can give you the list of them if you want.

COUNCIL MEMBER MILLER: Does that also include the labor unions that I represent?

MARLENE ZURACK: Council Member Miller, absolutely, and our One City performing providers

2 system, when we officially submitted our application
3 to the State, we included our partners like District
4 Council 37 and 1199 as part of the partnership. But
5 we also included many community-based organizations
6 in Queens and throughout the city, as well as other
7 healthcare providers; physician organizations,
8 federally qualified health centers. Some chose to
9 come with us. Some chose to go with other performing
10 provider systems. In terms of your question and your
11 comment about the loss of other hospitals, as you
12 know, during the time when it most acute that
13 hospitals were closing a few years, Queens Hospital
14 Center was able to increase its in-patient capacity.
15 Remember we added more than 40 beds. We were able
16 through--because of those changes that were
17 happening, particularly in the South Queens area with
18 the closures of other hospitals, we were able to
19 expand our Ambulatory Care Center. We were able to
20 expand our capacity in terms of our Emergency
21 Department. So all along we've been responding to
22 those dynamics. And as Dr. Raju mentioned, part of
23 the whole DSRIP process was the need for us and
24 others to do expansive needs assessments and to then
25 inform our decisions about what the DSRIP investments

2 would be based on those--those needs assessments.
3 And it will be an evolving process.
4 COUNCIL MEMBER MILLER: Yeah, I
5 appreciate it, and Queens Hospital is absolutely
6 phenomenal.
7 MARLENE ZURACK: Right.
8 COUNCIL MEMBER MILLER: They have really
9 the past few decades stepped it up so much, but with
10 that being said, with the closed--the impact on the--
11 the total closures throughout the borough what we
12 were able to do there was a mere drop in the bucket
13 in comparison to the needs. And so, when you look
14 outside-- And quite frankly, I'm looking at some of
15 your numbers, and Queens Hospital numbers are pretty
16 consistent. But when you go outside into the
17 private--
18 MARLENE ZURACK: [interposing] To the
19 long-term hospitals.
20 COUNCIL MEMBER MILLER: --you can--you
21 can spend hours in an emergency room, and days before
22 you get a bed. And that is just the reality that
23 we're dealing with. We want to be preventive. So we
24 are looking forward to working with you on this.
25 MARLENE ZURACK: Thank you.

2 COUNCIL MEMBER MILLER: Thank you.
3 CHAIRPERSON JOHNSON: Thank you, Council
4 Member Miller. There's a lot to talk about, but we
5 don't have a whole lot of time. So I'm going to try
6 to jump through a few things quickly, because the
7 public has been waiting, and I want to get to them.
8 So, as a result of this looming deficit, is there--
9 does HHC anticipate outsourcing any services?
10 DR. RAM RAJU: I'm not anticipating
11 anything now. No.
12 CHAIRPERSON JOHNSON: And where do
13 things stand on dialysis?
14 DR. RAM RAJU: Dialysis is before the--
15 the State. The State Council is taking a look at it.
16 From what I understand, they have asked them to come
17 back with some quality indicators to begin the next
18 cycle of community hearings. And they were asked to
19 provide some more data about the quality of the
20 dialysis vendors to the State, especially to the
21 State. [sic]
22 CHAIRPERSON JOHNSON: And you all are
23 working with NYSNA on trying to come up with folks to
24 put together an independent look?
25

DR. RAM RAJU: No, we are still ready to do this with the NYSNA, but unfortunately the two members we suggested was there because of the time frame. We offered them to come in, but they chose not to do that, not NYSNA, the two doctors we want to bring in. If they bring in more independent doctors to look into that, I'm open to that.

CHAIRPERSON JOHNSON: Thank you. Would HHC, is HHC considering consolidating any service? Are there any current services on the table that you're looking at consolidation on?

DR. RAM RAJU: I don't--I don't. Off hand, I don't know. Say it again?

MARLENE ZURACK: Function.

DR. RAM RAJU: Function?

MARLENE ZURACK: We're looking at potentially consolidating some administrative functions but not--

CHAIRPERSON JOHNSON: [interposing] Some what?

MARLENE ZURACK: Administrative functions, but not services.

DR. RAM RAJU: [off mic] Not services.

2 CHAIRPERSON JOHNSON: And could you
3 describe the community partners that are part of the
4 One City Health PPS?
5 DR. RAM RAJU: Yeah, we have a--our major
6 partner is SUNY Downstate is in our PPS. We have a
7 large group of community-based organizations as part
8 of it. We are also working closely with other PPSs
9 to have some common projects, to be able to do that.
10 We can currently give you a list of all of our
11 partners. It's over 200 different organizations. We
12 will be happy to provide that to you.
13 CHAIRPERSON JOHNSON: That's great. If
14 you could share that with us, that would be helpful.
15 Just to go back to a point that Council Member Miller
16 was making. I stepped out of the room. So, forgive
17 me if you answered this already. How much does HHC
18 currently spend on temporary staff, on temps?
19 MARLENE ZURACK: I actually have it
20 converted to FTEs as opposed to dollars, but-- So for
21 example, in total HHC has 45,000 full-time
22 equivalents, and temporary staff account for about 8%
23 of that.
24 CHAIRPERSON JOHNSON: Okay.
25

2 DR. RAM RAJU: But we are in the process
3 of moving them into full-time. That's why I talked
4 about that--
5 CHAIRPERSON JOHNSON: [interposing] Yes,
6 you talked about that.
7 DR. RAM RAJU: --to move them into full-
8 time and part-time.
9 CHAIRPERSON JOHNSON: It would be helpful
10 to see in the current budget how much is being spent,
11 the dollar amount on temps. How much specifically
12 has been spent on Winston Temps, the service. And
13 so, I would love to understand how much money HHC is
14 spending that way. What--Dr. Raju, I know you
15 mentioned this in your testimony, what measures are
16 being taken to address wait times for appointments?
17 DR. RAM RAJU: You know that is and
18 continues to be a challenge because of simply the
19 reason is our demand on the system definitely exceeds
20 the capacity of the system to provide that. And as
21 we are trying to do these things, what happens in the
22 market around us is also our big thing. What Council
23 Member, you know, Miller talked about is when the
24 hospital nearby closes, the capacity created gets
25 over-exceeded. But, we are approaching it in two

2 ways. One, we want to really make the--have evening
3 hours and weekend hours to that we can have more
4 capacity. People will be coming more into the
5 system. We are looking at increasing the
6 productivity so we are able to see more patients in
7 the system. That simply means the doctors need help
8 in navigating it, they need the extra help to do
9 that. So, we are looking at very--a bunch of options
10 making sure how we can support our workforce so they
11 can produce more. At the same time whether we can
12 get out of normal working hours, and move into
13 evening time and weekend time to produce the
14 capacity. Under the DSRIP, as we go into third and
15 fourth DSRIP, [sic] we are probably working with the
16 other community-based groups; doctors' groups and
17 other folks to create more access for our patients.
18 So this is a thing, which is in evolution. But our
19 idea is to produce as much access as possible, and
20 also geographically convenient access. And also, it
21 should be timely access. It cannot be just, you
22 know, you cannot-- But still, we are there. We
23 still continue to struggle. People wait for time for
24 considerable more time for the--for the time to get
25

2 an appointment, and sometimes they even wait to see
3 the doctor.
4 CHAIRPERSON JOHNSON: Yeah, that's
5 problematic.
6 DR. RAM RAJU: [interposing] It is.
7 CHAIRPERSON JOHNSON: I mean you
8 mentioned that because, you know, you need to keep
9 your--you need to keep your patient base to be able
10 to keep your revenues that you need to keep the
11 corporation running.
12 DR. RAM RAJU: Absolutely. You're right.
13 So that is why we are trying to work very closely
14 with everybody making sure that-- We need to get it
15 correct. Otherwise, we will be in trouble.
16 CHAIRPERSON JOHNSON: Adult patients
17 discharged with a principal psychiatric diagnosis,
18 who are readmitted within 30 days, have increased
19 from 4.4% in the beginning of Fiscal Year 2014 to
20 7.4% in Fiscal Year 2015, almost double. Why has the
21 number almost doubled? And how can we ensure that
22 patients are receiving the outpatients services that
23 they need to avoid readmission?
24 [background comments]
25

2 DR. RAM RAJU: Hello, Dr. Ross Wilson,
3 our Chief Medical Officer.
4 DR. ROSS WILSON: Good afternoon. If I
5 could briefly go back to the previous question about
6 access before I address this question. One area that
7 we've been very successful--
8 CHAIRPERSON JOHNSON: [interposing] Could
9 you just introduce yourself?
10 DR. ROSS WILSON: All right, Dr. Ross
11 Wilson, Chief Medical Officer for HHC. One area
12 we've been very successful at improving access has
13 been in pediatrics. And right across all of our
14 sites, we have expanded hours of service, and we have
15 wait times that are well, well, well within any
16 standards by insurance companies or other groups.
17 We've got there at half of the places for adults, but
18 we've made good progress. But we've been successful,
19 but we're not there yet. With regard to the
20 readmissions for patients with behavioral health
21 diagnosis, one of the things that's been achieved is
22 we have reduced the length of stay for patients with
23 mental health disorders about 40% over the last two
24 years. And this has been partly about preparing for
25 managed behavioral health. It's partly been about

2 changed treatment. There has been a small increase
3 in readmissions associated with that. That accounts
4 for a small amount, probably a quarter of that.
5 The rest of it is a whole range of
6 different issues. Mostly related to non-mental
7 health issues; homelessness, co-occurring drug
8 disorders; associated diabetes, et cetera. And so,
9 we're drilling down on this pretty hard, and that
10 rate of rise has now flattened. So we're looking
11 forward to seeing this actually go back down. But
12 across the country that figure, there is between 5%
13 and 10%. And so, we're not really out of line with
14 what happens in best practice around the country.
15 But it does definitely represent an increase
16 internally for us.
17 CHAIRPERSON JOHNSON: Thank you, Dr.
18 Wilson. Dr. Raju, I don't know if you saw it, but
19 there was an article in the New York Times. It was
20 yesterday I believe and the title of it was
21 *Healthcare Systems Try to Cut Cost by Aiding the Poor*
22 *and Troubled*. And it talked about innovative ways to
23 try to help people that most frequently end up in the
24 hospital system because they're going there for
25 things that you really don't need an emergency room

2 for if you were getting preventative care. You'd be
3 taken care of that way. And they talk about how the
4 federal government through a $10 billion innovation
5 center is trying to do things like help people who
6 may be diabetic to actually get the right food. And
7 they said they will even go shopping with them.
8 Innovative things to try to help people. Is HHC
9 doing everything along those lines in a similar way
10 for the people that are most likely to frequent the
11 hospital many, many times? The article talks about a
12 homeless individual who in a two-month period ended
13 up in the ER 17 times.
14 DR. RAM RAJU: Yes, I think the interest
15 is in care coordination. That's what we do. There
16 is a large care coordination comportment to the DSRIP
17 and we continue to do that. And what--going back to
18 what is part of it is you cannot just look at the
19 readmission, pure readmission because people--the
20 social-economic conditions play a big--a very big
21 role in the readmission process.
22 CHAIRPERSON JOHNSON: [interposing]
23 Poverty is to re-involve this?
24 DR. RAM RAJU: So poverty needs to be
25 taken care of. Homelessness needs to be taken care

of, right. We can't develop a population model in which all the things happen, unless there are other things coming. Because you can't keep the community health if they're not safe. If they don't have economic development. If they don't have jobs, and the education is not there. Right, all those things. Homelessness is a problem. All the things can keep you to the--what you're talking about readmissions as well as, you know, people seeking health and medical care. In fact, if you read the article, the first portion of it the person said he actually went to the Emergency Department not because he is a diabetic, because it was cold outside.

CHAIRPERSON JOHNSON: It was cold and he wanted a place to go.

DR. RAM RAJU: It was cold. So we get that all the time. Not only is it cold, people just, you know, come to the Emergency Department because we want them to come in. We don't want them to be hiding outside and they--and they, you know, get frozen. So, we have to, as the healthcare leaders, you know, we really have to work with other community providers and leaders to make the community safer for healthcare. Otherwise, healthcare alone cannot take

care of these things in a very isolated way to do that.

CHAIRPERSON JOHNSON: Thank you. So I'm--I'm going to try to run through these really quick--really quickly. There is also--not that I'm solely relying upon the New York Times. But there was also a good op-ed about the EMR, Electronic Medical Records, and how the current EMR system in many hospitals are facilities are not well designed. Do not match well with multiple systems, and they could be improved in many ways. HHC has included $150 million in its Preliminary Capital Budget towards new state-of-the-art EMR system to span HHC's entire patient care facilities. I don't know if you saw the op-ed. Read it. It talks about all of the problems associated with EMR because many of the EMR systems are not the best systems to actually use. And so, I'm wondering if you could give the Committee an update on this project. And is the project still on track to be complete by 2017?

DR. RAM RAJU: The project is on track at the present time. So we will continue to give you an update. EMR implementation is one of the biggest mammoth tasks any organization can take. Usually,

2 they have a problem with doing it in a smaller on
3 hospital. We will implement it across the city in 11
4 active care hospitals, and all over the nursing homes
5 and the clinics and our, you know, Federally
6 Qualified Health Care Look-Alikes. So this is a big
7 task and we are quite aware of it, and we are really
8 managing it. But we will give you an update on it.
9 But this is not an easy project. It's a big project.
10 CHAIRPERSON JOHNSON: Thank you. A
11 question on Ebola.
12 DR. RAM RAJU: Okay.
13 CHAIRPERSON JOHNSON: The unit at
14 Bellevue how many beds does HHC currently have at
15 Bellevue for Ebola or any other potential infectious
16 disease outbreak? Is it five?
17 DR. RAM RAJU: Two. Two beds.
18 CHAIRPERSON JOHNSON: Two beds?
19 DR. RAM RAJU: Yes.
20 CHAIRPERSON JOHNSON: Isn't that scary?
21 DR. RAM RAJU: It is compared to Nebraska
22 it's got two beds. MAH has got two beds, and Duke
23 has got two beds. So there are only 10 beds across
24 the nation to take care of the Ebola patients.
25 CHAIRPERSON JOHNSON: That's shameful.

2 DR. RAM RAJU: I know.
3 CHAIRPERSON JOHNSON: It's not your
4 fault.
5 DR. RAM RAJU: No. We are willing to
6 expand it, if the government will--
7 CHAIRPERSON JOHNSON: [interposing]
8 That's shocking.
9 DR. RAM RAJU: Yes.
10 CHAIRPERSON JOHNSON: Ten beds across the
11 country.
12 DR. RAM RAJU: That's right. That's all
13 they have.
14 CHAIRPERSON JOHNSON: So the patient who
15 was infected in New York and who luckily recovered
16 under the good care of your facility, and the doctors
17 and medical professionals there. If, in fact,
18 something have gone wrong, and more people had
19 contracted Ebola-- Let's just say 10 people ended up
20 getting it, but there are only two beds, where would
21 the other eight people go?
22 DR. RAM RAJU: You know, what they did
23 was they investigated a lot of hospitals across the
24 state and the city as Ebola hospitals. So they are
25 supposed to clear more and more beds. I'm pretty

2 sure Monty has got a couple of beds. Mount Sinai has
3 got, the LAJ [sic] unit has got. But the question
4 would be all right, it is--this is going to be
5 something the federal government should take a very
6 close look at it. Because this was Ebola yesterday.
7 It could be something else tomorrow. So we have be
8 in there. So we have asked the federal government to
9 designate us--Bellevue as an infectious disease
10 hospital whatever disease it is for the intake
11 procedure. Actually Region 2 of the CMS, which
12 includes New Jersey, New York, and Puerto Rico.
13 Hopefully, we'll be--we'll get approval. You know,
14 this is a very expensive proposition to keep the
15 staff clean all the time, and also keep the things
16 going. So there is a lot of work to be done. I hope
17 the federal government will look into that and
18 designate us as an Ebola designated center. So that
19 we can get some funding from the federal government.
20 CHAIRPERSON JOHNSON: Can you discuss
21 HHC's revisiting the contract renewal for Sedexo for
22 the food services--
23 DR. RAM RAJU: [interposing] Yes.
24 CHAIRPERSON JOHNSON: --at HHC
25 facilities? What have the patient and worker

2 feedback-- Well, what has the feedback been from
3 patients and workers on that vendor?
4 DR. RAM RAJU: You know, we just extended
5 the contract for ten more years. As a part of it, I
6 asked my senior staff to go and test the food.
7 CHAIRPERSON JOHNSON: Right.
8 DR. RAM RAJU: We asked them, but we are
9 tested two weeks ago with the--with their because we
10 cannot just give to patients what we don't eat. So
11 it is --it is not perfect. But it is--it is okay in
12 certain things, and not--could be improved in other
13 places. We have to hold them accountable, and we
14 have every intention of doing that. We have to
15 continuously monitor the satisfaction of the patient
16 with the food. And we do that right now, but it is
17 done through a mechanism, right. An independent
18 person does that. We need to make sure that he
19 continues to pay very close attention, and be able to
20 do that. One thing we also did as per the patient,
21 we included-- We actually started giving hot
22 breakfast in the morning. It is also coordinated
23 [sic] so now we have a hot breakfast. So we
24 currently, you know, work with the patient to do
25

2 that. But you are right. It is really to constantly
3 monitor the satisfaction closely.
4 CHAIRPERSON JOHNSON: So just a couple of
5 questions, and then I'm going to give you questions
6 that I'm not going to ask today, but are still
7 important. The sooner you can get them back to us
8 the better. So what is HHC's involvement in the
9 Mayor's plans to expand the six health clinics? And
10 are you seeking for HHC's federally qualified health
11 centers to be awarded some of these funds?
12 DR. RAM RAJU: We are in negotiations,
13 discussions with the--with the Mayor's Office, City
14 Hall as well as the Department of Health. You know,
15 we are trying to kind of find a concise,
16 comprehensive access improvement plan. So it is not-
17 [background comment]
18 DR. RAM RAJU: It is not final yet.
19 CHAIRPERSON JOHNSON: It's not final yet?
20 DR. RAM RAJU: Yeah.
21 CHAIRPERSON JOHNSON: How many people are
22 currently enrolled in Metro Plus, 500,000?
23 DR. RAM RAJU: 460--
24 MARLENE ZURACK: 469,000.
25 DR. RAM RAJU: 469,000.

2 CHAIRPERSON JOHNSON: And what would your
3 goal be to get it up to in the next year, in the next
4 five years?
5 DR. RAM RAJU: Next year 600,000 we are
6 looking for.
7 CHAIRPERSON JOHNSON: You want to get it
8 up 600,000. So you want an additional 140,000
9 people?
10 DR. RAM RAJU: Yes.
11 CHAIRPERSON JOHNSON: And that's why
12 you're investing the $15 million to try to work with
13 navigators and community partners to increase
14 enrollment. So next year by 600. And then in five
15 years what do you want it at, a million?
16 DR. RAM RAJU: Yeah. If we can get to
17 that, that will be good.
18 CHAIRPERSON JOHNSON: What's doable?
19 What's realistic?
20 DR. RAM RAJU: Well, it is--it is doable
21 depending on how quickly we expand the services,
22 expanding the insurance reform. And also how we are
23 going to deal with the--what--when Immigration Reform
24 comes in. If the Immigration Reform comes in, it may
25 become like more eligible for Medicaid over a period

of time, it will be very helpful to us. We do serve a lot of undocumented immigrants in our system.

CHAIRPERSON JOHNSON: Okay.

DR. RAM RAJU: And one more thing, we're also looking for is to have more employees to choose Metro Plus.

CHAIRPERSON JOHNSON: Good. So, we didn't get to ask questions. We asked a lot, I know, Dr. Raju, but we didn't get to ask about Medicaid reimbursement for--that the City receives $37.2 million reduction in intercity funds due to a change in how the City receives Medicaid reimbursement for inmates receiving services at HHC. How is it going to impact HHC's financial plan? Ho will the change impact health services for inmates? I would love an update. I know you mentioned some in your testimony on the $1.7 billion for the Sandy damages at Bellevue, Metropolitan, Coler, and Coney Island. It would be helpful to know--to get an actual timeline of when you think those changes will be made. What is HHC doing to ensure that newly insured patients of this new population doesn't have an impact on the access for uninsured populations?

2 The Capital Funding Commitment Plan
3 includes almost $73 million in Fiscal Year 2015 for
4 ambulances in HHC's Capital Program. How many
5 ambulances will that funding cover? What is the
6 timeline for the purchases of those ambulances? HHC
7 allocated $8 million in Preliminary Capital Budget
8 towards the construction of the new extension clinic
9 to Coney Island Hospital, the Vanderbilt Avenue
10 Health Center on an HHC owned property in the Clifton
11 Section of Staten Island. You mentioned that.
12 Getting an update on that project in a comprehensive
13 way, and the timeline associated with it. I'll end
14 with this. Really, I know it's not up to you, but I
15 really do not want to see those dialysis services
16 privatized. [applause] I do not think--I do not--
17 You I know take very seriously, Dr. Raju, the fact
18 that HHC takes care of the most vulnerable people in
19 New York City. Undocumented people, the uninsured,
20 people that are adversely affected with higher rates
21 of poverty. And the sickest of the sick are people
22 who are on dialysis. And to compromise the quality
23 of care that they receive would be a deep injustice
24 to those individuals who rely upon the great services
25 that they currently receive from HHC.

And so, I know that you are going to work together with NYSNA. I look forward to you guys coming to some type of agreement on the independent review. Thank you for your commitment to doing that, and not pushing it ahead last year. I really appreciate that. I have been thoroughly impressed by your leadership since you took over and your commitment to our public hospital system to advocating for what is right. When you spoke at the Bellevue CAD meeting a few weeks ago, you spoke from the heart about your own experience and why you do this type of work. And I've been very impressed and very moved by your hands-on leadership, and how seriously you've taken getting our public hospital system on firm financial footing because of the New Yorkers that really rely upon it.

HHC Hospitals, as you know, are really for many individuals are the last shred of a social safety net that exists for them. And without these facilities, lives literally would be lost. You know that. So, I'm grateful that you're here today. I'm grateful to your team, and being able to work with them, and I look forward to working together to advocate to people in positions in our Federal and

2 State governments to ensure that HHC gets its fair
3 share. And that you all continue the good work that
4 you do. There are still areas to improve in. I want
5 the Doctor's Council to get a good contract--
6 DR. RAM RAJU: [off mic] Yes.
7 CHAIRPERSON JOHNSON: --and to get it
8 done soon, and I also look forward to those temp
9 workers being converted to full-time employees at
10 HHC. So thank you very, very much.
11 DR. RAM RAJU: Thank you Chairman for
12 your comments and your time. We appreciate it--
13 CHAIRPERSON JOHNSON: [interposing] Thank
14 you very much.
15 DR. RAM RAJU: --we appreciate your
16 support.
17 CHAIRPERSON JOHNSON: [interposing] Thank
18 you. We are going to take a five-minute break, and
19 then we're going to come back for the public
20 testimony.
21 [pause]
22 [gavel]
23 CHAIRPERSON JOHNSON: Thank you all for
24 being so incredibly patient. It has been a long day
25 so far. We are going on hour five or into hour six.

2 So, I really appreciate the fact that you are all
3 here to testify on many different issues that are
4 important to public health in our city. I am going
5 to hopefully, as you all should have been instructed,
6 you all have written testimony. And I would love for
7 you to submit that. You're all going to have a
8 chance to testify, but we're going to limit folks to
9 two minutes, and the reason for is we have more than
10 30 people that want to speak today, and we'll be here
11 all evening if we go on much longer. All of your
12 testimony will be read by us, by the committee staff
13 and by myself. We take this very seriously, as you
14 can tell, the budget process.
15 So just because you don't get to say it,
16 doesn't mean we're not going to know it's important
17 to you. Because we review every piece of testimony
18 that is given to us. So we're going to call people
19 up, and we're going to put you on the clock at two
20 minutes, and please respect the clock. It's not
21 because we don't love you. It's just because we have
22 a lot of people who we want to hear from today. So
23 the first pane is Moira--Moira Dolan, from DC37;
24 Oscar Alvarado from DC37; Carmen Charles, President
25 of Local 420 from DC37; Dr. Matthew Hurley from

2 Doctors Council; and Anne Bovay from NYSNA. So
3 Sergeant, we may need an additional chair. Ray, if
4 you could just grab an additional chair to pull up to
5 the side. And is here, Matthew is here. Great. So,
6 Ms. Charles, maybe you could start and then we'll
7 just go down the row. Great. You just turn the mic
8 on. The red light has to be on. There you go.
9 CARMEN CHARLES: Good afternoon,
10 Councilman Johnson and members of the City Council
11 Health Committee. Thanks for convening this very
12 important hearing. My name is Carmen Charles. I'm
13 the President of Local 420. First, let me say I know
14 I'm not going through my two minutes, but I'll do the
15 important part. I speak on behalf of my members who
16 are employees of the Health and Hospital Corporation.
17 They live and work in the communities where HHC
18 hospitals are located. They serve patients who come
19 through the door--regardless of their ability to pay-
20 -with compassion, dedication, and professionalism.
21 These are just a few of the titles: Nurse's Aid,
22 Housekeeping Aids, Patient Care Associate,
23 Respiratory Technicians and so on. And many others
24 who are on the front line every day of the year.
25 Whether it's disaster or snow storm, or just a

2 regular day, my members are working hard to care for
3 all in need of healthcare. In my brief time I have
4 today, I would like to stress that we are all aware
5 of the financial challenges facing HHC due to reforms
6 in healthcare, including the Delivery System Reform
7 Incentive Program, which is DSRIP. We want to HHC to
8 continue to provide quality service, and we are
9 committed to working together to find new revenues,
10 and achieve rational savings. However, staff
11 reduction, aggressive management, consolidation, and
12 elimination of critical services and outsourcing of
13 vital direct, and indirect patient care have been a
14 high price to pay for the patients, the underserved
15 communities and the dedicated civil servants who
16 provide the care.
17 In May of 2010, HHC released its Four-
18 Year Cost Containment and Restructuring Plan to
19 address a budget deficit. Particularly in the area
20 of disproportionate share of hospital funding. [bell]
21 That is vital-- It's finished? That is vital to
22 convene--to convert--to cover indigent care costs.
23 However, Councilman, let me just go off for a second.
24 Part of the problem that Local 420 has it's the
25 agency workers that is a part of HHC workforce. Some

2 of them are there for six to eight years and more.
3 There is no reason for an agency worker, who was
4 supposed to be filling in for people who are out sick
5 to still be on the job for eight years. There is a
6 shadow workforce within HHC that is not being
7 addressed.
8 CHAIRPERSON JOHNSON: I agree with you.
9 CARMEN CHARLES: Okay, and you can't have
10 full-time employees working alongside people who are
11 not receiving any benefits. More importantly, we
12 have supervisors who are not trained. Who doesn't
13 know what a collective bargaining--our collective
14 bargaining agreement. And so, therefore, those are
15 part of the problems we have.
16 CHAIRPERSON JOHNSON: Anything that we
17 can do to be helpful--
18 CARMEN CHARLES: [interposing] Thank
19 you.
20 CHAIRPERSON JOHNSON: --and to work with
21 you, and to facilitate you all being able to work
22 better with HHC's leadership, we are going to do
23 that. I now, Ms. Charles, that you and I met. I
24 made a request to Dr. Raju that he come to speak to
25

you and your membership. He did that, and I think that was a good thing.

CARMEN CHARLES: Yes.

CHAIRPERSON JOHNSON: I know more work can be done, and you see today both myself and Council Member Miller pushed on getting rid of temp workers, and converting people to full-time employees with the training and benefits that they deserve and needs.

CARMEN CHARLES: I commend Dr. Raju because I have to say it is the first time in the history of HHC and in Local 420 that the President came to one of our meetings to talk about HHC's mission and to address some of the concerns of my members. And I'm saying it publicly, we look forward to being at the table. We cannot affect change. Dr. Raju has the great opportunity to be a change agent. But we can't say one thing in front of the City Council and do something else in the hospitals.

CHAIRPERSON JOHNSON: Well, if they're doing that, you let me know, and I will not be as nice to Dr. Raju as I was a few minutes ago.

CARMEN CHARLES: We will hold him accountable. Thank you--

CHAIRPERSON JOHNSON: [interposing] Thank you very much.

CARMEN CHARLES: --very much.

CHAIRPERSON JOHNSON: If you could turn the mic towards you. Thank you.

OSCAR ALVARADO: Good afternoon. My name is Oscar Alvarado, now Special Assistant to Local 1549 President Eddie Rodriguez. And I would like to thank you for allowing to testify, and for all of the past help you have give public health. Local 1549 represents over 4,000 clerical and administrative employees at the New York City Health and Hospital Corporation, and its public HMO Metro Plus. The cost of providing necessary quality services to the public continues to outpace this public system's cost of care and income. This is despite HHC's low administrative overhead. HHC is the key to making healthcare more accessible especially in the areas where the greatest disparities in healthcare exist.

A New York Post article last year spoke about the excessive tax dollars received by large hospitals with high paid CEOs who do not service anywhere near the number of poor patients that HHC does. The article speaks to the need to support HHC

and its mission to treat all those who come through its doors. Yet, HHC continues on a mission to privatize. There are at least 500 private temps performing clerical duties in HHC. That represents 10% of the clerical work. We also see continued moved to privatize dialysis and appointment calls and other responsibilities. We believe that this compromises the quality of work performed and patient confidentiality. Local 1549, Second Vice President Ralph Palladino is a patient at Bellevue Hospital where private temps are working in an appointment call center. And he say, quote, "As an HHC patient, I am appalled and concerned that my medical records number will be known to private temp agency employees. I question the vetting and security issues concerning every HHC patient." End of quote.

The City is proposing to spend more than $16 million on building community healthcare clinics in the next three years. This is wise, but the Union believes based on past history that those clinics will be privately run instead of being run [bell] by HHC. The City Council provided funding to expand these clinics a few years ago with public tax dollars, but they should not be private clinics, and

2 should be staffed with public employees. We believe
3 that public tax dollars should not be used to
4 building private healthcare institutions while HHC
5 continues to bleed. The City Council should inquire
6 as to who will run these clinics. In 1979, the City
7 tax levy dollars provided 33% of HHC's funding. Now,
8 it is below 10%. This was curtailed courtesy of
9 Mayor Giuliani who tried to privatize and destroy the
10 public system. In the 2016 budget, we are asking for
11 increasing city tax levy funding for HHC Public
12 Health. We're also asking the City and HHC to cease
13 privatizing HHC staffing and services, and hire civil
14 servants. We believe funding for community health
15 clinics should be for public facilities, not private
16 gain. Thank you, sir.
17 CHAIRPERSON JOHNSON: And I agree with
18 you on all of that. Thank you very much.
19 MOIRA DOLAN: Good afternoon. My name is
20 Moira Dolan. I'm representing Henry Garrido, our
21 newly appointed Executive Director of DC37. We
22 represent 17,000 members at HHC. Regarding the
23 privatization of dialysis, we appreciate your
24 outspoken opposition to the privatization, and we
25 invite you to join us at the next full meeting of the

New York State Public Health Planning Council meeting on May 11th. Where you can join us in the opposition to any decision to turn over these vital patient, core patient services to a private vendor who is unacceptable.

CHAIRPERSON JOHNSON: I'll be there.

MOIRA DOLAN: May 11th for everybody else.

CHAIRPERSON JOHNSON: Be there.

MOIRA DOLAN: Regarding the headcount reductions that are projected through June 2016, Dr. Raju spoke of creating a category called Global FTEs and working on reducing the number of temporary agency staff, which we have been advocating for many, many years. We hope and pray that they are serious about reducing temporary employees and not full-time employees. As we testified last year, we have already had lost over 37 head--37,000-37-- Now, see what happens when you adlib. 3,737 heads over the course of the five-year Road Ahead Plan. So clearly, we have cut enough for represented employees, and full-time employees. He also spoke about benchmarks being developed for standardized work across the corporation. The benchmarks should not be the

2 minimum possible staffing level, and it should
3 represent the varied conditions that exist in each
4 community and each facility. And as you asked about
5 headcount, we also want to see more detailed
6 breakdown of full-time, part-time, per diem, hourly,
7 temporary and affiliate staff.
8 Despite all this bad news about reduced
9 revenue there some possibility for good news [bell]
10 through the Workforce Development funds coming
11 through DSRIP. We anticipate that there will be
12 significant funds for development and training, and
13 we anticipate working with HHC on identifying areas
14 of growth, areas of retraining and skills upgrading.
15 We do want to indicate that there are payroll
16 problems that continue to exist. Yes, the collective
17 bargaining settlements were paid, but not everyone
18 was paid fully or properly. There is too much
19 whackamole types of problems on in--
20 CHAIRPERSON JOHNSON: [interposing] Get
21 us that information and we will help you with it.
22 MOIRA DOLAN: Yes. And finally, we
23 support the CPHS agenda items including Access Health
24 New York City.
25

2 CHAIRPERSON JOHNSON: Thank you very
3 much.
4 MOIRA DOLAN: Thank you very much.
5 CHAIRPERSON JOHNSON: Tell Henry I said
6 hi.
7 MOIRA DOLAN: I will.
8 CHAIRPERSON JOHNSON: Ann, do you want to
9 go?
10 ANNE BOVAY: Yeah.
11 CHAIRPERSON JOHNSON: Okay.
12 ANNE BOVAY: I wish to thank New York
13 City Health--New York City Council Health Committee,
14 and you Chairperson Corey Johnson for your support of
15 public health system for this hearing today. I am
16 Anne Bovay [sp?]. I am President of HAT and the
17 Executive Council for New York State Nurses
18 Association, which is more 8,000 nurses who work for
19 HHC. The New York State Nurses Association is a
20 member of the People's Budget Coalition, and fully
21 supports Access Health New York City because of its
22 potential to provide healthcare access information to
23 all communities including the underserved in and
24 linguistically competent way. It is an appropriate
25 response to the City's increasingly diverse

populations. Or, I should say variety populations. Because I don't like that word diverse. As it would reduce disparities in health services and address these inequities in accessing primary care.

Obviously, I'm going to talk about--against privatization of dialysis. And basically, in HHC. First of all, the mortality rate is high. The Nephrologists says HHC says it's no good, right. And there's a compromise in terms of quality care. I'm cutting to the chase, and I've said this before years ago in terms of the City Council. If a private agency can make money, why can't we? And we've had a longer history in terms of quality care. And I also think it needs to be considered that there--like a Bellevue Hospital we are privatized and I think not only preventing further privatization, but the reversal of the privatization that has already happened in regards to that as well. We're asking this committee to hold a hearing as soon as possible to also hear the patients, their family and community members prior to that hearing that's going to happen in May. So we have a further understanding of the issues at hand.

2 And I just want to take a personal
3 privilege to talk about infection control that [bell]
4 at Bellevue has about 50 beds that have negative
5 pressure, and it came about because of, you know,
6 multi-drug resistant TB. Also we had that Small Pox
7 scare and Anthrax, et cetera. So have a lot of
8 physical resources available that I think it would
9 be, you know, good for you to see. But as a
10 provider, what I see is the number of people that
11 need to be able to handle this and what we have a
12 lacking of. But we do have the physical resources.
13 CHAIRPERSON JOHNSON: Thank you. Thank
14 you, Ann. Dr. Hurley.
15 DR. HURLEY: Good afternoon, Chairman
16 Johnson and members of the Health Committee. My name
17 is Dr. Matthews Hurley. I'm First Vice President of
18 Doctors Council, SEIU, which represents the doctors
19 in HHC and New York City Department of Health and New
20 York City Jails. We thank you for the opportunity of
21 testifying. I'm just going to skate over a number of
22 the--of my testimony to keep within the two minutes.
23 We appreciate the collaboration with the City Council
24 in getting the services, labor and delivery reopened
25 at NCB. Unfortunately, the input and--unfortunately,

2 the input of the community and healthcare workers is
3 not prioritized at HHC as we would like. As we are
4 still moving--as HHC is still moving to privatize
5 chronic dialysis at Lincoln, Metropolitan, Harlem and
6 Kings. And as Anne Bovay said the Nephrologists have
7 not even been brought into the discussions, and they
8 have deep reservations about the vendor, Big Apple.
9 Our doctors seek a greater voice in
10 quality patient care, and that is why we have put
11 forward our white paper in trying to have more
12 frontline engagement. We support the Mayor's efforts
13 to expand fund community health centers in
14 underserved neighborhoods to fund an annual child
15 health service--survey. We also--we can do more to
16 improve disparities and outcome by increasing the
17 amount of oral healthcare programs that are available
18 to the--to our children. Right now it's a patchwork
19 quilt, and it's insufficient to deal with the oral
20 health needs of our young. We at Doctors Council
21 support wholly People's Budget Coalition efforts and
22 Access Health organization to outreach in public
23 education in their communities on their options for
24 health [bell] coverage. We also urge the City
25 Council to support what's going around now, which is

2 the Asthma Free Housing Bill. It's coming back
3 around. We believe in it. It will give a greater
4 fight for clinicians to be able to help the asthmatic
5 patients. We also support Lady Chirlane McCaray's,
6 our First Lady's effort to address mental issues in
7 our communities. And currently, staffing is below
8 where it should be in recruitment and retention
9 challenges in Corizon. And it's not just the
10 Corizon. It's also the Department of Corrections.
11 It's about getting patients to see the clinicians
12 that are there. So I think everybody needs to be
13 brought to task.
14 CHAIRPERSON JOHNSON: Thank you, Dr.
15 Hurley. Thank you for testifying at our Oversight
16 Hearing on Corizon. Thank you for being there, and
17 representing the doctors that do this really hard and
18 important work on Rikers Island, and thank you to all
19 five of you. You all collectively represent nearly
20 all of the men and women that actually keep our
21 hospital and public health system moving. Without
22 your members, it would cease to exist. So, I really
23 appreciate you all being her today. And it is always
24 a pleasure to work with you all collectively and
25 collaboratively to make sure that our public health

2 system and our hospital system does even better. And
3 that the men and women that keep it going are treated
4 with dignity, fairness and respect. And get the
5 wages and benefits that they deserve. So thank you
6 all very much.
7 ANNE BOVAY: Thank you.
8 [applause]
9 CHAIRPERSON JOHNSON: So, next Alana
10 Leviton from the Citizens Committee for Children;
11 Courtney Bryan, the Center for Court Innovation;
12 Lorraine Gonzalez Camastra from the Children's
13 Defense fund; and Anthony Feliciano from CPHS.
14 [pause, background comments]
15 CHAIRPERSON JOHNSON: Lorraine is not
16 here. So I believe Lorraine-- Is not here? Lorraine
17 is not here. So, we're going to call up Marilyn
18 Saviola from the Independent Care System.
19 MALE SPEAKER: [off mic]
20 CHAIRPERSON JOHNSON: Excuse me?
21 MALE SPEAKER: [off mic]
22 CHAIRPERSON JOHNSON: It's okay. We're
23 not doing it and you can still come up, and we'll
24 still--you can still testify.
25 [pause]

2 CHAIRPERSON JOHNSON: Thank you very
3 much. So you may begin in whatever order. How about
4 we start here and we move our way down. Go ahead.
5 ALANA LEVITON: Good afternoon. My name
6 is Alana Leviton, and I'm the Policy Associate for
7 Health and Mental Health at the Citizen's Committee
8 for Children. In an effort to be brief, I'm just
9 going to give you the highlights reel of my testimony
10 today, and I hope that you will review the written
11 testimony.
12 CHAIRPERSON JOHNSON: We will.
13 ALANA LEVITON: The Preliminary Budget
14 made some important steps to address income
15 inequality and improved child safety and wellbeing in
16 New York City. However, we believe that there's a
17 great deal more to look at and evaluate as we move
18 towards an Executive Budget. We were pleased to see
19 that the Preliminary Budget included several new
20 investments that will strengthen children's access to
21 high quality health services. We hope that the
22 Council will approve the budget--sorry--the money to
23 create the neighborhood health hubs, and urge the
24 administration to ensure that these hubs provide
25 mental health services for children. We also support

2 the budget proposal about invest money to create an
3 annual child health survey. The last and only child
4 health survey was conducted in 2009. The inclusion
5 of funding in the budget to annualize this survey is
6 critical for information and tailoring future
7 interventions. And we urge the Department of Health
8 to maintain the breadth of the 2009 survey by
9 preserving measures that I've listed in my testimony.
10 We also are grateful to the City Council for your
11 ongoing commitment to advancing initiatives that
12 support children's health. And we hope that you'll
13 make these investments again this year, include the
14 Infant Mortality Reduction Initiative, and the
15 Callen-Lorde Community Health Center. Finally, while
16 the Preliminary Budget included critical new
17 investments, we believe that the Executive Budget and
18 ultimately the Adopted Budget must go further to
19 improve the healthcare for New York City's children
20 and families.
21 We respectfully request that the Council
22 create a new initiative, Access Health NYC, which
23 would provide pre and post-enrollment health
24 insurance assistance to parents, children and
25 individuals. Although New York City has one of the

2 lowest rates of uninsured children of any large city
3 in the country, approximately 70,000 children still
4 do not have health insurance. Many families have
5 [bell] difficulty navigating the health insurance
6 system. Not to mention understanding basic terms
7 associated with healthcare coverage including
8 premiums, networks and co-pays. Access Health will
9 help New Yorkers understand their rights as
10 healthcare consumers and effectively use their health
11 insurance benefits to access timely high quality
12 care. Thank you.
13 COURTNEY BRYAN: Good afternoon, Chair
14 Johnson and Council Member Barron. My name is
15 Courtney Brian. I'm the Director of Criminal Justice
16 Operations at the Center for Court Innovation, and
17 thanks for having me speak today. I'm here to urge
18 the Committee on Health to support funding for the
19 Center for Court Innovation as we continue to develop
20 new and innovative public health approaches in the
21 criminal justice system both with helping connect
22 folks coming through our courts with Medicaid and
23 health home access. As well as reducing violence and
24 aiding victims of trauma with mental health needs who
25 are caught up in the Criminal Justice System. At the

2 Midtown Community Court, which is in your district,
3 which I know--I believe you visited before, as well,
4 we're actually working with DOHMH, and the Court
5 System to partner to provide enrollers and navigators
6 on site in the Court to be able to connect people to
7 those much needed services. And we're hoping this is
8 going to be a pilot for the rest of the city.
9 At the Center for Court Innovation we
10 firmly believe that public health is directly linked
11 to violence reduction and community wellbeing. In
12 response, the Center's Anti-Gun Violence Initiative,
13 Save Our Streets, has been implemented in Crown
14 Heights, Bed-Stuy and the South Bronx. To mount
15 change by modifying community norms, and spreading
16 the message that gun violence is not okay. We use
17 credible messengers to perform outreach and conflict
18 mediation directly towards individuals at high risk
19 of future gun violence. As well as public education
20 efforts. All of these efforts have resulted in
21 significant sustained reductions in shoots in Crown
22 Heights since its launch in 2010. And we're at 122
23 days without a shooting in Bed-Study so far.
24 Another initiative I want to highlight is
25 just the work with justice involved folks at Rikers

2 Island with behavioral health needs. So that the
3 Center for Court Innovation is working in Brooklyn
4 and the Bronx to provide alternatives to detention
5 for those who have mental health needs at Rikers,
6 which is over a third of inmates are diagnosed with
7 mental health needs. So we're very active in that,
8 as well as with the human trafficking intervention.
9 Court intervention that was launched [bell] in
10 partnership with the Chief Judge of the State. Just
11 to highlight a few other areas that I wanted to the
12 Committee to be aware of that the Center is involved
13 in. With police/community relations, Project Reset,
14 where we're trying to get young people out of the
15 Criminal Justice System before they're even arrested.
16 As well as the Brownsville Community Justice Center.
17 Which I'm sure you're all aware of where we're trying
18 to have a neighborhood community justice center up
19 and running. We're hopeful within the next year. So
20 thank you for your attention.
21 CHAIRPERSON JOHNSON: Thank you, Ms.
22 Bryan.
23 MARILYN SAVIOLA: Good afternoon. I can't
24 speak as fast in two minutes.
25

2 CHAIRPERSON JOHNSON: You can take your
3 time, Marilyn.
4 MARILYN SAVIOLA: I'll try.
5 CHAIRPERSON JOHNSON: Take your time.
6 MARILYN SAVIOLA: I'm with an
7 organization. My name is Marilyn Saviola and I'm
8 with an organization to manage long-term care
9 planning called Independent Care System. And we've
10 been--our niches is working with people with physical
11 disabilities to make sure they get the healthcare
12 they need from the services to live in the community.
13 As part of our mission in talking with people and
14 based on my own experience, the issues I have in
15 accessing healthcare. When people talk about access
16 to healthcare, they're talking about people who don't
17 have insurance or under-insurance. We're not talking
18 about that. We're talking about being able to get
19 into the facility, being able to get into a room at a
20 table that goes up and down. A lift, a transfer lift
21 and staff that do not see us as problems. They see
22 us as someone else who is entitled to equal care.
23 About ten years ago, the CDC identified
24 women with physical disabilities as a medically
25 underserved population. Yet, no one has addressed

2 this as a public health issue, and people are being
3 turned around. The population I represent are people
4 who are all on Medicaid. They range in age from 20
5 to 101, and we--our goal is to keep people going in
6 the community, and moving ahead as a fighter. We are
7 now responsible directly. We're not only promoting
8 the healthcare, but paying for it. And the barriers
9 continue to go on, and more and more people are
10 turned around. Which in 2013 [bell] caused us to
11 write a partnership with New York Life [sic] for the
12 public's interest. The you had the other report
13 saying breaking down barriers. And that initiated a
14 City Council hearing, which was actually chaired by
15 Councilwoman Arroyo, and to look at what was going
16 on. But she held it as an oversight hearing. And
17 prior to that we had been working with the State
18 Department of Health saying, what are you guys doing?
19 You have facilities all over this state that someone
20 with a physical disability can't access. Yet, you
21 are the regulators. You're the payers. What are you
22 doing? Which generated a Dear Administrator letter
23 that was sent to all counselors--all large hospital
24 centers and community centers throughout this state.
25 Reminding them of their legal responsibilities in

2 complying with not only the Americans with
3 Disabilities Act, but what state and local was on
4 anti-discrimination. And we had this hearing, and
5 the only one who showed up was HHC. No one to talk
6 from proprietary hospitals or health centers showed
7 up. Just HHC. Then we spoke really candidly about
8 the inaccessibility of HHC as well. At the same time
9 since most people with disabilities get Medicaid,
10 they go to HHC facilities. And Robin had taken a
11 combative stance. We were approached by Senator--
12 excuse me--Council Member Arroyo and some others to
13 work with HHC to see what we can do. Which started a
14 very interesting relationship between us and HHC.
15 Usually, as an advocate I'm usually fighting these
16 battles of what they're not doing. But I'm here to
17 talk about what we're doing with them, and what
18 remains to be done.
19 We started a partnership in 2013 to work
20 with certain HHC facilities that had been identified
21 by HHC to we could start influence and make the
22 facilities accessible, or women's health facilities.
23 All of a sudden, the federal government and the state
24 and city said, Effective May 1st all facilities have
25 to be ADA compliant. This will not happen because

2 there's no money it. Even some equipment has yet to
3 meet standards. And although this started small, we
4 just take small steps. So we--we just--we started
5 working with HHC and working with City Council. And
6 City Council allocated $5 million for capital
7 improvements over a two-year process. Where we would
8 be able to work with HHC to find out what had to be
9 done to make it not ADA compliant, but the first
10 steps in getting it. What could be steps taken now
11 so the people, you know, could work, and we did it.
12 We surveyed eight facilities. We did a disability
13 training of 270 healthcare professionals at Glen
14 Falls Hospital, Queens Hospital, North Bronx and
15 several other HHC [sic] centers. We developed a
16 training manual, and a disability awareness and
17 training curriculum, and a competency curriculum for
18 gynecologists who actually was created in most part
19 by--when the HHC doctors---
20 CHAIRPERSON JOHNSON: Marilyn, we're
21 going to have to bring it to a close, but we're happy
22 to review your testimony. I have this wonderful
23 packet--
24 MARILYN SAVIOLA: [interposing] Yes, we
25 have written testimony, too.

2 CHAIRPERSON JOHNSON: --that you put
3 together. And I am happy to hear that you have been
4 able to have a collaborative relationship, and not an
5 adversarial one with HHC. I know that last year
6 during the budget hearings we talked with HHC about
7 this. And they detailed and outlined some of the
8 improvements that were being made. If there are
9 other things that you need us to push on, we're
10 having to have that conversation with HHC leadership
11 to move it forward. And this is an incredibly
12 important issue, and one that I look forward to
13 working with you on.
14 MARILYN SAVIOLA: Thank you.
15 CHAIRPERSON JOHNSON: Thank you very much
16 for being here. Thank you.
17 ANTHONY FELICIANO: Good afternoon. My
18 name is Anthony Feliciano, and I'm the Director of
19 the Commission of the Public Health System. I will
20 talking--supportive Access Health NYC, but other
21 initiatives. But you are going to hear more details
22 from the breadth of support that we've been gathering
23 around this issue on Access Health. I want to thank
24 Health Committee Chair Johnson, Council Member
25 Barron, and Health Committee staff for being

supportive in the past about the initiatives that we've been fighting for, particularly how we address the health disparities. What I want to talk about is how Access Health NYC helps support New York City neighborhood, key New York City neighborhoods. It's basically to fill in the gap that the ACA has not done when it comes to outreach and education. For not just enrollment, but really going further about navigating the healthcare system and knowing your rights. And so, some key neighborhoods are like Jackson Heights, Corona, Elmhurst, the Rockaways and Queens. Almost all of the Bronx. Washington Heights in Manhattan, Sunset Park, Williamsburg, Central Brooklyn. These are key areas and part of my package is a map that shows the uninsured by Council District. But also the folks who speak English as a second language and other populations that access healthcare would actually help and move forward. The whole presence there is to actually support local grassroots key base organizations to build capacity around education. And, outreach around several issues including helping around people with disabilities. Including the re-entry population and other underserved communities throughout the city.

2 I just want to also state that as part of
3 that is the scope of work that we've added to our
4 Division of Labor that we work very closely in the
5 coalition. And now recently we're working with
6 Community Service Society. As they seen, their
7 community help line--consumer help line is an
8 important complemented piece to both of our work.
9 What we do want to say is each part has a very clear
10 mythology and understanding that we have to the re-
11 granting with some CBOs the [bell]--the initial, the
12 TA work and also the reporting. And so in terms of
13 just going to health disparities, we are in
14 conjunction with Citizens Committee for Children the
15 things that they're supporting. We do want to say
16 that we have concerns for the contracting for Infant
17 Mortality Reduction Initiative, issues concerning
18 that. And obviously the privatization of dialysis,
19 and the moving forward of trying to renew the 10-year
20 contract with Sodexo with HHC. Those things are
21 major to us. I think for us that we want to work
22 with the Council Member obviously. Thank you for
23 championing Access Health NYC. It's to also work
24 around the district. There is very much lacking of
25 community engagement around a very complicated

2 process of the Medicaid Waiver. And we want to work
3 with the Council Members to do educational forums,
4 and hearings around DSRIP that can be not only
5 focused on the community engagement side, but also
6 the finances and how the money is being used. Thank
7 you.
8 CHAIRPERSON JOHNSON: Anthony, thank you,
9 and may I just say, you know, we've been working
10 together on this for a long time now. I guess a year
11 is not too long, but it feels like a long time. And,
12 the packet of information that you've put together
13 for us and for other council members with the maps,
14 with the languages, with the insurance non-enrolled
15 and non-insured rates is very impressive. And I may
16 say that, you know, you have a champion in me, but
17 you need a champion in all the boroughs. And so, I'm
18 glad Council Member Barron is here because we need
19 people. You know, I believe in this. It's not going
20 to affect that many people in my own district. It's
21 primarily communities of color that need this. And
22 so, we need to ensure that there is widespread
23 support in the Council. So that through our
24 initiative process and budget process it gets the
25 money that it deserves. So thank you, and I want to

2 acknowledge that we have been joined for a little
3 while now by Council Member Barron. I am glad that
4 she is here. Thank you. Thank you all very much.
5 So up next Beverly Grossman from CHCANYS; Dan
6 Lowenstein from the Primary Care Development
7 Corporation; Michelle Villa Gomez from the ASPCA; and
8 Constance Robinson-Turner from the NYU Dental School.
9 If you all could come up, that would be great. On
10 deck up next is Chris Norwood, from Health People;
11 Deborah Pollock from--I can't read the writing; Reed
12 Vreeland from Housing Works; and Alex Lauren [sp?].
13 So that's on deck.
14 [background conversation, pause]
15 CHAIRPERSON JOHNSON: Okay, if we could
16 begin on this round. Michelle, if you want to go
17 first, and then we'll go to Beverly and Dan and then
18 we'll work our way down the line. So go ahead.
19 [background conversation, pause]
20 CHAIRPERSON JOHNSON: Go ahead.
21 MICHELLE GOMEZ: Good afternoon. My name
22 is Michelle Villa Gomez. I'm the Legislative
23 Director for the ASPCA. I thank you for the
24 opportunity to be at this very important and
25 listening to everyone's work. I just want to put

2 something else on the radar. The ASPCA has been with
3 the City Council for a number of years to improve
4 conditions in the City's animal shelters. And we are
5 supporting legislation, Intro 485 that would require
6 animal shelters be built and maintained in every
7 borough. We've heard about the issue of Access.
8 That's one of the issues that's important to us as
9 well. We want the residents of Queens and the Bronx
10 to have an opportunity to have a full-service animal
11 shelter. Have a place where they could go if they
12 lost their animals. Have a place they could go to
13 surrenders strays that they may find, and have a
14 place they could go in order to adopt. The Bronx and
15 Queens on their own would be one of--probably the
16 third largest city in the United States. And for us
17 in the animal welfare community, it's unheard of that
18 places with such large populations would not have
19 access to this really important community resources.
20 We want to urge the City and the Department of Health
21 to properly fund and maintain these shelters. We
22 estimate, and we're willing to sort of work with the
23 City to reach the final amount on this. But we
24 estimate that we would need about $40 million in
25 capital money to build shelters and build new

2 shelters. That figure would change if we were able
3 to retrofit an existing facility. But we believe
4 that we have an opportunity right now to build these
5 shelters and build them right. We also estimate that
6 we would need about $7.5 million in expense and
7 operating expense for the shelters. And we stand
8 ready to assist and consult in anyway that we can.
9 But we just want to reiterate how important it is for
10 the people of Queens and the Bronx to have access to
11 this vital city resources. Thank you--
12 CHAIRPERSON JOHNSON: [interposing]
13 Thank you.
14 MICHELLE GOMEZ: --and thank you,
15 Chairman Johnson.
16 CHAIRPERSON JOHNSON: Thank you,
17 Michelle. [bell] Wow. [laughter] Amazing. Okay,
18 Beverly.
19 BEVERLY GROSSMAN: I feel like the race
20 is on.
21 CHAIRPERSON JOHNSON: Okay.
22 BEVERLY GROSSMAN: [laughs] Thank you
23 for letting me provide testimony. My name is Beverly
24 Grossman, and I am the Senior Policy Director at the
25 Community Healthcare Association of New York State,

2 the State's primary care association for federally
3 qualified health centers. We are pleased that Mayor
4 de Blasio included $16.5 million for health center
5 expansion in his Preliminary Budget. This would
6 provide working and capital grants to facilitate the
7 development and expansion of at least ten high
8 performing community-based primary care--primary care
9 health centers in underserved high need New York City
10 communities. We serve as the voice of community
11 health center the leading providers of primary care
12 in New York State. We are FQHCs or not-for-profit
13 federally appointed primary care providers that
14 operate 370 sites throughout New York City with 7--
15 with 33 sponsoring health centers. They provide--
16 they are located in medically underserved areas, and
17 provide high quality cost-effective primary care to
18 anyone seeking care regardless of insurance status.
19 Each federally qualified health center is governed by
20 a consumer majority board.
21 That means 51% of their board members
22 must be patients. And these folks work to identify
23 and prioritize the services needed most in their
24 communities. New York City has a severe shortage of
25 primary care. Twenty-six New York City neighborhoods

2 are federally designated primary care shortage areas,
3 and hospital emergency departments have become
4 significant substitutes for primary care capacity in
5 low-income populations in New York City. A report by
6 CHCANYS with the support of the New York State Health
7 Foundation analyzes FQHC capacity and geographic
8 areas and the potential sustainability for expansion.
9 And then sorted New York City neighborhoods into
10 three tiers ranked in the order of priority areas in
11 terms of need and sustainability. [bell] Tier 1
12 included 16 neighborhoods with the highest need and
13 the most probability for sustainability. Mayor de
14 Blasio's pledge to create at least 16 community
15 health center sites in Tier 1 neighborhood is based
16 on this report. We believed that he--this funding
17 would provide the working and capital grants to
18 facilitate the development and expansion of these
19 community health centers in the areas that they are
20 most needed. And we urge you to support the Mayor's
21 investment in health center expansion.
22 CHAIRPERSON JOHNSON: We support it. I
23 have a question for you. Are your workers unionized?
24
25

2 BEVERLY GROSSMAN: I don't have exact
3 numbers, but the largest FQHCs are, and I would
4 estimate over half of them.
5 CHAIRPERSON JOHNSON: Which Union?
6 BEVERLY GROSSMAN: 1199.
7 CHAIRPERSON JOHNSON: Great. Thank you
8 very much.
9 BEVERLY GROSSMAN: Thank you.
10 DAN LOWENSTEIN: Hi, I'm Dan Lowenstein
11 with the Primary Care Development Corporation.
12 Chairman Johnson, Council Member Barron and staff.
13 So just quickly. PCDC is a non-profit that works to
14 expand access to primary care in underserved
15 communities. We do this through capital investment,
16 technical assistance and then advocacy for strong
17 policies that support primary care. And I will say
18 when it comes to community health centers, these are
19 good investments. We have invested in over 100
20 health centers. They're good financial investments.
21 They're good social investments. They get the job
22 done in the communities when it comes to primary
23 care.
24 Just a little bit about where we are in
25 primary care in New York City. We've got about over

2 two million people across the state. Probably half of
3 them in New York City that lack access to primary
4 care. The reason is that we spend so little on
5 primary care. About 5% of the healthcare dollar is
6 spent there. Now, a lot of what DSRIP is supposed to
7 do is change that, and we are hopeful but we are also
8 very cautious. You'll see that there are five
9 principles of primary care success in DSRIP that we
10 have that we've included in testimony. And
11 basically, you know, we are encouraged that
12 practically all of the PPSs have to have their
13 providers be medical homes. We're encouraged that
14 the health centers and other primary care providers
15 are in the government structure. And we're
16 encouraged that--that, you know, that--that all of
17 these PPSs have to develop primary care plans. But
18 we're also very cautious particularly when the State
19 budget came out. But that is the Governor's Budget.
20 There are a few things that we disagree with. It cut
21 medical home incentive funding. Denied health
22 centers' access to capital. All of it went to
23 hospitals, and there are some other things that you
24 can read about there. We also support the Mayor's
25 Initiative to bring $16.5 million on funding the 16

2 health centers. This is a great start. We also
3 recognize it's not going to be enough. The average
4 health centers has served about 10,000 patients. It'
5 cost about $7.5 million, give or take a lot of
6 millions. [bell] So that's going to require
7 leverage, and we--and one of the things we need to
8 have is a good loan guarantee program backed by the
9 City of New York to make sure health centers get the
10 financing that they need. Thank you.
11 CHAIRPERSON JOHNSON: Thank you, Dan, you
12 know, just so everyone knows. The testimony that you
13 have prepared, everyone must testify. So it was
14 really incredible and the details are really
15 important so--and we read all of this. So I don't
16 want you to feel like we're not going to look at it.
17 And this testimony is so well done, and yours, Dan,
18 and Beverly's and everyone else that's come up. So
19 just because you're not able to read it today,
20 doesn't mean we're not looking at it. And I'm also
21 happy to-- You know, you all know this. We're happy
22 to work with you privately on anything you bring up
23 here today as well that you're not able to put into
24 the record, but I just wanted to say that. Thank you
25 very much for your testimony. Thank you. Constance.

2 CONSTANCE ROBINSON-TURNER. Yes. Good
3 afternoon, Chairman Johnson, Council Member Barron.
4 My name is Constance Robinson-Turner. I am the
5 Program Manager for the NYU College of Dentistry,
6 Smiling Faces Going Places Mobile Dental Care
7 Program. And, I thank you for the opportunity to
8 come before you today to talk about crucial funding
9 of our program. I'm joined today by Dr. Andrew
10 Schenkel, Director of the Community Dental Care
11 Programs at NYU, and Jennifer Cuervo, Guidance
12 Counselor at New Heights Middle School in Brooklyn,
13 New York to discuss discretionary funding of $300,000
14 for the Dental Van Program.

15 For 15 years we've provided all
16 healthcare and dental education to over 2,000
17 children annually from visiting public schools, day
18 care centers, Head Start centers. However, in
19 November 2013, the Bloomberg Administration funded
20 certain City Council initiatives by baselining them
21 in the DOHMH budget including the Dental Van. We've
22 learned in Fiscal 16 that DOHMH intends to use the
23 Dental Van funds for other purposes within the
24 agency. And not to provide dental services through
25 our van program. In short, this is critical to the

2 survival of our program. As you know, with many low-
3 income children the problem they're facing is
4 accessing quality dental care. And we provide
5 comprehensive care as well as oral health
6 instructions. Again, we are asking for your
7 continued support. The Council has always been
8 supportive of us. In the past, they funded us for
9 $268,000. This year we are asking for $300,000,
10 which is an increase of $32,000 so that we can result
11 in another 200 additional patients that we can see.
12 So I'm not just going to have my colleagues share
13 their comments.
14 [pause]
15 JENNIFER CUERVO: Good afternoon. My
16 name is Jennifer Cuervo. I'm the Guidance Counselor
17 in New Heights Middle School in Brooklyn. I got to
18 see first hand the invaluable and irreplaceable work
19 that the NYU Dental Van does in our community. The
20 Dental Van has been visit New Heights for the last
21 two years. And each year over 70 of our scholars
22 received dental care aboard the van. Our scholars
23 always return from the van with large smiles and only
24 wonderful things to say about their experience.
25 Making a visit to the dentist is something the

2 children look forward to. I speak for our counselors
3 when I say that without this program, many children
4 in our communities would not have access to quality
5 dental care as often times the mobile Dental Van is a
6 student's first trip to the dentist. On top of the
7 excellent care they receive from the dental school's
8 skilled, friendly, enthusiastic practitioners, the
9 children also receive essential oral health
10 instruction that will serve to benefit them and their
11 entire family for years to come. This treatment and
12 education would have been difficult to obtain for the
13 medically underserved children in our school. Many
14 teachers, parents, and school administrators would
15 certainly the Dental Van's absence if it were to
16 cease its operations. I hope that the City Council
17 will continue to fund this important program, and
18 urge you to continue support of the program in the
19 FY16 Budget. Thank you again for the chance to speak
20 about the community's positive experience of this
21 incredible program.
22 CHAIRPERSON JOHNSON: Thank you.
23 DR. ANDREW SCHENKEL: Good afternoon.
24 [coughs] My name is Dr. Andrew Schenkel, and I am
25 the Director of Community Dental Care Programs at New

2 York University College of Dentistry. The Mobile
3 Dental Van Program is the focus of our school's
4 education, service and education are mission. And,
5 I'm here today to add two points my colleagues.
6 First, the children that we see on the van will
7 likely not access dental care any other way if they
8 lose the opportunity to access care through the van.
9 Not because of a lack of other opportunities in the
10 city. We ourselves are available always on First
11 Avenue. But, simply because as was stated in prior
12 testimony access to care is a very complicated issue.
13 And for whatever reason, these children access dental
14 care through our van program. We know from our
15 experience in the community that expecting them to
16 access care some other way is unfortunately just not
17 realistic. My final note about the van program is
18 that the experience gives our students an opportunity
19 to interact with the community; learning the needs of
20 the local populations; and bring smiles to children
21 who are in need of dental care. Such experience
22 makes our students much more likely to continue this
23 type of community service when they are in practice
24 on their own either by working in a community clinic
25 or volunteering their free time to help the

underserved. We hope that the City Council continues this crucial funding for our program in Fiscal Year 16. Thank you for your time and attention.

CHAIRPERSON JOHNSON: Thank you, Ms. Cuervo and Dr. Schenkel. I need you to fill out these forms separately. So if you could please do that, that would be great. And, I just want to say a parting gift from the Bloomberg Administration was the baselining of these funds, which as you heard earlier today, I don't entirely-- I love the Health Commissioner, but I don't entirely agree with her assessment that this is as good as some people are portraying it. The NYC Dental Van along with many other great initiatives that this Council has funded for many years is now jeopardized, as you all know, and that's why you're here. So I've been raising hell. I'm going to continue to raise hell from now until the budget is adopted. But you all have to raise hell, as well. Not to me. I'm on your side.

DR. ANDREW SCHENKEL: Yes. [laughter]

CHAIRPERSON JOHNSON: You have to go to the people that make these decisions, which is the other side of City Hall, and other folks in the Council and get them on your side. Because I am--

2 As you heard earlier, I am very worried about the
3 impact that the baselined now RFP'd monies, you know,
4 hundreds of community groups could lose out now on
5 these services that the Council has prioritized for
6 years. I think it's a story that no one--that no one
7 has written yet actually. The impact that this is
8 going to have all across the city. Primarily in
9 communities of color and low-income communities who
10 have relied upon this funding by the Council. And
11 this RFP and procurement process is unattainable for
12 many organizations, or the concept papers were not
13 written in a way where many groups could even qualify
14 for it. So I'm glad you're here.

15 DR. ANDREW SCHENKEL: Thank you.

16 CHAIRPERSON JOHNSON: Don't raise hell
17 with me, but you know, [laughs] go to other people
18 because we need to fix this. And I'll say that I had
19 a wisdom tooth taken out last year at your place on
20 First Avenue--

21 DR. ANDREW SCHENKEL: [interposing] Yeah.

22 CHAIRPERSON JOHNSON: --and they did a
23 fantastic job.

24 DR. ANDREW SCHENKEL: Thank you.

25

2 CHAIRPERSON JOHNSON: And it was
3 affordable. [laughter] So, thank you all.
4 CONSTANCE ROBINSON-TURNER. Thank you.
5 CHAIRPERSON JOHNSON: Okay, our next
6 panel-- Oh, sorry, Council Member Barron has a
7 question. So sit back down. I'm going to give it to
8 Council Member Barron.
9 COUNCIL MEMBER BARRON: Thank you, Mr.
10 Chair. It's not a question. Just a comment. As you
11 commended NYU for their dental school work, as a
12 child I went there and my parents both worked, but
13 didn't have those extra funds to have the services of
14 dentistry. And it was there that I went, and when I
15 was about 14 years old, I got a gold crown on a
16 tooth, and it stayed in my mouth for about 60 years.
17 Well, almost 60 years. So the work that was done was
18 great. Thank you.
19 DR. ANDREW SCHENKEL: [off mic] Thank
20 you.
21 CHAIRPERSON JOHNSON: Okay, up next is
22 Reed Vreeland; Deborah Pollock, Chris Norwood, and
23 Alex Leone. On deck, Jacqueline Reinhard, Iris
24 Sampayo, Kent Mark, and Bobbie Lee. If you could
25

2 please give your testimony to the Sergeant so he can
3 pass it up towards us. Thank you, Inez. Thanks.
4 [background comments]
5 CHAIRPERSON JOHNSON: Okay, Chris, do you
6 want to start?
7 CHRIS NORWOOD: [off mic] Sure. Thank
8 you very much.
9 CHAIRPERSON JOHNSON: If you could please
10 turn the mic towards you, and speak directly into it.
11 CHRIS NORWOOD: I'm trying to watch the
12 clock. [sic] [laughs]
13 CHAIRPERSON JOHNSON: Thank you for being
14 so patient, and being here all day.
15 CHRIS NORWOOD: You're very patient, too,
16 and it's very pleasant. Thank you. I am Chris
17 Norwood, Executive Director of Health People. Health
18 People is a unique community-based organization that
19 teaches people with chronic disease and AIDS to teach
20 other people effective self-care and prevention.
21 From this perspective, first I would like to say we
22 strongly support Access Health. We do assessments in
23 our community, the South Bronx. And, for example,
24 59% of people the State is now letting out of prisons
25 for re-entry in the South Bronx do not have health

2 insurance when they're sent there, and this is a
3 problem all over the city. So Access Health will
4 enable us to get these people right into care, which
5 is very important. The other issue I would like to
6 talk about is, I was, you know, a little taken aback
7 today that the City did not discuss in any way an
8 overall plan for real diabetes prevention.
9 Obviously, diabetes prevention is the most important
10 prevention in our city. And it is also increasingly
11 clear it not only prevents heart disease, but it is a
12 significant preventive of Alzheimer's Disease. The
13 City has received some funds from the CDC. I
14 honestly don't know how much. I was hoping to learn
15 today. To do something called the DPP, the National
16 Diabetes Prevention Program. This is a multi-session
17 course that is twice as effective as medication in
18 help pre-diabetics avoid diabetes. I'm really taken
19 aback, though. We don't know how these CDC funds are
20 being used. We heard some of them might be RFP'd to
21 community-based organizations. That was months ago.
22 We've heard nothing since. And also, I have to point
23 out that it's very strange the City isn't putting one
24 dime of it's own costs into the most effectively
25 mammothly proven diabetes prevention, which is the

2 DPP. We recently--we have with private money, a
3 small amount, trained residents of public housing
4 [bell] to teach other residents the DPP. And in the
5 most recent class as the Chauncey [sic] Housing
6 people lost 6.3% of their body weight. So I will
7 stop. Put my conclusion down to three words, which
8 is: Demand the DPP.
9 CHAIRPERSON JOHNSON: Thank you, Chris,
10 and we're happy to try to get some answers from Dr.
11 Maybank who's running the Center for Health Equity.
12 I know that they are doing something on diabetes.
13 You know, it's primarily focused in East Harlem. We
14 should be doing stuff throughout the entire city, and
15 not just in one neighborhood. But I'm happy to try
16 to get you the information of what the city is doing,
17 and ask these questions because you're absolutely
18 right. And as we know, diabetes disproportionately
19 affects poor people, and people of color. And it's
20 entirely treatable if we get them the primary care
21 preventive medicine that they need. So thank you.
22 [pause]
23 DEBORAH POLLOCK: Good afternoon. My
24 name is Deborah Pollock and I'm the Director of
25 Social Services for a community development

2 corporation called West Harlem Group Assistance. I
3 am here in support of a proposal that we have
4 submitted for discretionary funds for a program
5 called Communities for Healthy Foods. That's what
6 you couldn't read in my handwriting, Communities for
7 Healthy Foods. Communities for Healthy Foods is a
8 new innovative approach to expand access to healthy
9 food in four of New York's economically challenged
10 communities through community-based organizations.
11 There are four community-based organizations of which
12 WHGA is one. We started--we started ours in a vacant
13 storefront of ours by asking our community what they
14 needed and what they wanted. They wanted access.
15 They wanted affordability. They wanted education,
16 and they wanted food, but food is only the first
17 step--the first step. We could feed people and they
18 could be not hungry for just about an hour, but that
19 doesn't solve the root causes. So in that hub we do
20 intake to determine what the other root causes might
21 be. Is there a domestic violence in their household?
22 Is there a mental health issue in the household? Are
23 people enrolled in health insurance? Are people
24 enrolled in the programs that they need for their
25 households. Are there problems in their apartments?

2 Do they have legal representation if they have a
3 court case? There's a myriad of issues that we cover
4 during the time that they are at the food pantry, and
5 hopefully get them assistance for all of their
6 issues. Again, we work with a--with a number of
7 community partners. It's a program that can be
8 replicated throughout the city. We've asked for--
9 the four partners have asked for $760,000 to continue
10 this very important program. We're asking for your
11 support, and we're asking for the support of your
12 fellow Council members, and we hope we can count on
13 that.
14 CHAIRPERSON JOHNSON: Go meet with them
15 one by one.
16 DEBORAH POLLOCK: We're trying.
17 CHAIRPERSON JOHNSON: Are you doing it?
18 DEBORAH POLLOCK: We're doing it.
19 CHAIRPERSON JOHNSON: Good. Thank you.
20 DEBORAH POLLOCK: Thank you.
21 CHAIRPERSON JOHNSON: Thank you for being
22 here.
23 DEBORAH POLLOCK: Thank you.
24 CHAIRPERSON JOHNSON: Reed.
25

2 REED VREELAND: Hello. My name is Reed
3 Vreeland, Director of Policy at Housing Works. Thank
4 you, Council Member Jonson for your leadership, and
5 your work as Health Committee Chair, and thank you
6 also to the other members of the committee. I was
7 very grateful to hear Commissioner Bassett's remarks
8 this morning, especially her emphasis on the need for
9 more affordable housing in New York City and across
10 the state. Commissioner Bassett also mentioned the
11 blueprint on ending the AIDS epidemic in New York
12 state by 2020. It will be essential to have city
13 support of this plan, and I'm here today actually as
14 part of the End AIDS New York 2020 Coalition to ask
15 the City Council to create a city version of that
16 plan for an initial investment of $10 million. As
17 you know, New York State has borne the highest--has
18 borne the highest burden of the HIV epidemic since
19 1981. And approximately 80% of the state's epidemic
20 resides here in New York City, the majority of the
21 people living with HIV in the state. The blueprint
22 to end the AIDS epidemic will particularly serve
23 communities hardest hit by HIV, communities of color
24 and the LGBT communities in particular. While the
25 Governor's leadership has been crucial in

2 establishing the New York Plan to end AIDS, support
3 from Mayor de Blasio and the City Council is vital to
4 our success and our city's effectiveness in ending
5 AIDS. I just want to really underline the historic
6 moment we have here, and the toll that this epidemic
7 has taken [bell] not in--across our whole--our entire
8 city. I'm going to go down a few of the bullet
9 points of what this investment would entail, this New
10 York City investment.
11 So the End AIDS New York Coalition
12 requests that the City fund an additional $10 million
13 investment in ending the AIDS epidemic in New York
14 City to put key blueprint recommendations in to
15 action for Fiscal Year 2016. One of the things this
16 would do is enhance and streamline linkages to HIV
17 prevention and care at the seven New York City STD
18 clinics to bring people living with HIV into care,
19 and also initiate PrEP for high-risk HIV negative
20 individuals. This request would also establish NPEP
21 Non-Occupational Post-Exposure Prophylaxis to a
22 preventative post-exposure treatment, and create NPEP
23 centers for excellence across the city, one in each
24 borough. It would also fund DOHMH medical provider
25 training on PEP and PrEP, as well as conducting--

establishing a learning collaborative for HIV care providers to support this scale-up to overcome adherence barriers and promote--promote vital suppression. In today's epidemic, you know, it is possible to--we're really trying to get more people on treatment and help people take their meds. And make sure people can live the healthiest lives they can.

CHAIRPERSON JOHNSON: Thank you, Reed.

REED VREELAND: So these are a few, and there are more, but I will submit this to you.

CHAIRPERSON JOHNSON: Yes, please get us a copy.

REED VREELAND: And I--I greatly appreciate your support.

CHAIRPERSON JOHNSON: And please get the Governor to release the report.

REED VREELAND: We will--we're on it and--

CHAIRPERSON JOHNSON: [interposing] Because people in the city don't want to take action until the report is released--

REED VREELAND: [interposing] And we're--

2 CHAIRPERSON JOHNSON: --and the clock is
3 ticking.
4 REED VREELAND: Absolutely and we're
5 right there with you. Thank you so much for your
6 support.
7 CHAIRPERSON JOHNSON: Thank you. Alex.
8 ALEX LEONE: Hello. I'm Alex Leone. I
9 just wanted to--I'm just here to-- Well, thank you
10 first for having me. I just want to let you know
11 about the Medicolegal investigators, who are a
12 function of the Medical Examiner's Office in which
13 they had the Preliminary I guess budgetary. We
14 basically are physician assistants that have been
15 hired into Medical Examiner system with the name
16 medicolegal investigators. We basically do--
17 basically we--I don't want to say the dirty work or
18 the first responding work for the medical examiners.
19 There are 19 of us that currently go out into the
20 city of 8.5 million people. We work 24/7 365 days a
21 year. Being that there are only 19 of us, we've been
22 very short-staffed. There is not much mention about
23 us because, you know, we do a lot of the work
24 underneath that doesn't get known. We go out and
25 examine the bodies. We go take--intake the hospital

2 calls so that the medical examiners look into the
3 cases the following day. So everything that comes
4 into the medical examiners are known to them from us.
5 And being that, you know, there's only 19 of us,
6 they've made some adjustments to hire eight more
7 medicolegal investigators. But they're them at a
8 very low salary that is not consistent with what a PA
9 average salary makes.
10 CHAIRPERSON JOHNSON: What's the salary?
11 ALEX LEONE: It's at about $100,000. We
12 get paid--
13 CHAIRPERSON JOHNSON: [interposing] So
14 when you say that you think there should be more, you
15 need more people to do your type of work?
16 ALEX LEONE: We need a lot more people.
17 There are 30 medical examiners and there are only 19
18 medical investigators working 24/7 365 days a year.
19 CHAIRPERSON JOHNSON: We will ask Dr.
20 Sampson about it.
21 ALEX LEONE: I just want to let you know
22 that we're here. We've been working with them, and
23 there is not much mention of us. But that's also in
24 response to why you're seeing those an increases in
25 cremation request time, [bell] the increase with the

families, the Ebola issue. We're the one that actually go out into the scene. We deal with the police out in the field. We take and listen to all hospitals and doctors calling cases in, and we present the cases at the end of the day to the medical examiners.

CHAIRPERSON JOHNSON: Well, I know that's very hard work, very trying work, and I'm sure you have to see a lot of difficult and upsetting things. So thank you for taking the time--

ALEX LEONE: [interposing] I'm happy to.

CHAIRPERSON JOHNSON: -- out of your very busy schedule to be here, and we're happy to follow up and ask questions of the Chief Medical Examiner's Office, and understand this a bit more. So thank you for being here.

ALEX LEONE: Thank you.

CHAIRPERSON JOHNSON: Thank you. So, up next is Jack-- Thank you all. Up next Jacqueline Reinhard; Iris Sampayo, Kent Mark, and Bobbie Lee. If you could please if you have additional copies of your written testimony, if you would please give it to the Sergeant. He's right behind you, and he will give it to us.

2 [background comments]

3 CHAIRPERSON JOHNSON: Okay, you may be

4 begin.

5 [pause]

6 SERGEANT-A-ARMS: Push the button.

7 JACQUELINE REINHARD: Good afternoon.

8 I'm Jacqueline Reinhard, Executive Director of SHARE,

9 and this is Ivis Sampayo. She's our Senior Director

10 of Programs. Thank you, Chair Johnson, for having--

11 giving us this opportunity to speak today. And, if

12 possible, we'd like to share our four minutes. We

13 prepared our presentation that way.

14 CHAIRPERSON JOHNSON: Sure.

15 JACQUELINE REINHARD: On behalf of SHARE

16 and the 32,000 women that we serve each year, thank

17 you for the Council's outstanding ongoing support of

18 SHARE, and the Ambassador Initiative most recently

19 with the Fiscal Year 15 Grant of $135,000. The

20 Bilingual Ambassador Initiative directly serves 6,000

21 medically underserved African-American, Latina, and

22 Immigrant women each year ensuring that they have the

23 information and support they need to protect their

24 health. The Ambassador Program was stated by SHARE

25 to address the healthcare disparities among women in

2 the low-income communities of color, disparities that
3 have been well-documented over the last decade.
4 According to the Center for Disease Control and
5 Prevention, Black women have the highest death rates
6 of all racial and ethnic groups, and are 40% more
7 likely than white women to die of breast cancer. The
8 reasons for this difference result from many factors
9 including having fewer social and economic resources.
10 To improve this disparity, Black women need more
11 timely follow-up and improved access to high quality
12 treatment.
13 IVIS SAMPAYO: Latino women are about 20%
14 more likely to die of breast than non-Latino White
15 women diagnosed at a similar age and stage, according
16 to the American Cancer Society. Latinas are
17 significantly more likely to present at a later stage
18 with larger tumors that are more difficult to treat.
19 It is believed that these disparities exist because
20 of different access to treatment, and lower rates of
21 mammograms than the Latino community. SHARE's
22 Ambassador program is a grassroots effort intended to
23 reach and empower medically underserved general
24 populations in the African-American and Latino
25 communities in New York City. This programs educates

and trains African-American and Latino women who are survivors of breast and ovarian cancers, and their family members to serve as advocates in their own communities. The Ambassadors work in communities throughout Brooklyn, Bronx, Manhattan and Queens. In 2014, ten African-American and 12 Latino women served as chair ambassadors. Through their collective efforts they made a total of 90 presentations at health fairs, community, medical and senior centers in their respective neighborhoods. In total, their efforts reached 5,975 individuals in their communities in 2014, a record number for this initiative.

SHARE maintains a database to track all aspects of the program. In addition, we offer bilingual materials. More than 11,000 were distributed in 2014. Help lines, support groups, 10 Latina and two African-American with about 1,268 attendees annually, and survivor patient navigation at Bellevue and Mount Sinai's Saint Luke and Roosevelt Hospitals with approximately 500 women served. Numbers don't put a face on our work. One recent story stands out. Lisa Franklin, and ovarian cancer survivor and dedicated ambassador who so moved

2 WNBC anchor Pat Battle that she devoted a segment to
3 her personal story and outreach work. Although
4 Lisa's own prognosis has deteriorated [bell] in the
5 last month, she continues to devote herself to
6 educating and empowering other women.
7 The Ambassador Initiative has made a
8 critical difference in the health of African-American
9 and Latina New Yorkers. From the breast cancer
10 survivor who had her daughter undergo genetic testing
11 after attending a presentation in a library in Queens
12 to the young Latina who was ready to stop her breast
13 cancer treatment without the support of SHARE.
14 CHAIRPERSON JOHNSON: So I read down the
15 rest of the way--
16 IVIS SAMPAYO: [interposing] Thank you.
17 CHAIRPERSON JOHNSON: --as I was
18 listening, and I totally am with you. You know, you
19 heard what I said before, which is this is very
20 problematic, the baselining and the RFPing of these
21 critically important initiatives that provide the
22 unbelievable service that you all do, and that many
23 other organizations do on a whole host of issues. I
24 am with you on figuring out a way for the Council to
25 either come up with the money on our own as part of

the budget to create new initiatives for the groups that are not able to compete for the RFP for the baseline funds. Or, to have the--the other side of City Hall be in the Mayor's Office to give us additional money to do this. We have to figure out a way to do it. I'm glad you're here to testify because it's really important to get this on the record. But again, I'm fully with you. You have to the council members whose neighborhoods you're in. Tell them what the impact is going to be in their communities. Make the case to them because I'm raising hell, but I need other people to start being a little crazy with me, and making noise. And we don't have much time. So, you all and many other organizations that are going to be detrimentally impacted by this process need to get out there and start making the case to as many council members as possible and be strategic about it.

JACQUELINE REINHARD: Okay.

CHAIRPERSON JOHNSON: Okay?

JACQUELINE REINHARD: We will and thank you. Thank you for listening.

CHAIRPERSON JOHNSON: Thank you very much.

2 KENT MARK: Good afternoon, Chair
3 Johnson, Council Members, HHC personnel and my
4 colleague from Bellevue. I appreciate the
5 opportunity to speak to you today, and I did not
6 submit any written testimony at this point. My name
7 is Kent Mark. I'm both a Bellevue patient and a
8 community advisory board member at Bellevue.
9 However, my comments today are on my behalf and my
10 behalf alone, and are not on behalf of the CAB and I
11 want to make that clear. I'm thankful for the
12 foresight that went into bringing HHC into existence,
13 and for the medical services it provides. And for
14 that I'll be able--be forever thankful and grateful
15 And I in no way underestimate the magnitude of the
16 problems faced by the HHC in the comments that I make
17 here today. I thought about what I wanted to say
18 today, and how I could do this in a constructive way.
19 And I think the people need to know what the problems
20 are within the HHC in order to fix them. And I think
21 the patients probably know. The patients know the
22 problems that face patients the best.
23 Culture is used as a constant excuse or a
24 reasons for what goes on in facilities such as
25 Bellevue and other HHC facilities. And culture being

2 defined as an intellectual or a developing
3 intellectual moral faculties or enlightenment, we
4 should do better. And we should really get to the
5 point, in my opinion, where culture does not eat
6 strategy for lunch. I think Dr. Raju has to receive
7 for the good work he does. And him coming on board a
8 loud and clear message from those in City government
9 who support his positive actions. That they will
10 continue to support his actions, whatever they may be
11 in the cleaning of house at HHC and oversight until
12 we get it correct. And we serve the patients in both
13 a respectful, dignified--respectful and dignified
14 manner and an expedient manner. There are a lot of
15 good people in the HHC system.
16 There's a lot of good people that work at
17 Bellevue, but we need more people that are dedicated
18 and invested in order to keep the morale up. The
19 morale is not at a very high level in the estimation
20 of many people. Whether that be patients, employees,
21 the administration, et cetera. And we also need
22 people who do not violate the public trust as
23 compensated employees. And we need people who are
24 willing to be held accountable, and responsible for
25 their performance or lack thereof. [bell] I believe

2 that he problems begin at the top and filter down. I
3 spent a week in breakthrough, and I find that
4 breakthrough was good for the workflow, but it really
5 doesn't solve all of the other problems. We've had a
6 number of fiascos with where the patient-- We were
7 supposed to have a patient-centered facility, but it
8 goes off center and we're not with the patient.
9 I would take the note that the Law
10 Department--in my closing comments--what they said
11 the other day when they testified that it's part of
12 their job is to look at what operational issues are
13 in need of corrections or reform, and take those
14 corrections and reform and do something to correct
15 and reform those issues prior to them becoming more
16 serious in injunctive relief and monetary relief. I
17 think we need to be good custodians. I say this from
18 my heart. This is not an indictment of the HHC in
19 any way, but it is a plea for all of to work
20 together. And I came here today because I care, and
21 I want the HHC and Bellevue, and the rest of the
22 institutions within to be all that they can be.
23 Thank you.
24 CHAIRPERSON JOHNSON: Thank you, Mr.
25 Mark, for your advocacy and for being here today.

2 BOBBY LEE: Hi, my name is Bobby Lee, and
3 I'm a community activist, and a colleague of Kent,
4 and I support his testimony. I like to stand--sit
5 here today and tell you about what I consider a new--
6 new bunch of initials, I-N-C-D. So that--what I
7 think that stands--what I say that stands for is
8 Idiopathic Nosocomial Clinical Disorder. Now, that's
9 a mouth full for most of us. But, what it really
10 comes down to is when you go to a healthcare
11 facility, and you're healthy and you come out with
12 something, where is this documented? Where is this
13 trail? We do not separate the healthy from the
14 unhealthy. So when you bring people to a clinic, and
15 you have 50 people waiting there, and you're putting
16 everybody together, you're creating a healthcare
17 situation. And none of this is being documented or
18 followed. So, as an activist, I'd like to see
19 something be--something done to alleviate this issue.
20 Because we want healthy people, but if we put healthy
21 people and unhealthy people together, it's obvious
22 what's going to happen. Where you have this whole
23 stigma of I have to clean my hands. I have to wear a
24 mask, but yet we put healthy and unhealthy people
25 together, and there is nothing to be done about it.

2 Since I have a few minutes, I would also
3 like to discuss the fact that at Bellevue Hospital,
4 we have food service--a vendor for food service, and
5 it's high-end vendor. So I don't understand how you
6 get a high-end vendor when you have low-income there
7 and expect those people to be serviced. It just eats
8 the hell out of me. And the third thing I would just
9 like to say as my time is ending, is that when we
10 give prescription drugs to people, [bell] and they
11 are supposed to be baseline values because they tell
12 you there is liver disorder and kidney disorder,
13 there is no follow up on that. And we need to have
14 that done because I have a neighbor who is in an
15 assistant living facility, and she's given these
16 drugs and there is no medical back-- There is no
17 baseline values for her. They just give her the
18 drugs, and this is being done throughout healthcare.
19 Thank you.
20 CHAIRPERSON JOHNSON: Thank you, Mr. Lee,
21 for being here today.
22 BOBBIE LEE: Sure.
23 CHAIRPERSON JOHNSON: Thank you all. Up
24 next Anna Krill, Irene Ninonuevo and Christopher
25 Bramson. And then our last panel will be Noilyn

2 Mendoza, Claudia Calhoun, Nora Chavez, and Esther
3 Lock, leaving the best for last. Anna, you may
4 begin.
5 ANNA KRILL: Good afternoon. My name is
6 Anna Krill and I am here today on behalf of Astoria
7 Queens Sharing and Caring to ask that the Council
8 allocated $250,000 to Sharing and Caring in the FY16
9 Budget. This funding is critical for Sharing and
10 Caring's survival and will be used to: (1) Offset
11 the loss of the Cancer Initiative funding in the
12 upcoming budget; and (2) expand our highly successful
13 and popular flagship program--education program Be a
14 Friend to Your Mother, high school outreach program
15 to public high schools throughout Queens. Since
16 2009, FY10 Sharing and Caring has received funding
17 under the Council's Cancer Initiative. With the
18 baselining of the initiative in the FY15 Budget,
19 these funds will no longer be award starting in FY16
20 to community groups, which provide direct and/or
21 supportive services to breast cancer survivors and
22 their families. Instead, this funding will be
23 awarded via RFP to one organization for the purpose
24 of implementing and monitoring a citywide colorectal
25 cancer prevention navigation program. The loss of

2 this funding will significantly impact on our ability
3 to assist cancer survivors and their families.
4 Sharing and Caring is a comprehensive cancer
5 supportive advocacy organization serving men and
6 women with various forms of cancer throughout Queens
7 County and throughout the City of New York. Through
8 our hotline, educational symposiums, cancer
9 screenings in our local office, we assist
10 approximately 4 to 5,000 individuals annually.
11 As a 21-year cancer survivor, I am not
12 only blessed to still be alive, but blessed to be
13 part of an organization that not only educates and
14 empowers, but an organization that actively helps to
15 save lives. Day in and day out cancer survivor's
16 [bell] family members and community members contact
17 our office seeking help. Be it counseling, direct
18 service, linkage to screening or treatment or just a
19 shoulder to cry on. My staff and I are always there
20 for whoever calls or walks to our doors. No one is
21 ever turned around--away. Our situation is dire, and
22 your help is imperative so that we can continue our
23 mission of providing direct services as well as
24 counseling support and hope to those diagnosed with
25 cancer. Thank you.

2 CHAIRPERSON JOHNSON: Thank you Anna for
3 the amazing work that you do, and that you've done
4 for many years through the money that the Council has
5 designated to your organization. It's amazing work.
6 It's great to hear your personal story, and I know
7 you help a tremendous number of people. I'm not
8 going to repeat what I said before. You heard what I
9 said before. I'm with you, but you need to go to
10 some of the other folks and make case. Because I
11 can't just be sounding the alarm by myself. We need
12 people to weigh into the Speaker and to the Mayor,
13 and let them know that we can't allow this to move
14 forward because it's going to have a significant
15 impact on our local communities. So thank you.
16 ANNA KRILL: Thank you.
17 CHAIRPERSON JOHNSON: Irene. Okay.
18 Whatever--whatever you--
19 CHRISTOPHER BRAMSON: Great. So thank
20 you all for your patience and for being here all day.
21 It's a long day for sure. But I appreciate the
22 opportunity to speak on behalf of the New York City
23 Sexual Assault Initiative. Irene and I are two
24 representatives from that four group--four--four
25 organization group. And we have designed programs to

2 specifically address the needs of underserved
3 populations in New York City. So my name is
4 Christopher Bramson, and I'm the Assistant Director
5 of the Crime Victims Treatment Center at St. Luke's
6 and Roosevelt Hospitals. We've been around since
7 1977, and provide a lot of different services free of
8 charge to any survivor of a violent crime.
9 In 2005, the New York City Sexual Assault
10 Initiative by the Speaker, and it was $250,000 to
11 five different programs to address the different
12 needs of specific populations of survivors that we
13 knew as programs were underserved in New York City.
14 So for CVTC, that meant the creation of New York
15 City's first and still only free program to treat
16 male survivors of sexual assault, childhood sexual
17 abuse and intimate partner violence. In 2005, when
18 we got funding, we saw about a dozen men per year.
19 And now ten years later we serve 165 men every year.
20 So it makes up about 20% of our overall population.
21 So we have tailored support groups for men. We do
22 individual therapy. We have created a lot of
23 different outreach materials to help normalize
24 feelings and reduce the immense shame that often
25 surrounds male victimization. And because of the

2 success of all of these programs, which were made
3 possible through Council funding, we are now unable
4 to meet the needs of all the people who are seeking
5 services from us.
6 So we have had a wait list for Spanish
7 and men, male clients for the past number of months,
8 almost a year. And so, what we would do with the
9 increased funding that we're asking for, we got
10 $250,000 ten years ago. And so this year we're
11 asking for a total of $600,000 to be split between
12 the four programs. So we will continue to work with
13 men. Irene will talk about what she does at
14 Cambridge Heights. SAVI, which is part of Mount
15 Sinai, will use this money to hire a Mandarin-
16 speaking therapist to work with their increased
17 number of trafficking survivors. And the Alliance--
18 the New York City Alliance Against Sexual Assault.
19 There's a lot of training [bell] for medical
20 practitioners.
21 One thing I would just really like to
22 quickly call attention to is that you have all doubt
23 noticed a really big increase in media attention of
24 sexual assault on campus, on the sports field,
25 discussions around consent. And those are really

2 important conversations to have. It's great that
3 it's getting attention from the media, because it
4 makes our work easier to teach people how to talk
5 about those issues. But the problem is that on a
6 statewide level, and all over the place the money
7 that funds the programs that help survivors of sexual
8 violence is being cut. So the New York State Budget
9 is set to cut sexual assault service money by 43%
10 this year, which is $4 million. And that comes at a
11 time when the Governor has made a huge deal, and
12 called a lot of attention to campus sexual assault.
13 And they are coming to programs like us. We have
14 been approached by about six different universities
15 in New York City to design programs to do all this
16 stuff to help survivors. And we don't have the
17 money, and they're cutting our money. So I think
18 that, you know, this means really huge layoffs across
19 the State, and it's real public health crisis. In
20 New York City specifically, according to a CDC study
21 2-1/2 million New York City residents will experience
22 some sort of sexual violence over the course of their
23 lifetimes. And that doesn't include any other crimes
24 statistics. It's sexual violence. So, I think it's
25 really important that we all come together, and that

this city makes it its responsibility to allow us to do the work that sometimes helps save people's lives. Thank you.

CHAIRPERSON JOHNSON: Thank you. Color me surprised by the Governor saying one thing and then cutting money--

CHRISTOPHER BRAMSON: [interposing] Isn't it ironic?

CHAIRPERSON JOHNSON: --three seconds later.

CHRISTOPHER BRAMSON: [laughs]

CHAIRPERSON JOHNSON: Thank you. Irene.

IRENE NINONUEVO: Good afternoon. My name is Irene Ninonuevo from the Child Sexual Abuse Treatment and Prevention Program at the Kingsbridge Heights Community Center. We are the only mental health program that provides completely free and long-term treatment to children ages 3 to 21 who have experienced child sexual abuse. So I'd like to take the opportunity to speak about the prevalence of child sexual abuse. So one in four girls and one in six boys are sexually abused by the age of 18. That means if you go into an auditorium full of 200 girls and 200 boys at least 50 girls and at 16 to 30 boys

2 will be sexually abused by age 18, but 60% are not
3 reported. So it could be double that, right. And if
4 people do not receive treatment the trajectory is
5 very negative. They experience major depressive
6 disorders, suicidality, self-harm such as cutting,
7 substance abuse, sexual trafficking, post-traumatic
8 stress disorder. Not only that, they spend 18% more
9 on medical bills annually because of chronic
10 illnesses such as chronic back pain, hip pain,
11 gastrointestinal issues such as chronic fatigue
12 because the mind and body are always connected.
13 Unfortunately, approximately 48% of children who have
14 been sexually abused engage in re-enactment, meaning
15 they also touch other children sexually.
16 There is also increasing research that
17 indicates that trauma is not just passed on from
18 generation to generation through child rearing and
19 family dynamics. But it makes a change in the DNA,
20 which then gets passed on to children and
21 grandchildren of trauma survivors. So the
22 implications of child sexual abuse is staggering. So
23 if we do not address this significantly, it means
24 generations from now New York City families and
25 communities will still be grappling with the negative

impact of child sexual abuse. So there is a disease [bell] that affects at least 25% of the population, and it impacts the individual's physical, mental health, academic and occupational functioning. And if there is a high percentage, then this disease will be passed onto the next generations, we would call that an epidemic. Child sexual abuse is a silent epidemic. So we are requesting the New York City Council to increase funding so that we can decrease our wait list. And we can increase capacity because there are a lot of children and families out there who need our help. We want to be the generation that significantly makes an impact on stopping the intergenerational cycle of child sexual abuse in New York City. And we're asking the New York City Council to increase support. Thank you.

CHAIRPERSON JOHNSON: Thank you both for being here and for your patience. You taught me a lot. I actually didn't know how staggering and upsetting the numbers actually are. And, we should be doing more. The City should be doing more and the State should be doing more, and it's shameful that the State Budget-- You know, our Budget is a document of our priorities and of our values. And a

2 43% cut is sickening actually. So, you know, you
3 have our support. Ultimately, you know, I wish we
4 could wave the magic wand, but it's not all up to me.
5 You have to continue to talk to other members of the
6 Council and the Speaker--
7 CHRISTOPHER BRAMSON: [interposing] Yes.
8 CHAIRPERSON JOHNSON: --and continue your
9 advocacy from now until the budget is adopted to try
10 to get the money that you guys need and deserve. So
11 thank you very much.
12 IRENE NINONUEVO: Thank you for your
13 time.
14 CHAIRPERSON JOHNSON: Thank you. Okay.
15 Last, but not least Noilyn Mendoza, Claudia Calhoun,
16 Nora Chavez and Esther Lock, and I have no idea what
17 you guys are going to testify about today. [laughter]
18 [pause]
19 CHAIRPERSON JOHNSON: Is Esther not here?
20 NOILYN ABESAMIS-MENDOZA: She's not here.
21 CHAIRPERSON JOHNSON: Okay.
22 NOILYN ABESAMIS-MENDOZA: So it's
23 shorter. [laughs]
24 CHAIRPERSON JOHNSON: That's okay.
25 That's okay.

2 NOILYN ABESAMIS-MENDOZA: Good afternoon,
3 Chair Johnson and Council staff--
4 CHAIRPERSON JOHNSON: [interposing] Good
5 evening. [laughter]
6 So--
7 CHAIRPERSON JOHNSON: I'm joking.
8 [laughter]
9 NOILYN ABESAMIS-MENDOZA: I'm going to
10 try to be quick. My name is Noilyn Abesamis-Mendoza.
11 I'm the Health Policy Director at the Coalition for
12 Asian-American Children and Families. CACF is also a
13 proud member of the People's Budget Coalition. We
14 recognize the tremendous gains that the State has
15 seen with the full implementation of the Affordable
16 Care Act, as well as expansion of Medicaid. Over two
17 million New Yorkers have enrolled in coverage through
18 the State Marketplace with an estimated 15% Asian-
19 Pacific Americans. Indeed, the APA community has
20 greatly benefitted. However, there are still large
21 segments of the population that still do not have
22 coverage.
23 The burden fell on and continues to fall
24 on community-based organizations to fill these gaps.
25 The lack of adequate language assistance, and

2 targeted culturally competent marketing to the APA
3 community led considerable misinformation and
4 confusion, and in some cases deterred Asian-Americans
5 from enrolling in the marketplace Medicaid or Child
6 Health Plus even if they were eligible. Information
7 relayed on mainstream and ethnic news often focuses
8 nationally with little differentiation to State-
9 specific provisions that are more expansive for
10 eligibility and health insurance program. This
11 required many CBOs to translate and correct
12 marketplace documents and conduct outreach campaigns
13 about--about coverage options. CBOs also interpreted
14 benefit packages, serve as liaisons between their
15 clients, and insurance companies, and help clients
16 choose providers and book appointments.
17 Lastly, CBOs link New Yorkers who are not
18 eligible for health insurance programs because of
19 their immigration status to affordable options like
20 HHC options, as well as FQHCs. These activities
21 often went above and beyond enrollment assistance,
22 and were often done without or with limited financial
23 support. In order to reach New Yorkers not yet
24 accessing health care, [bell] New York needs to
25 create a program that connects with underserved

2 communities. The City Council can unlock the
3 potential of healthcare reform in New York City by
4 putting $5.5 million for a new initiative, Access
5 Health NYC, which would fund CBOs to provide public
6 education outreach in the community about their
7 rights and options to access quality care. And we
8 thank you for your leadership on this, Chairman
9 Johnson. Access Health NYC is an urgently needed
10 initiative, and we urge the City to ensure support to
11 develop and enhance in order to adequately meet the
12 needs of our diverse communities. To close, I also
13 wanted to let you know that we are planning an
14 Advocacy Day on April 14th where we plan to have a
15 press conference as well as continue our meetings
16 with City Council. Thank you.
17 CHAIRPERSON JOHNSON: Thank you, Noilyn.
18 Claudia.
19 CLAUDIA CALHOUN: Good evening. It's
20 very exciting to be here, and we really want to thank
21 Council Member Johnson for everything he's done on
22 ensuring health access. The NYC is a statewide
23 membership organization that serves immigrants
24 serving organizations. There are many in New York
25 City and also from across the state. Specifically,

2 what I'm going to talk about today are some of the
3 experiences that we know about from members of our
4 health collaborative that are really on the
5 frontlines of some of these issues. Access Health
6 NYC is a citywide proposed funding initiative that
7 would provide $5.5 million to get the word out to
8 many vulnerable populations. I'm going to talk
9 specifically about immigrants in terms of how they
10 can get both coverage when they're eligible and
11 access to services when they're not eligible for
12 public insurance.
13 Noilyn said it really well, New York
14 State provided funding to navigate organizations.
15 Some of them have done amazing work with immigrant
16 communities getting them plugged in. But those funds
17 aren't for outreach and education. Those funds are
18 to support enrollment. And so, we really believe
19 that CBOs need additional support to do events in the
20 community to be able to get the word out beyond just
21 individuals helping people sign up. Specifically, we
22 know that language access challenges have been a huge
23 issue. We think the CBOs are the answer because they
24 have both the cultural competence and the language
25 access to get the word out to groups that don't speak

2 English. We know also the complexity of benefits for
3 populations who may be multi-immigration status
4 households can be very daunting. And we know that
5 CBOs are really the ones that they trust to
6 understand this maze of benefits that they may be
7 eligible for. And finally, given the fact that we
8 hope that the President's injunction will be lifted,
9 and administrative relief will go forward. You're
10 going to have a whole new group of New York City
11 residents who are eligible for ACA and DACA and
12 Access Health is going to be really, really key in
13 helping those people take advantage of Medicaid.
14 And then, I'll just close by saying what-
15 -Noilyn said this really well. The CBOs are already
16 doing this work. They are already answering
17 questions. They are already helping people with--
18 people with issues that come up. And the other thing
19 I want to highlight is we're very excited to be
20 partnering with CSS because they bring this real
21 expertise in post-enrollment services. And
22 immigrants who have gotten--gotten insurance for the
23 first time are going to need to learn how to use it.
24 And so, it's very exciting that we're going to--that
25

2 that is being wove into what Access Health will do.
3 So thank you very much.
4 CHAIRPERSON JOHNSON: Thank you. Thank
5 you for being here today. Nora.
6 NORA CHAVEZ: Hello. Yeah. So I'm Nora
7 Chavez, and I am the Director of Community Health
8 Advocates at the Community Service Society. [coughs]
9 CSS sponsors the State's largest navigator program
10 consisting of a network of 33 community-based
11 organizations, members of commerce, and other small
12 business serving groups. Together, we offer
13 enrollment services in 61 out of New York State's 62
14 counties. In addition, CSS administers community
15 health advocates, and all Personal Enrollment
16 Consumer Assistance Services, which helps New Yorkers
17 understand and use their health insurance. And if
18 uninsured, access low-cost services.
19 This testimony of CSS urges the City
20 Council to cement the successful implementation of
21 the Affordable Care Act by (1) funding the Personal
22 Enrollment Consumer Assistance Services that CSS's
23 toll-free help line through the Access Health New
24 York City Collaborative, and (2) restoring funding to
25 the network of community-based organizations through

2 the program formerly known as New York City MCCAP,
3 but now called CHA.
4 Getting to bring one million New Yorkers
5 insured is an important first step. But ensuring
6 that consumers actually use their new coverage to
7 access care is to--is to attain the ultimate goal of
8 having New--having healthy New York City communities.
9 From the perspective of newly insured consumers the
10 health insurance remains complicated. Eighty-eighty
11 percent of marketplace enrollees reported that they
12 were uninsured at the time of enrollment. Both the
13 newly covered as well as those who have been covered
14 for years reported needing help with post-enrollment
15 issues. Consumers need help understanding insurance
16 claims like deductibles, co-payments, co-insurance
17 and maximum out-of-pocket costs. Following complex
18 processes to resolving insurance disputes, filing
19 complaints, and appealing claim decisions.
20 In 2010, New York State designated
21 Community Health Advocates, CHA, as New York's
22 Independent Consumer Assistance Program. To date,
23 CHA has brought financial resources, training, and
24 technical assistance to 21 community-based [bell]
25 organizations, small business serving groups and

2 chambers of commerce across New York State to provide
3 direct services in localities. It has established a
4 license--a live answer multi-lingual toll free help
5 line that handles 10,000 calls per year. It has
6 assisted 200,000 New Yorkers since 2010, and saved
7 approximately $14 million to New Yorkers since 2010.
8 CHA was originally a New York City funded
9 program called the NYC MCCAP, and when CHA expanded
10 it to become a statewide network, they--it lost
11 because it had to distribute the funds across the
12 state, it lost its diversity, ethnic diversity and
13 its strength in New York City. So we are asking
14 today for-- Our recommendations are to fund Access
15 Health New York City, New York City's request for
16 $5.5 million under this initiative. The CHA Helpline
17 would receive funding to provide for some enrollment
18 assistance services over the phone. And to support
19 community-based groups at New York City Council
20 Districts. And also restore New York City, the New
21 York City MCCAP.
22 CHAIRPERSON JOHNSON: Thank you. That
23 was an amazing performance to get all that in so
24 quickly. I want to thank you all for your help in
25 the Council's efforts, and enrolling people during

the last enrollment period. We couldn't have done it without all of you, partnering with you all. So we really appreciate our continued partnership, and the ability to work together for the benefit of New Yorkers that need it most. So thank you very much. I also want to acknowledge that I am really grateful that John Jurenko and LaRay Brown have spent the entirety of the meeting here from HHC from HHC, [applause] which is great. And I want to thank them for being here and for all of their hard work, and for listening to all of you on these important issues. So, we started at 10:00 a.m. It's 4:45, almost seven hours later. I want to thank you all for being here. We're going to do it again in just a couple of months for the Executive Budget, and with that, this hearing is adjourned.

[gavel]

C E R T I F I C A T E

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

Date April 9, 2015